A STUDY OF NIGHT ADMINISTRATION AT BROOKE GENERAL HOSPITAL, FORT SAM HOUSTON, TEXAS

A Problem Solving Thesis

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CHAPTER I

INTRODUCTION

General Information

Quite unlike most businesses, the operation of a hospital requires uninterrupted service twenty-four-hours-a-day, seven-days-a-week. Unfortunately, many hospitals shut down a major portion of their facilities after normal duty hours.[1] However, the pattern of providing patient care, including a full range of services in the evenings and on weekends and holidays, will continue to expand because of the ever-increasing costs of maintaining patients in a hospital.[2]

To insure that the quality of night administration is maintained at an acceptable level, hospitals have attempted various staffing concepts. The most common of these include having the senior nursing supervisor on duty at night assume administrative responsibility;[3] utilizing administrative personnel on the evening and night shifts on an officer-of-the-day duty-roster basis;[4] utilizing administrative personnel on the evening and night shifts on an "on call" basis;[5] and creating a night administrator position.[6] There is another solution which is being currently

attempted which involves the unit-manager concept with a unit-manager supervisor remaining on duty during the evening and night shifts.[7] This solution at present does not always give complete administrative coverage; however, it does give the nursing units an effective, coordinated program for evening and night administration.[8]

The reason that hospitals are attempting to give twenty-four-hour-a-day, on-the-premises administrative coverage is that a lack of competent administration may disrupt hospital procedure, expose the hospital to unnecessary legal risk, or endanger the lives of those for whom care is provided.[9] However, the greatest incentive is having a qualified manager present to prevent problems from becoming unmanageable during the night, thus saving many wasted hours the next working day attempting to rectify the situation.[10] Simply stated, this twenty-four-hour coverage means having one standard of administration for both day and night so that decisions made in both time periods will be consistent with hospital policy.[11]

Hospital Setting and History

Brooke General Hospital had its beginning in 1872, as a station hospital. In 1938, patients were first admitted

to the new hospital--currently called the Main Hospital. The station hospital was redesignated "Brooke General Hospital" in 1946, by the War Department. This designation was made in honor of Brigadier General Roger Brooke, Medical Corps, United States Army, because of the outstanding manner in which he had involved himself with the community during his tenure as hospital commander of the old station hospital from 1929-1933.[12]

Since that time, Brooke General Hospital has grown with the addition of two separate buildings, Chambers Pavilion in 1942, and Beach Pavilion in 1944. These additional buildings create both professional and administrative problems for the hospital staff because of their location in regard to separation of staff and duplication of services, i.e., food service and operating rooms. Brooke General Hospital has also undergone numerous fluctuations in patient load and staff, most recently as a result of the Vietnam War, but also including World War II, and the Korean War.[13]

The current mission of Brooke General Hospital is to maintain and operate 900 beds in support of active-duty Army personnel and their dependents; retired personnel, and their dependents; and other personnel authorized the use of

the hospital.[14] The population served includes approximately 13,800 active-duty personnel,[15] 39,000 dependents of Army active-duty personnel, 38,000 retired members, 17,000 dependents of retired members, and active-duty personnel of other services and their dependents, totaling approximately 108,000.[16]

During the fiscal year 1971, there was a total of 299,580 occupied bed days, with 15,856 admissions, and 1,442 births. Speciality clinic visits, medical examinations, and dispensary visits totaled 861,422.[17] The average daily work load statistics for Brooke General Hospital for Fiscal Year 1971, are reflected in Table 1.

Conditions Prompting the Study

Brooke General Hospital has used the administrative officer-of-the-day (AOD) concept in providing administrative services during other than normal duty hours for many years (Definitions, Appendix A).[18] In this system all company grade Medical Service Corps (MSC) and Adjutant General Corps (AGC) officers are placed on a duty roster in order to provide administrative coverage from 1630 hours to 0730 hours on week days and from 0800 hours to 0800 hours on weekends and holidays.[19]

TABLE 1

BROOKE GENERAL HOSPITAL AVERAGE DAILY WORK LOAD, FISCAL YEAR 1971

Bed occupied	820.8
Admissions	43.4
Births	4.0
Spec. Clinic Visits/Med. Exams/ Dispensary Visits	2,360.1
Pathology Procedures	7,215
Radiology Films Exposed	1,805
Dental Treatments	274
Pharmacy Prescriptions	3,003
Centralized Materials Service Line Items Issued	7,909
Food Service Rations Served	1,204

Source: Personal interview with Management Officer, Brooke General Hospital, February 28, 1972.

This system has provided service to the hospital, but the service has been less than adequate on numerous occasions, thus causing unnecessary work, confusion, and sometimes, embarrassment to the hospital. This less than satisfactory situation prompted the executive officer toward deciding that there must be a better way to provide these services to the hospital.

Statement of the Problem

The problem is to determine the best method of providing administrative services during other than normal duty

hours to Brooke General Hospital, Fort Sam Houston, Texas.

Objectives

The objectives of the study are:

1. To analyze the existing method of providing administrative services to Brooke General Hospital during other than normal duty hours.

2. To examine problem areas unique with Brooke General Hospital for which special consideration is required.

3. To define the scope of administrative services desired during nonduty hours at Brooke General Hospital.

4. To examine alternative methods of providing night administration to Brooke General Hospital.

Criteria

Any proposed solution to the above problem should:

1. Provide for competent, consistent, and continuous in-house administrative service to Brooke General Hospital during other than normal duty hours.

2. Be reasonable in terms of manpower and overall costs.

3. Be in accordance with Department of the Army regulations and publications which govern hospital management.

Limitations

A review of available records and other pertinent data at Brooke General Hospital brought to light the following limitations:

1. Current manpower limitations will not permit the establishment of a new position unless a currently filled position is deleted.

2. Historical data from Brooke General Hospital is relative only to the administrative-officer-of-the-day concept for providing administrative services during other than normal duty hours.

Assumptions

It is assumed that:

1. There will be no change in the number and type of hospital services operated during other than normal duty hours.

2. There will continue to be a sufficient number of Medical Service Corps and Adjutant General Corps officers to sustain a duty roster for AOD and there will be no change in the rank of officers who perform AOD.

3. There will be no significant change in the

patient load or the mission of Brooke General Hospital.

Research Methodology

The initial step was to gain a working knowledge of the administrative services which are required to be provided to Brooke General Hospital during other than normal duty hours.

During the two visits made to Brooke General Hospital, interviews were held with the following people:

1. Executive Officer--to obtain the reasons or conditions which prompted the study and obtain background information on the setting and history of the hospital.

2. Chief, Patient Administration Division--to determine the scope of activities within the registrar field which are performed by the AOD.

3. Assistant Chief, Patient Administration Division--to determine the adequacy of the service provided by the AOD.

4. Management Officer--to obtain statistical information on the Hospital.

5. Assistant Chief, Department of Nursing--to gain insight into the nurses' concept of night administration.

6. Chief, Manpower Branch, Personnel Division, Brooke Army Medical Center--to determine any manpower limitations.

7. Adjutant, Brooke General Hospital--to determine scope of activities in the adjutant's area of responsibility which are performed by the AOD.

8. Chief Clerk, Patient Administration Division--to gain an insight into activities performed by the AOD which carry over into normal duty hours.

9. Executive Officer, Walter Reed General Hospital, Walter Reed Army Medical Center--to determine if a permanent night administrator had been used in a military hospital.

10. Bill Stubbins, Personnel Director, Baptist Memorial Hospital, San Antonio, Texas--to determine the system used by Baptist Hospital to provide night administration to the hospital.

11. Mrs. Ellen Botto, Coordinator of Education, Southwest Texas Methodist Hospital, San Antonio, Texas--to learn something of the unit manager concept of nursing unit administration and its possible relationship with night administration, and to determine the system used by this hospital of providing night administration.

12. Chief, Administrative Services Division, Brooke Army Medical Center--to discuss the possibility of combining the Brooke Army Medical Center "Staff Duty Officer" function with the hospital Administrative Officer-of-the-Day (AOD).

13. Sam Engel, Director, Unit Managers, Lutheran General Hospital, San Antonio, Texas--to determine if there was any relationship between the evening unit manager and a permanent night administrator.

14. Ten officers at Brooke General Hospital who are currently performing the AOD duty--to determine certain facts which could not be extracted from the AOD reports.

An extensive review of civilian and military literature produced very little material written specifically on the subject of night administration. In addition, inquiries were made to the American Hospital Association and the American College of Hospital Administrators on the subject of night administrators with negative answers from both organizations.

A review of hospital records was made to determine exactly what the activities of the AOD have been for the first half of fiscal year 1972.

Finally a questionnaire was sent to civilian hospitals

know to use a permanent night administrator, to civilian hospitals whose method of providing administrative services during other than normal duty hours was unknown and to a Veterans Administration hospital known to be using a permanent night administrator (Appendix B).

The response to the questionnaire was good; however, the answers to the questions varied so widely that compilation of the results was impossible. For example, two hospitals claiming not to have a permanent night administrator, did in fact have individuals working in that capacity even though they were titled "unit manager"[20] and "night business manager."[21] Thus, the questionnaire responses were used for information only (see pages 13 and 14 for the results of a survey in 1969 by the National League of Nursing).

Literature Review

Hospital management is a function which continues throughout the twenty-four hours of the day, seven-days-a-week. This function cannot be confined to the eight hours of the first shift of each day, known as normal duty hours. Hospital administration cannot be proclaimed a profession if administrators fail to support the medical professionals

who do work during other than normal duty hours.[22]

In too many instances the hospital is found without the stabilizing influence of the administrator who is absent during the hospital's nonduty hours. All the professional efficiency of the hospital is concentrated during the day shift with subsequent tapering off in the late afternoon and evenings to a skeletal staff on the "graveyard" shift. While there may be valid justification for the quantitative decrease in personnel during these evening and night shifts, there is no support for any reduction of quality in the evening and night personnel.[23]

The hospital administrator who provides little or no administrative coverage during other than normal duty hours can expect administrative problems to arise during these hours. The problems occur because the administrator for administrative coverage is largely dependent upon the personnel of a department or service which is already required to operate on a twenty-four-hour-a-day basis.[24] These departments are generally more concerned with problems of their own and therefore spend most of their time in their area of responsibility. Thus, they have little time available to pursue problems arising from general hospital operations.[25]

The use of part-time administrative officers for duty on night and weekends is inadvisable because these individuals frequently lack the continuing knowledge of hospital policies, procedures, and resources necessary for proper action. This type of administrative coverage can also leave holidays with less than satisfactory coverage even if night and weekend coverage is satisfactory.[26]

There are three systems in use today that appear to provide the best administrative coverage for hospitals during other than normal duty hours. These are the officer-of-the-day system,[27] the permanent night administrator system,[28] and the "on call" system.[29] The on-call system is basically nothing more than a variation of the AOD system. However, the most common system in use in civilian hospitals is to have the senior nursing supervisor on duty assume night administrative responsibility for the hospital.[30] This is shown to be true in a 1969 survey of 1,172 short-term, general hospitals conducted by the National League for Nursing. In this survey it was found that nursing service took over the administration of one-half of the hospitals surveyed during the evening and night hours on the weekdays and of 40 per cent of the hospitals during the weekends. About

25 per cent of the hospitals using nursing service personnel for administration during the nights on weekdays were large hospitals.[31]

However, various staffing concepts, such as the unit manager, are being tried currently to relieve nurses of administrative responsibilities and since the aim of these programs is full-time coverage, it would appear that the trend is to relieve nursing of as many administrative problems as is possible.[32] One proposal went so far as to recommend that the director of Nursing Services (Chief, Department of Nursing in Army Class II hospitals) be replaced by a Nursing Service manager (nonnurse) and that with the exception of a registered nurse, staff advisor, and the clinical nursing specialists, no nurses be assigned above a "team leader" level.[33]

Footnotes

[1]Michael D. Tyne, Implementation of Unit Management (Columbus, Ohio: Hospital Planning Department, Ross Laboratories, n.d.), p. 18.

[2]Eugene Feldman and Norman G. Hirsch, "Night Administration Must Meet Daytime Standards," Modern Hospital, CX (January, 1968), 80.

[3]Ibid.

[4]James O. Hepner and David A. Gee, "Officer-of-the-Day Gives Hospital Weekend Coverage," Modern Hospital, XCVIII (April, 1962), 108.

[5]Feldman and Hirsch, p. 81.

[6]Ibid., p. 80.

[7]Tyne, p. 18

[8]Personal interview with Mrs. Ellen Botto, Coordinator of Education, Southwest Texas Methodist Hospital, San Antonio, Texas, February 29, 1972.

[9]Warren L. Rutherford, "Can Evening and Night Nursing Supervisors Meet Their Administrative Demands," Hospital Topics, XLI (November, 1963), 33.

[10]Personal interview with Colonel Milton Cohen, Executive Officer, Brooke General Hospital, Fort Sam Houston, Texas, February 28, 1972.

[11]Feldman and Hirsch, p. 83.

[12]Brooke Army Medical Center, Regulation 10-3, "Organization and Functions, Brooke General Hospital, November, 1970, with change 1 dated February 9, 1971.

[13]Personal interview with Major John Candelaria, Assistant Chief, Patient Administration Division, Brooke General Hospital, Fort Sam Houston, Texas, February 28, 1972.

[14]Personal interview with Colonel G. Cardenas, Chief, Patient Administration Division, Brooke General Hospital, Fort Sam Houston, Texas, February 28 and April 10, 1972.

[15]Brooke General Hospital, "Morbidity Report," January, 1972.

[16]Brooke Army Medical Center, p. 7.

[17]Personal interview with Captain Jeff Turner, Management Officer, Brooke General Hospital, February 28, 1972.

[18]Cardenas interview.

[19]Brooke General Hospital, Memorandum 210-1, "Officers of the Day," March 28, 1969, with 2 changes dated April 15, 1969, and February 20, 1970, p. 2; "Special Instructions for the Administrative Officer-of-the-Day (AOD) Adjutant," DA Brooke General Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas, n.d.), p. 1.

[20]Personal interview with Sam Engel, Director, Unit Managers, Lutheran General Hospital, San Antonio, Texas, April 17, 1972.

[21]Telephone interview with Bill Stubbins, Personnel Director, Baptist Memorial Hospital, San Antonio, Texas, February 28, 1972.

[22]"Shame on the Absent Administrator," Hospital (London), LXIII (March, 1967), 83.

[23]Sister M. Theophane, "Wanted: Night Administrator Position Vacant," Hospital Progress, XLI (February, 1960), 55.

[24]"Shame on the Absent Administrator," p. 83.

[25]Hepner and Gee, p. 108.

[26]Ibid.

[27]Ibid., p. 109.

[28]Theophane, p. 55.

[29]Feldman and Hirsch, p. 81.

[30]Ibid., p. 80.

[31]News Section, "Survey Finds Many Nurses Fill Administrative Gaps," Hospitals, XLIII (January, 1969), 114.

[32]C. J. Schumaker and M. J. Wood, "Proposal for Expanding Unit-Management Concept," Hospital Topics, XLVIII (June, 1970), 40; C. Phillip Hannan, "Planning and Implementing a Workable Unit Management System," Hospital Progress, L (May, 1969), 132; Marion G. Egolf, "Unit Management Program Provides More Effective Use of Personnel," Hospitals, XLIII (July, 1969), 78.

[33]Schumaker and Wood, p. 40.

CHAPTER II

DISCUSSION

Existing System

The existing system of providing administrative services to Brooke General Hospital during other than normal duty hours is an administrative officer-of-the-day system. The officers who are used in the rotation on a duty roster basis are company-grade Medical Service Corps (MSC) and Adjutant General Corps (AGC) officers.[1] These officers are relatively junior officers with little or no hospital administrative experience; many of these officers are also specialists in the allied sciences, such as pharmacy, optometry, social work, podiatry, and military community oral health. Though they are certainly competent in their respective speciality areas, they often lack the knowledge and background necessary to make satisfactory decisions on situations confronting them during their tour of duty.[2] The duties which these officers are required to perform are generally in the field of patient administration; during normal duty hours these duties are performed by the personnel

of the Patient Administration Division. Approximately 85 to 90 per cent of the AOD's duties fall into this area while the remaining responsibilities fall under the control of the Hospital Adjutant or the Brooke Army Medical Center Personnel or Logistics Divisions.[3] There are numerous duties to be performed by the AOD:[4] the processing of death cases, to include notifying the next of kin, casualty reporting--if necessary--and partial processing of paperwork involved in disposition of remains is the primary duty of the AOD. These duties include assisting the physician in preparing the necessary paperwork for postmortum examination, and removal of skin and/or eyes. The AOD must also notify the county medical examiner in the event of the death of special types of patients, i.e., suicides, homicides, and injuries to victims when the accidents occur off Fort Sam Houston reservation.[5]

The AOD must notify the next of kin in seriously ill and very seriously ill cases, including casualty reporting if necessary. This duty also includes notification of removal from the seriously ill list or very seriously ill list.[6]

Other primary duties include the depositing of

patients' valuables and currency in the Patients' Trust Fund, reporting unusual occurrences (such as admission of a general officer, thefts within the hospital, or rape) to the appropriate office or headquarters, signing of emergency leaves for patients and staff when deemed necessary by the appropriate supervisor or commander, reporting of equipment failures and emergency facility repairs to the proper office, and the processing of air evacuation requests on emergency patients who must be moved to Brooke General Hospital by helicopter before the next duty day.[7]

The AOD is responsible for any of the numerous administrative problems which may arise during the tour of duty such as receipt and storage of pharmacy items and radioactive materials, furnishing of clinical records to staff members, communications with the LBJ Ranch, clothing and baggage rooms, disciplinary problems, release of medical information, communication with Brooke Army Medical Center Public Affairs Officer, and reporting of AWOL patients to the Provost Marshall.[8]

It is also the AOD who acts as the hospital representative when cases of attempted suicide, drug overdose, and child abuse, and so forth, appear in the emergency

room (see Table 2 for review of AOD Reports).[9]

TABLE 2

ANALYSIS OF AOD REPORTS FROM JULY 1, 1971, TO DECEMBER 31, 1971

Event	Weekend and Holiday	Weekday	Total
Deaths Processed	75	100	175
Seriously Ills Processed	178	210	398
Maintenance Problems	50	40	90
Leaves Handled	35	15	50
Emergency Air Evacuations Processed	4	4	8
Discipline Problems	10	24	34
Miscellaneous*	111	151	262

*Miscellaneous includes a wide variety of activities, ranging from locating beds for the "Professional Officer of the Day" to recording phone calls. The majority is simply listing personnel absent without leave, drug overdoses, child abuses, and attempted suicides in which no action is required by the AOD, other than to record it.

Source: Review of the AOD reports from Brooke General Hospital from July 1, 1971, to December 31, 1971.

The time period covered on the tour of duty is from 1630 hours of the assigned duty day until 0730 hours of the following morning for weekday tours. For Saturday, Sunday, and holidays the duty day begins at 0800 hours of the assigned duty day and ends at 0800 hours the following day.[10] There are at least five officers and NCO's from the Patient

Administration Division who can be called by the AOD at any time of the day or night for advice and instructions, although they are not specifically "on call." The Adjutant of the hospital is also available for matters involving his areas of responsibility, such as leaves, passes, and admission of VIP's.[11]

The AOD is provided a room in the hospital for his use because he is required to remain in the hospital area during his tour of duty. The room is furnished with a telephone, a safe for valuables and money picked up from patients, and a bed. During the tour, the working area for the AOD is either the information desk of the Main Hospital or the Admissions and Dispositions Office.[12]

Administrative support for the AOD comes from three areas: the information specialists who maintain the information desks at the Main Hospital and Beach Pavillion; the personnel in the Admissions and Dispositions Office when any typing is necessary--the NCO in charge of the Admissions and Dispositions night shift is knowledgeable in the areas covered by the AOD and can provide specific information when requested--and the NCOD who is on a tour of duty with the AOD. The NCOD at Main Hospital, an E-6, is responsible for

security, policing of the grounds, and raising and lowering of the flag; while the NCO at Beach Pavillion has these same duties (except for the flag detail) and also aids the AOD in any way that he can, such as collecting patients' valuables, reporting equipment and physical plant problems, and quelling disturbances.[13]

Before an individual is placed on duty as the AOD for the first time, he must receive a detailed briefing from the Hospital Adjutant and the Assistant Chief of the Patient Administration Division on the particular areas which might require his attention during his tour, such as deaths, seriously ill patients, and failure of utilities or equipment. In addition, the new AOD must spend one night (until 2400 hours) on duty with an experienced AOD so that he may gain some experience from the time thus spent. The Adjutant and the Chief of the Patient Administration Division also have a meeting of all personnel who perform AOD on an "as needed" basis; this meeting is usually required about once every six weeks.[14]

These three training devices are considered necessary and effective. However, all parties involved realize that the training does not truly qualify an inexperienced

officer as an expert in any phase of his responsibilities. It is felt that the complexity of the events concerned and the wide range of possible events make a totally effective training program impossible.[15]

The AOD receives from the Adjutant and the Chief of Patient Administration Division three instruction books which are for his use. The instruction book from the Adjutant covers the numerous incidents which can occur in his area of responsibility and gives the required action to be taken. The Chief of Patient Administration Division supplies two books; the first is a set of general instructions and sample forms which apply to most of the areas in the Patient Administration Division responsibility. The second book is a visible file index which specifies the exact actions which are required for some fifteen categories of patients (active duty, dependents, and so forth) in the event of their death. These instructions are very detailed and specific, yet at times to the inexperienced and untrained individual, they can be very complex and difficult to follow.[16]

There is also an alternate administrative officer of the day detailed who can be called in to aid the AOD if necessary, or can replace him if for some reason the AOD

cannot complete his tour of duty.[17] However, the alternate AOD has not been called to aid the AOD in at least three years, based on the memory of the current Adjutant and the Chief of Patient Administration.[18]

The AOD provides his report of the tour's activities to the hospital Executive Officer on Department of the Army Form 8-195 "Report of the Administrative Officer-of-the-day" (Appendix C). In addition, he completes and presents to the chiefs of the various services and divisions numerous items of importance. For example, in the area of patient administration, the "Hospital Report of Death," permission for postmortum examination, and copies of telegrams sent are turned over to the Chief, Patient Administration Division; copies of signed receipts for drugs or equipment are turned over to the pharmacy or the Brooke Army Medical Center Logistics Division; and copies of emergency leaves are turned over to the Adjutant.

The advantages of the AOD system are numerous and are well founded. They include:

1. The physical presence of the AOD in the hospital makes him easily and quickly available when needed. This capacity for first-hand observation and investigation of

situations results in the use of person-to-person administration rather than administration-by-telephone, which is sometimes the result of off-site administrative coverage.[19]

2. The AOD does expand in-house administrative support to the hospital twenty-four hours a day, seven-days-a-week, thus giving complete coverage as far as time is concerned.

3. In an AOD system where only hospital administrative personnel are on the duty roster "the night coverage system is an integral part of the over-all administrative coverage which encompasses the normal working day."[20]

4. The tour of duty as AOD is an important part in the education of all the people who perform the duty. The administrative and nonadministrative officers alike learn something new each and every time they perform the duty.[21]

5. Using the AOD system of night administration requires no additional Table of Distribution and Allowance (TDA) positions within the hospital. Thus, the cost is nominal because personnel already receiving salaries are providing the service.[22]

The disadvantages of this system of night administration are also numerous and extremely difficult to overcome.

They include the following:

1. There are currently twenty-eight officers on the duty roster to act as AOD. Many of these officers are semi-professional personnel without training in administration. Others are students, such as pharmacy and hospital administration residents, who may have not learned the general policies of the hospital management. Less than half of the officers on the duty roster are connected in any way with administration.[23]

2. Many of these officers are very uncomfortable making administrative decisions and thus defer decisions until the next duty day (after they are relieved from duty). Other decisions appear to be made with reckless abandon, apparently with the idea that any decision is better than no decision and that any mistake can be corrected later.[24]

3. Even with the detailed instructions given to the AOD's there is much inconsistency in the manner in which actions are taken and decisions are made. This inconsistency forces the personnel involved with the follow-up in each situation to make a detailed analysis of the action taken or decision made for completeness and accuracy.[25]

4. A serious deficiency results from having the

tour of duty begin at the end of a working day. Obviously, the person performing as AOD is not as alert and rested as one who has not worked all day.[26]

5. The day after an officer serves as AOD is likely to be less than a complete workday for that officer since the officers who perform the AOD duty are usually allowed compensatory time in the morning or the afternoon, even though Brooke General Hospital Memorandum 210-1 "Officer-of-the-Day" does not require it. If the officer does not utilize the compensatory time, he will certainly perform at less than his normal capacity.

Special Considerations for Brooke General Hospital

Brooke General Hospital has numerous unique characteristics which require consideration in order to determine their effect upon night administration. The first and primary consideration is that of the physical plant. Brooke General Hospital is actually three hospitals under one management. The Main Hospital has 245 operating beds, while Beach Pavilion has 422, and Chambers Pavilion has 80. The remainder of the beds are allocated to the medical holding ward, a ward staffed for patients who do not need direct

patient care. The allocation of beds by departments is also split among the three buildings with Main Hospital housing medical, obstetrics-gynecology, pediatric (newborn), and surgical patients; Beach Pavilion housing medical, pediatric, psychiatry and neurology, dental, and surgical patients; and Chambers Pavilion housing only psychiatry and neurology patients.[27]

This splitting of the physical plant causes duplication in many areas, such as operating rooms, food service, radiology, pathology, and pharmacy. There are also many problems generated in the area of patient transportation between buildings.

The area of duplication is of concern to night administration in that the AOD (in the current system) is responsible for all three buildings dispensing direct patient care and, in fact, is responsible for the fifty-seven buildings used by the hospital. If there is a death at Beach Pavilion or a disturbance at Chambers Pavilion, the AOD must attend to it.[28] There is one noncommissioned-officer-of-the-day (NCOD) at Beach Pavilion and one at the Main Hospital to assist the AOD. Chambers Pavilion, with its smaller patient load, has only a charge-of-quarters on duty after

normal duty hours.[29]

There are also four nursing supervisory positions for duty in Beach Pavilion and the Main Hospital during all nonduty hours. Field grade Army Nurse Corps officers and senior NCO's provide this coverage.[30]

The second consideration requiring attention is the organization of Brooke Army Medical Center (Appendix D). Brooke General Hospital is a Class II hospital located within the Brooke Army Medical Center command structure.[31] Because of this, virtually all administrative services except Patient Administration Division, Housekeeping Division, Food Service Division, and Troop Command are not part of the Hospital, but are part of Brooke Army Medical Center (Appendix E). Thus, Brooke General Hospital loses the expertise of many administrative officers on the AOD duty roster because they are assigned to Brooke Army Medical Center.[32]

The United States Army Institute of Surgical Research (USAISR), a Class II unit which does research in cases of burns and renal failure, occupies two wards of Brooke General Hospital with a total bed capacity of sixty. The patients on the "burn ward" have a constant requirement for skin from

human cadavers, necessitating the consent of the legal adult next-of-kin. This requirement, in addition to death and seriously ill requirements generated by the United States Army Institute of Surgical Research, places an added work load on the AOD because the Institute receives administrative support from Brooke General Hospital during other than normal duty hours.

A third area requiring consideration is that Brooke General Hospital is a specialized treatment center and is a teaching hospital; thus the condition of the patients at Brooke General Hospital is of such a nature that a death rate of more than one a day is normal.[33]

The last point requiring special consideration is not unique to Brooke General Hospital alone, but is unique to military hospitals when compared to civilian hospitals. Military hospitals, particularly large speciality hospitals such as Brooke General Hospital, have the almost constant requirement for casualty reporting to higher headquarters when there is a death or when a patient of a particular category (active duty, retired military, or a dependent whose sponsor is overseas) is placed on the seriously ill list.[34] These reporting procedures are complicated and require special knowledge in

determining when to send a report, what information to include, and to whom the report should be sent. These procedures are covered extremely well in the "AOD Instruction Books," carried by the AOD; however, there are numerous situations which occur that are not covered that require the skills of an administrator.

Also in death and seriously ill cases in most civilian hospitals, the necessary action for notification of the next-of-kin, postmortum request, and release of remains are handled by the doctor and nurse concerned or other personnel.[35] In the military hospital most of these problems are handled, at least partially, by the AOD.[36]

Quantity and Quality of Night Administrative Services Desired for Brooke General Hospital

The administrative services provided to Brooke General Hospital during nonduty hours must be equal in quality to the administrative services provided during duty hours. To desire less than this would be to desire inferior services for the patients of Brooke General Hospital and their families.

The hospital commander must have someone to represent him through nonduty hours. "The chief executive

officer shall designate an individual to act for him in his absence in order to provide the hospital with administrative direction at all times."[37] This sentence is extracted from the 1970 Accreditation Manual for Hospitals, and points out the necessity for a responsible individual on duty at all times.

The individual empowered to act for the hospital commander in administrative affairs must be someone who is knowledgeable and responsible. It should be someone who will make decisions and take actions which are consistent with the commander's policies and directives.[38]

This individual must have the complete support of the hospital Executive Officer, the hospital commander's representative for administrative services. He must also be responsible to the executive officer so that meaningful dialogue between the two can be established.[39]

The administrative services during nonduty hours must be responsive to the needs of the patients, their families, the hospital staff, and other headquarters. Inquiries from others must be answered quickly and with some degree of assurance so that the confidence which others have in the hospital is not undermined. Nothing can be less

reassuring to the family of a deceased member than a staff which does not appear professionally or administratively adequate when questions concerning the deceased are asked.

In short, the quality of nonduty-hours administrative services must be adequate to provide satisfaction to the patient, the Executive Officer, and to the hospital departments for which the service is provided. In addition, the individual in charge of night administrative services is responsible for relieving medical personnel of all administrative duties not requiring the expertise of a physician and for such administrative management and nonmedical supervision as is necessary to relieve medical personnel of nonmedical decisions.[40]

The quantity of services provided at night must be sufficient to satisfy the routine, expected situations such as deaths and seriously ill cases, but still have the flexibility to cover the nonroutine matters--such as civil disturbances, emergency operating plans, and admissions of VIP's--for instance, former President Lyndon Johnson. In the routine matters, the Executive Officer has the right to expect complete and accurate actions without assistance, and in the nonroutine matters he should expect that night personnel

on duty be astute enough to seek help if needed.

Since a hospital is a twenty-four hour a day, seven-days-a-week operation, there is a necessity for continuity of operations in both medical and administrative matters. The quality of administrative coverage must be such that this continuity is not lost because of lack of qualified personnel or because of a mistaken idea that as long as the situation does not regress over nonduty hours, all is well.

Modifications of the Current System

The current system of providing administrative coverage during other than normal duty hours can be modified in numerous ways. The Hospital Commander has the resources and authority to initiate the four modifications that will be discussed in this section.

At present there are twenty-eight officers on the Brooke General Hospital AOD duty roster. Of these officers, seventeen are in the allied sciences (pharmacy, social work, and so forth) and eleven are in administrative positions of some type.[41] There are also twenty-two company grade officers of various corps (MSC, Judge Advocate General, and Finance) assigned to Brooke Army Medical Center. These

individuals are in administrative jobs such as logistics, personnel, and comptroller and provide their services to the organizations under the command of Brooke Army Medical Center, including Brooke General Hospital.[42] These officers are currently on the duty roster of "staff duty officer" (SDO) at Brooke Army Medical Center; this duty is considered to be an extra duty somewhat like AOD.[43]

The "staff duty officer's" function is small and is primarily concerned with security within the Brooke Army Medical Center Headquarters building. There is no duty that must be done at a specific time of day or night and there is a noncommissioned officer-of-the-day (NCOD) on duty in the same building, which is adjacent to the Main Hospital building of Brooke General Hospital.[44]

The first modification of the current AOD system considered was to combine the Brooke General Hospital AOD and the Brooke Army Medical Center SDO in order to bring together the administrative expertise of both organizations. There would not necessarily have to be a name change or consolidation as it is a common practice in the Army for one to "wear two hats." The combining procedure would cause no problems in either command which would be insurmountable.

The advantages of this solution are:

1. Brooke General Hospital would gain administrative expertise which would aid in solving problems requiring administrative decisions.

2. This procedure would eliminate unnecessary duplications of like services within Brooke Army Medical Center; for example, the signing of emergency leaves and responding to casualty information requests from other stations.[45]

3. Brooke Army Medical Center officers would become more aware of hospital problems.

The disadvantages of this solution are:

1. The element of inconsistency still exists and is, in fact, magnified because of the fifty different officers performing the duty versus the twenty-eight officers currently carried on the roster.

2. Unit integrity would be broken with officers of one headquarters performing duty in a subordinate unit headquarters.

3. There could be problems caused by non-medical personnel performing AOD since there is a diversity of officer corps assigned to the Brooke Army Medical Center.

4. It would be extremely difficult to maintain policy guideline communication with the Brooke Army Medical Center officers who are even less aware of hospital policies

than are hospital officers.

This modification could be further amended so that the combined listing of fifty officers would be reduced by the seventeen allied science officers from Brooke General Hospital, leaving only the thirty-three administrative officers to perform the duty. As is discussed in a subsequent paragraph, this action is undesirable because of morale problems.

The most common modification of the AOD system in civilian hospitals is that of the on-call system. The variant from the AOD system is the location of the on-call officer which in the AOD system is in the hospital while in the "on call" system, it may be at the officer's home or other approved area.[46] With the work load and the necessity for immediate action at Brooke General Hospital, the "on call" modification would not be suitable for full-time coverage.

A third modification considered was the delection of allied science officers from the duty roster, leaving only the administrative officers on the roster. This solution is undesirable from a morale standpoint because all of the officers are of the same Army branch and the general feeling of MSC officers is that what one must do, all must do. This modification would also require that the officers remaining

on the roster perform the duty more often than they currently do.[47]

The fourth modification considered was to add Medical Service Corps officers in the grades of major and lieutenant colonel to the AOD duty roster. This addition would add experienced personnel to the duty roster, but the total number of officers in this category is small and would make very little impression on the current problems. In addition, the deletion of field-grade officers from the duty roster at the time of promotion to major is an established and cherished tradition among Medical Service Corps officers. The loss of this privilege would create morale problems.[48]

As can be seen by the discussion of the possible modifications to the current AOD system, the inherent weaknesses, such as inconsistent in decision-making, difficulty in communication with officers who perform the AOD duty, and inexperienced officers on the duty roster are not alleviated by the changes and are sometimes magnified by them.

Assistant Chief of Nursing as Night Administrator

As stated previously, the Department of Nursing at Brooke General Hospital has four field-grade positions which provide coverage sixteen-hours-a-day in the Main Hospital

and Beach Pavilion on weekdays and twenty-four hours per day on weekends and holidays. These personnel are exclusively for supervision of the nursing units in their respective buildings. Each shift in each building also has an NCO working with the nurse supervisor.[49]

Quite often in civilian hospitals, the senior nursing supervisor on evening and night duty assumes responsibility in general administrative matters because she is the highest ranking individual on duty.[50] McGibony states that, "During the night shifts the nurse in charge acts as an assistant to the director and may be called upon to represent the administrator for certain functions which may be specifically delegated to her."[51] However, to the hospital staff, the nurse's authority in general administrative matters is often open to question since there is a tendency to regard her as a supervisor of nurses only. In order to overcome this suspicion, it would be necessary for the hospital commander to provide written orders that her authority is complete during the hours of her shift.[52]

Though this method of providing night administration is used extensively in small and medium-size hospitals, in large hospitals with teaching programs it is more realistic to assume that the assistant chief of nursing for evenings

and nights is too fully occupied with her own duties and with Department of Nursing problems to give sufficient attention to general administrative matters.[53] The question of whether general hospital administrative responsibility should be delegated to nursing supervisors should be answered with two questions in mind.[54]

First, can the nursing supervisors be expected to have the training and knowledge to meet the administrative responsibilities of night administration? Secondly, can the nursing supervisors assume the administrative responsibilities without harming their primary responsibility as nursing care supervisors?

In January, 1969, one author wrote:

> Nursing supervisors are engaged in two distinct and different professions, nursing and management; with, if anything, management being the more important to the accomplishment of their principal objective namely, the welding together of people toward the providing of compassionate and effective patient care.[55]

However, since that short time past, the idea of unit managers has come into its own. The thrust of this concept is "the placement of management-trained personnel in professional entities of the health care organization for the management of non-professional activities in those entities."[56] This concept also envisions the unit managers and the unit manager supervisor as part of administration, not as part of

the Department of Nursing.[57] Though this new concept is not the subject of this study, it does show that there is considerable thought being given to new staffing concepts which should shift nursing personnel away from nonpatient care functions.[58] Thus, the trend is to remove administrative responsibility from nurses as much as is possible.[59]

The sole advantage of this solution is that the cost of the service would be nominal because of the use of already salaried personnel. However, even this advantage would be limited since it may become necessary to hire additional nursing personnel because the nursing supervisor would have less time to devote to nursing problems.

The disadvantages of this solution would be numerous. First, Brooke General Hospital is a large teaching hospital, and the evening and night supervisors do not need the added responsibility which would come with this solution. Secondly, nursing supervisors are primarily trained and experienced in matters related to nursing.[60] Thirdly, if this solution were imposed at this time in the federal service, it could further aggravate an already and always existing problem of nursing shortage by requiring that more nursing time be spent in general administrative areas.[61] Lastly, at Brooke General Hospital, the attempted imposition

of this solution would meet much resistance from the Department of Nursing.[62]

The Permanent Night Administrator

Sister M. Theophane said:

> The community which entrusts its sick and injured to the ministrations of a hospital whose daytime performance it had observed, admired, and acknowledged, has a right to comparable competence in administration and care throughout the night. Management, in turn, faces the unequivocal obligation to fulfill those expectations.[63]

The alternatives examined heretofore have placed important administrative responsibilities upon personnel who were either assuming the responsibilities as an additional duty on a duty roster basis or who are already performing a complete eight-hour duty day. With the next alternative, these same responsibilities are placed upon an individual as his primary duty. The alternative is that of a permanent night administrator to provide administrative coverage during other than normal duty hours.

The position of night administrator is unique in its relationship to the key management personnel of the hospital and the employees on the evening and night shifts. Under the supervision of the executive officer the night administrator would be an official, personal representative of the

administration in a wide variety of operational situations occurring during other than normal duty hours. If such a position were created, the person assigned to it would have to be thoroughly familiar with hospital policies and procedures as a basis for evaluation and decision-making. He would have to possess a high degree of administrative judgment, tact, and skill because he would function almost entirely in an advisory role with respect to physicians, supervisors and other hospital personnel, patients, and visitors. His authority would be exerted when such action is necessary to meet an emergency need or when delay would create a significant problem. Even then, his actions should be consistent with the authority and responsibility of the supervisor having administrative jurisdiction over the activities or employees during normal duty hours.[64]

There are no set criteria established in the literature as to when a permanent night administrator is required or even "nice to have" in a hospital. However, at least three criteria should be applied when considering the possibility of establishing a permanent night administrator position at any hospital: the size of the hospital, the volume and nature of night activities,[65] and overall costs and manpower requirements.[66]

Brooke General Hospital is currently operating 900 beds with a bed occupancy of approximately 750. Although no authority has stated that a specific size hospital requires a night administrator, the size of Brooke General Hospital and the complexity of the physical plant would certainly meet the criteria for a permanent night administrator if size and need are directly correlated. However, the size of the hospital is not necessarily the most important determinant in contemplating the services of a qualified administrator for the night staff.[67]

The volume and nature of night operations at Brooke General Hospital are currently dependent upon the level of activity within the hospital itself. The AOD under the current system has no set responsibilities other than the security of the hospital. It is possible that the AOD can spend his entire tour of duty idle, although this is very seldom actually done. There are no plans at the present time to make any change in the number of hospital services and the type of hospital services operated during other than normal duty hours.[68] However, there is certainly the possibility that administrative functions, other than those AOD functions listed on pages 19 and 20, could be placed upon the permanent night administrator to insure that his time would

be well spent. These functions could include total processing of death cases for the Registrar, supervision of a reinforced evening housekeeping staff, and any other job not required to be completed during duty hours.

The third criteria of cost and manpower appears to be a big area of concern. Initially, there would be little chance of reductions in manpower, and all savings would be nontangible benefits as a result of the accuracy and consistency in the work done by the night administrator. However, in the future--after the operation of the night administrator has been evaluated thoroughly--it is possible that some additional responsibilities could be placed there, thus cutting costs elsewhere in the hospital. One hospital surveyed attributed the reduction of night nursing supervisory personnel to the establishment of permanent night administrator positions.[69] It must be remembered also that the hospital is attempting to provide an improved service which will benefit the patient, and that cost must be related to the improved service.

Brooke General Hospital has already experimented with a position entitled "assistant executive officer for Beach Pavilion" with the idea in mind of bringing hospital management to a direct patient care building which is

separated from the Main Hospital. Although the evaluation on this position is incomplete at this time, it would appear that the same concept could be used in establishing a permanent night administrator position. The title of "assistant executive officer for night operations" would be consistent with civilian terminology which empowers the assistant administrator to act in behalf of the administrator in all matters throughout his tour of duty, but keeps him accountable to the administrator (executive officer) for acts performed and decisions rendered.[70] The title "night administrator," however, implies that the individual functions in an associate relationship to the official administrator.[71] For a possible job description of a permanent night administrator at Brooke General Hospital see Appendix F.

The advantages of the "assistant executive officer for night operations" in providing administrative services to Brooke General Hospital during other than normal duty hours are numerous. These advantages are almost completely involved with the idea of consistency which comes from having a limited number of qualified personnel performing the services rather than a large number of personnel with a high turnover rate.

1. Consistency will provide effective continuity

of operations. Brooke General Hospital is operating a twenty-four hour a day hospital, and after-duty hours coverage is not simply a matter of a holding situation or maintaining the status quo.[72]

2. The different hospital elements served by the assistant executive officer for night operations, as well as higher headquarters and other external sources of inquiry, will be provided more accurate, complete, and timely information. This better service will cause less time to be consumed during normal duty hours analyzing action taken and decisions made during the night.[73]

3. The hospital staff will have an individual to whom they can turn when they need help in solving problems. This should give the staff a feeling of assurance in the person of an experienced and qualified individual.[74]

4. The consistency gained with an assistant executive officer for night operations will accord the hospital better reaction time to such problems as emergency operating plans, disasters, and incidents of civil disturbances because there is one person who is fully qualified in charge of the hospital.[75]

5. A program of full-time coverage with an assistant

executive officer for night operations would provide competent, consistent, and continuous in-house administrative services during other than normal duty hours. This would allow on-site problem solving at the time of the crisis rather than after the crisis has passed.[76]

The disadvantages of the assistant executive officer for night operations are primarily concerned with costs and manpower. This is of importance to federal agencies because of the current cutback of the Armed Services and Civil Service.[77]

1. Finding a qualified individual who is willing to take the job is difficult because of the night, weekend, and holiday duty hours.[78] However, this problem could be alleviated in military facilities with the assignment of junior Health Care Administrators who may eventually become Hospital Executive Officers. These officers, because of the scarcity of Executive Officers positions generally desire jobs in this career field.[79]

2. The establishment of assistant executive officer for night operations positions would not initially reduce manpower requirements or tangible costs, and in fact may increase them. This presumption is based upon the fact that

the service is now provided "free" by the AOD.

3. The assistant executive officer for night operations could be viewed as a quasi-administrator whose authority is limited to a specific time period and whose decisions are subjected to review and validation by the executive officer.[80]

4. If the assistant executive officer for night operations is not brought into the mainstream of hospital policy-making, it is possible that he will become ill-informed on current hospital policies.[81]

At Brooke General Hospital, any decision to implement an assistant executive officer for night operations would involve at least two variables: the personnel category to be used in the position or positions (commissioned officer, NCO, civil service), and the amount of coverage desired. The amount of coverage desired would determine the number of positions to be established.

The category of individual desired for the position of assistant executive officer for night operations would be greatly influenced by the personal philosophy of the hospital commander and the executive officer. However, there are several facts which should be considered in making the decisions.

First, duties which can be assigned to each category of personnel must be considered. For example, commissioned officers can be placed on orders as adjutants, whereas civilian employees and NCO's cannot.[82] If either of the latter two categories were used, some other commissioned officer must be available for actions requiring an adjutant (such as ordering removal of organs and tissue from a human cadaver).

Secondly, the cost of the program must be considered. There are definite overlaps in the pay scales of officers, NCO's, and civil service employees which make the factor difficult to analyze until the grade level of personnel desired has been determined. Captain, E-8, and G.S.-9 are the grades which probably would be the most suited in each of the three personnel categories.

The ideal amount of coverage for the assistant executive officer for night operations would be sixteen hours per weekday and twenty-four hours per day for weekends and holidays, or 128 hours in a week which has no holidays. According to the Army Staffing Guide, it would require four positions to give this full-time coverage to the hospital.[83] There are methods which can be used to supplement the assistant executive officer for night operations. However, it

should be remembered that for each decrease in time covered by permanent-party personnel, there will be a corresponding decrease in efficiency.

Footnotes

[1]Brooke General Hospital, Memorandum 210-1, p. 2; "Special Instructions," p. 1.

[2]Cardenas interview.

[3]Cohen interview.

[4]"Special Instructions"; "Special Instructions for the Administrative Officer of the Day--Patient Administration Division," DA Brooke General Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas, n.d.

[5]Cardenas interview.

[6]Candelaria interview.

[7]Cardenas interview; Peronal interview with Major Joe Guinn, Adjutant, Brooke General Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas, March 1, 1972.

[8]Ibid.

[9]Cardenas interview.

[10]Brooke General Hospital, Memorandum 210-1, p. 4.

[11]Candelaria interview; Guinn interview.

[12]"Special Instructions," p. 2.

[13]Cardenas interview.

[14]Ibid.; Guinn interview.

[15]Candelaria interview; Guinn interview.

[16]Ibid.

[17]Brooke General Hospital, Memorandum 210-1, p. 3.

[18]Carderas interview; Guinn interview.

[19]Feldman and Hirsch, p. 81.

[20]Ibid.

[21]Cohen interview.

[22]Personal interview with Miss Kay Berman, Chief Manpower Branch, Personnel Division, Brooke Army Medical Center, February 29, 1972.

[23]Guinn interview.

[24]Candelaria interview.

[25]Personal interview with MSG. Robert Tanksley, Chief Clerk, Patient Administration Division, Brooke General Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas, March 1, 1972.

[26]Feldman and Hirsch, p. 83.

[27]Cardenas interview; Brooke General Hospital, Memorandum 40-2, "Hospital Bed Capacity and Bed Distribution," September 25, 1969, p. 4.

[28]"Special Instructions."

[29]Brooke General Hospital, Memorandum 210-3, "Non-commissioned Officers of the Day," March 11, 1969.

[30]Personal interview with LTC. Ellen Gann, Assistant Chief, Department of Nursing, Brooke General Hospital, Brooke Army Medical Center, February 29, 1972.

[31]Brooke Army Medical Center, Regulation 10-2, "Organization and Functions, Headquarters Brooke Army Medical Center," December, 1971 with change #1 dated February 15, 1972, p. 7.

[32]Ibid.; Brooke Army Medical Center, Regulation 10-3, p. 11.

[33]Cardenas interview

[34]Army Regulation 600-10, "The Army Casualty System," June 7, 1968.

[35]Letter from Bexar County Hospital District, San Antonio, Texas, in response to questionnaire, March 2, 1972; Letter from Cook County Hospital, Chicago, Illinois, in response to questionnaire, April 3, 1972; Letter from Baylor University Medical Center in response to questionnaire, March 21, 1972.

[36]"Special Instructions."

[37]Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 1970 (Chicago: Joint Commission on Accreditation of Hospitals, 1971), p. 23.

[38]Baylor University Medical Center,Job Description for Evening Administrator, Job number 07-25, May 5, 1970.

[39]Cohen interview.

[40]"Station Policy," Memorandum #42-71, Veterans Administration Hospital, Houston, Texas, December 1, 1971.

[41]Guinn interview.

[42]Brooke Army Medical Center, Regulation 10-2, p. 7.

[43]Personal interview with LTC Roger Rivard, Chief of Administrative Services, Brooke Army Medical Center, April 10, 1972.

[44]Ibid.

[45]Ibid.

[46]Feldman and Hirsch, p. 81.

[47]Cohen interview; Guinn interview.

[48]Guinn interview.

[49]Gann interview.

[50]Feldman and Hirsch, p. 80.

[51]John R. McGibony, Principles of Hospital Administration (New York: G. P. Putnam's Sons, 1969), p. 427.

[52]Malcolm T. MacEachern, Hospital Organization and Management (Chicago: Physicians' Record Co., 1957), p. 113.

[53]Feldman and Hirsch, p. 80.

[54]Rutherford, p. 33.

[55]Melvern J. Gross, "Should Nurses Be Involved in Management," Hospital Management, CVII (January, 1969), 59.

[56]Schumaker and Wood, p. 39.

[57]Egolf, p. 79; Hannan, p. 136; Tyne, p. 9.

[58]Schumaker and Wood, p. 40.

[59]Notes taken by John W. Robinson, LTC., Unit Management Institute, San Antonio, Texas. Presented by: Texas Society for Hospital Nursing Service Administration and Texas Hospital Council of Hospital Nursing, October 7-8, 1971.

[60]Feldman and Hirsch, p. 80.

[61]Schumaker and Wood, p. 40.

[62]Gann interview.

[63]Theophane, p. 55.

[64]Baylor University Medical Center.

[65]Theophane, p. 56.

[66]Berman interview.

[67]Theophane, p. 56.

[68]Cohen interview.

[69]Engel interview.

[70]"Duties of Assistants," Modern Hospital, XCIV (January, 1960), 49; Theophane, p. 55; Sister M. Theolinda Moore, "Needed: Assistants or Assistance?," Hospital Topics, XLVII (October, 1969), 49.

[71]Theophane, p. 56.

[72]Letter from Veterans Administration Hospital, Houston, Texas, March 2, 1972, in response to questionnaire.

[73]Tanksley interview.

[74]Theophane, p. 56.

[75]Ibid.

[76]Letter from Cook County Hospital.

[77]Berman interview.

[78]Feldman and Hirsch, p. 80.

[79]Cohen interview.

[80]Feldman and Hirsch, p. 80.

[81]Letter from Baylor University Medical Center.

[82]"Assignments, Details, and Transfers Officers," DAR 614-100 dated January 21, 1969, with change 3 dated September 22, 1971, pp. 304.

[83]Berman interview.

CHAPTER III

CONCLUSION

As with other large Class II Army hospitals, Brooke General Hospital has a definite need for an individual whose primary function is to provide general and medical administrative support to the hospital during other than normal duty hours, and who, as such, is responsible for all administrative actions taken and decisions made during other normal duty hours. The best method of providing this type of administrative service is with the permanent night administrator. No other alternative can give the expertise that is needed in order to provide the desired service.

Recommendations

The following recommendations are presented:

1. That the present system for providing administrative services to Brooke General Hospital during other normal duty hours be discontinued.

2. That a permanent night administrator system be instituted to provide administrative services during other than normal duty hours and that positions necessary to

institute the system be converted from current hospital positions.

3. That the job title for the night administrator position be "Assistant Executive Officer for Night Operations" and that the supervision of these individuals be with the hospital executive officer.

4. That further studies be conducted to determine:

a. The category of personnel best qualified to perform in this capacity and the appropriate rank and/or pay grade.

b. The current hospital positions that are best suited for conversion to the permanent night administrator system.

c. The optimum number of hours' coverage necessary to provide the best service at the lowest cost.

d. What additional responsibilities can be placed upon the "Assistant Executive Officer for Night Operations."

APPENDIX A

DEFINITIONS

DEFINITIONS

The following definitions are provided for terms that will be used throughout this thesis:

Administrative Officer-of-the-Day (AOD)--a company grade Medical Service Corps (MSC) or Adjutant General Corps (AGC) officer who is responsible for administrative coverage of Brooke General Hospital during other than normal duty hours. This is an additional duty, not a full time job for one individual.[1]

Administrative Services--any and all of the services within the hospital that can be considered as nonmedical, usually classified under general administration and medical administration. General administration includes the office of personnel, logistics (or supply), comptroller, and so forth, while medical administration includes the administrative responsibilities encountered in the nursing unit.

Army Class II Hospitals--the group of Army hospitals which come directly under the command of the Army Surgeon General. These hospitals are generally large, specialized treatment centers with teaching programs. Brooke General Hospital is included in this category of hospitals.

Casualty Reporting--the various reports made to the Department of the Army Casualty Branch on seriously ill patients and deaths which occur in the hospital.

Company Grade Officer--a commissioned officer in the grade of second lieutenant, first lieutenant, or captain.

Field Grade Officer--a commissioned officer in the grade of major, lieutenant-colonel, or colonel.

Non-Commissioned-Officer-of-the-Day (NCOD)--an NCO designated to work with the AOD. His duties are generally security-oriented, rather than administration-oriented.[2]

Other than normal duty hours--Monday through Friday, 1630 hours to 0730 hours; Saturday, Sunday, and holidays, 0800 hours to 0800 hours.

Footnotes

[1]"Special Instructions," p. 1.

[2]Brooke General Hospital, Memorandum 210-3, p. 1.

APPENDIX B

QUESTIONNAIRE PREPARED BY THE WRITER CONCERNING THE BEST METHOD OF PROVIDING ADMINISTRATIVE SERVICES TO A GENERAL HOSPITAL DURING OTHER THAN NORMAL DUTY HOURS

QUESTIONNAIRE PREPARED BY THE WRITER CONCERNING

THE BEST METHOD OF PROVIDING ADMINISTRATIVE

SERVICES TO A GENERAL HOSPITAL DURING

OTHER THAN NORMAL DUTY HOURS

1. What method does your hospital use to provide administrative services during other than normal duty hours?

2. What benefits do you feel that you receive from this type of system?

3. What problems, if any, do you have with this system?

4. Is the unit manager concept used at your hospital, particularly in connection with the night administrator?

5. What are the responsibilities of your night personnel? Do any of these responsibilities carry over into normal working hours?

6. If the answer to question five does not include some partial processing of death cases and seriously ill cases, who does the necessary notifications and other paperwork? (This is one of the most important functions of the administrative officer-of-the-day at Brooke General Hospital.)

7. How many employees fill your night and weekend positions and does this give seven-day-a-week coverage? For how many hours per day?

8. If a permanent night administrator system is used, what grade is the night administrator, and how does this grade compare with other administrative personnel in the hospital?

9. Please send copies of any job descriptions and regulations which pertain to the positions used for administrative coverage during other than nonduty hours.

APPENDIX C

DA FORM 8-195 REPORT OF ADMINISTRATIVE OFFICER OF THE DAY

REPORT OF ADMINISTRATIVE OFFICER OF THE DAY

(AR 40-2)

PERIOD COVERED	
FROM *(Hour & Date)*	TO *(Hour & Date)*

Complete in single copy only. Submit to Executive Officer upon completion of tour of duty. Attach copies of all messages sent or received with notation of action taken where appropriate.

HOSPITAL

1. HOSPITAL	HOUR OF INSPECTION	RESULT *(Include needed repairs and any fire or safety hazards noted)*
2. P&N WARDS PRIS WARD	HOUR OF INSPECTION	RESULT
3. GUARD-HOUSE	HOUR OF INSPECTION	RESULT *(Include status of guard book)*
4. GROUNDS	HOUR OF INSPECTION	RESULT
5. MOTOR VEHICLES	HOUR CHECKED	RESULT *(When applicable list of vehicles will be attached)*
6. GUARD	HOUR OF INSPECTION	RESULT

7. INSPECTION OF MESSES — HOUR — HOUR

TYPE OF INSPECTION	SAT-ISFAC-TORY	UNSAT-ISFAC-TORY
a. QUALITY OF FOOD CHECKED		
b. QUANTITY OF FOOD CHECKED		
c. SANITATION		

EXPLAIN DEFICIENCIES NOTED

9. RETREAT	10. REVEILLE
HOUR	HOUR

8. ADDITIONS TO SERIOUSLY ILL LIST AND DEATHS*

NAME	WARD	ADMIN ACTION COMPL
SERIOUSLY ILL		
a.		
b.		
c.		
d.		
e.		
f.		
DEATHS		
g.		
h.		

REMARKS *(Comments, recommendations, unusual circumstances, etc. Use reverse side if necessary)*

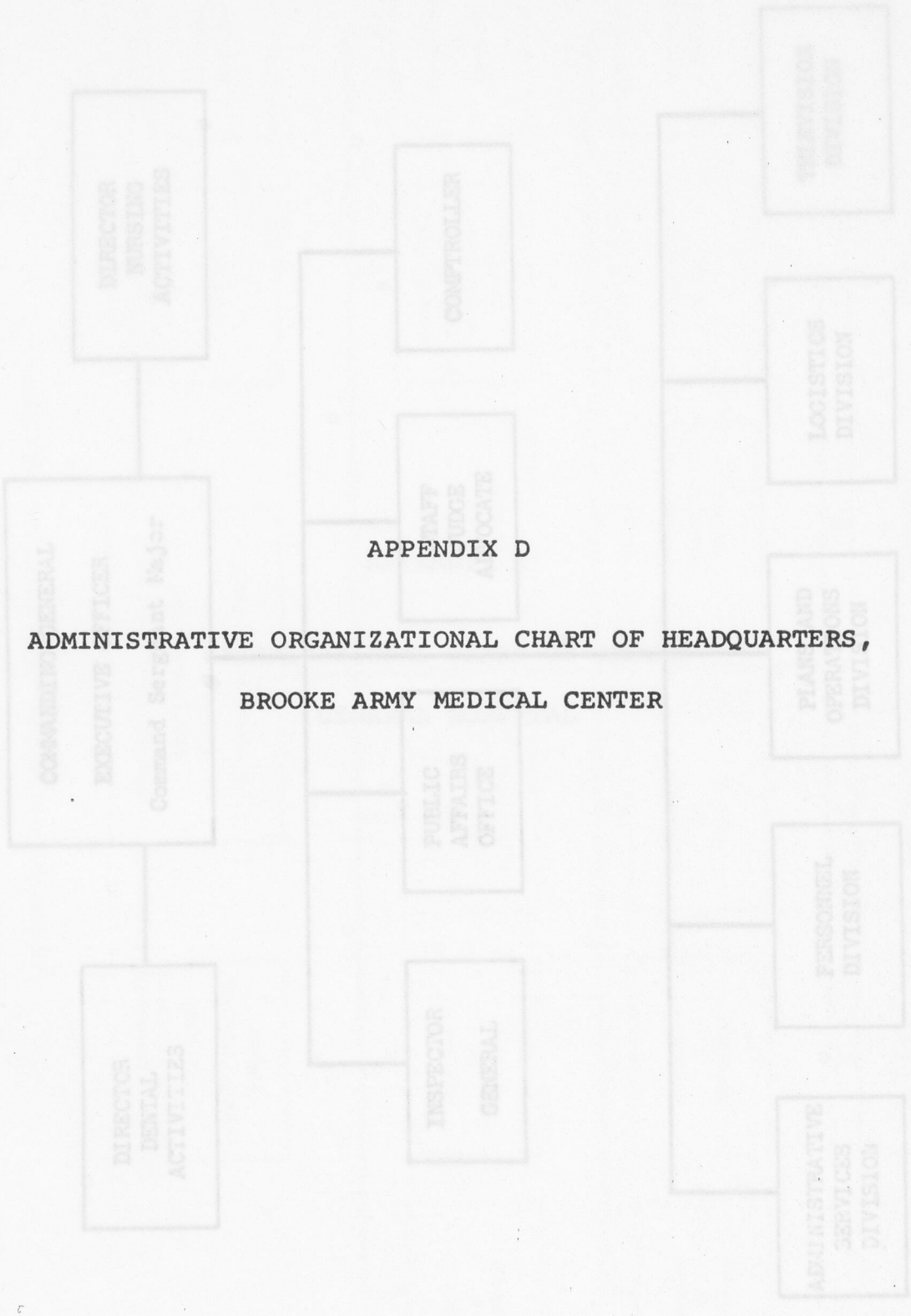
PRINT OR TYPE NAME & GRADE OF ADMIN OFFICER OF THE DAY	SIGNATURE

*IF ADMINISTRATIVE ACTION IS NOT COMPLETED EXPLAIN IN REMARKS SECTION.

DA FORM 1 FEB 54 8-195 REPLACES DA FORM 8-195, 1 MAR 48, WHICH IS OBSOLETE GPO 931978

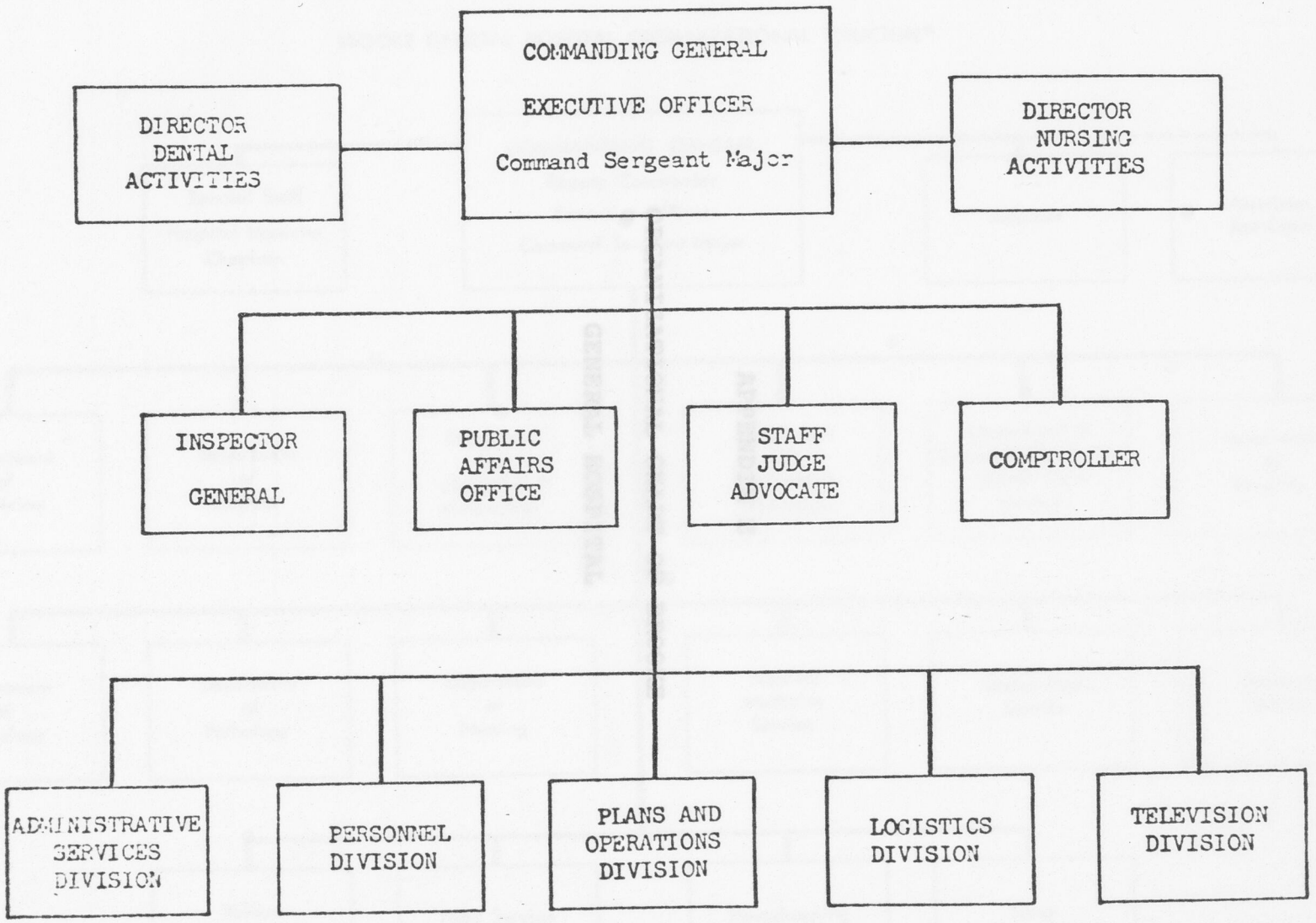
APPENDIX D

ADMINISTRATIVE ORGANIZATIONAL CHART OF HEADQUARTERS, BROOKE ARMY MEDICAL CENTER



Source: Brooke Army Medical Center Regulation 10-2, "Organization and Functions, Headquarters Brooke Army Medical Center," December, 1971 with change #1 dated February 15, 1972, p. 6.

HEADQUARTERS BAMC, ORGANIZATIONAL STRUCTURE

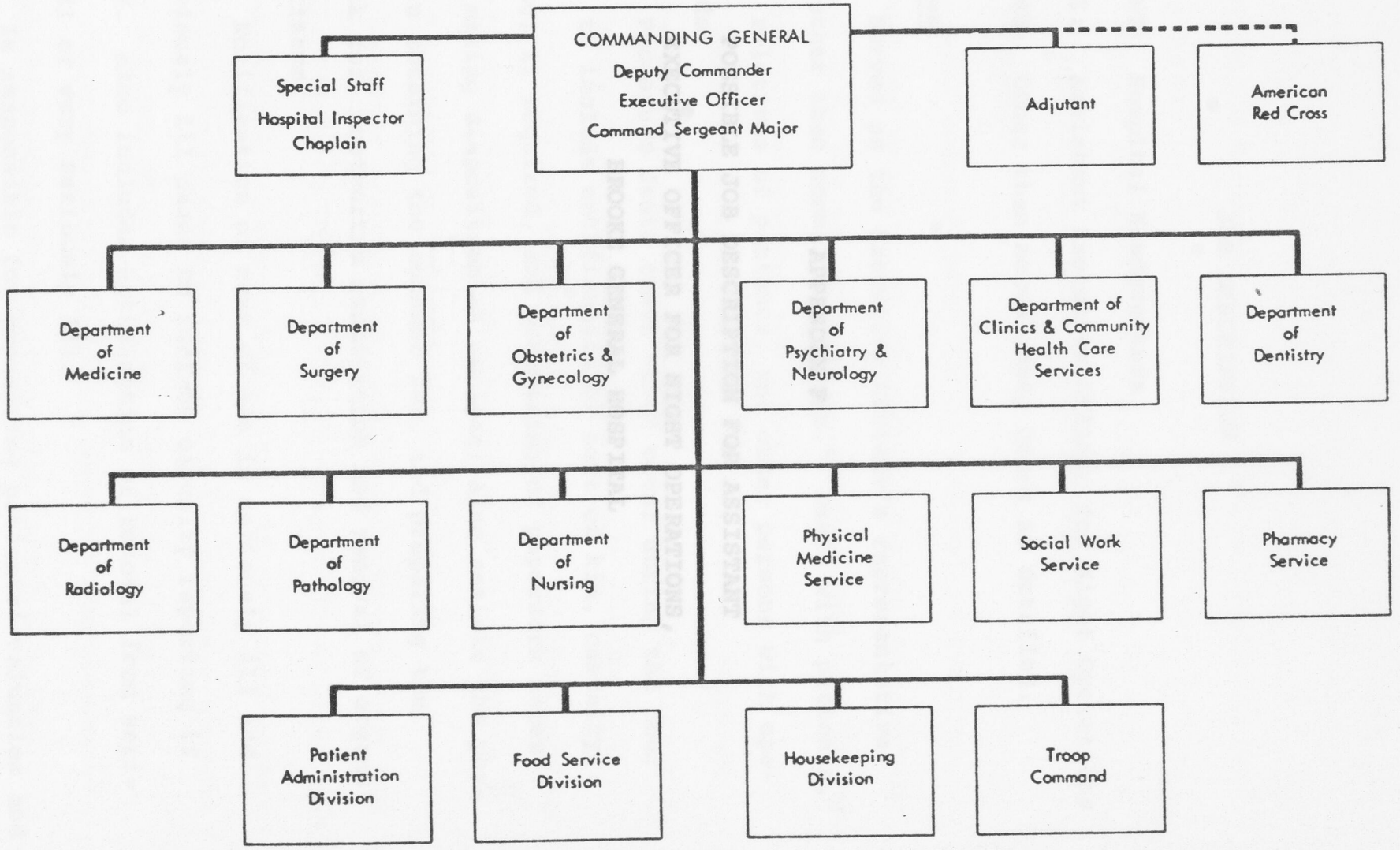


Source: Brooke Army Medical Center Regulation 10-2. "Organization and Functions, Headquarters Brooke Army Medical Center" December, 1971 with change #1 dated February 15, 1972, p. 6.

APPENDIX E

ORGANIZATIONAL CHART OF BROOKE GENERAL HOSPITAL

BROOKE GENERAL HOSPITAL ORGANIZATIONAL STRUCTURE*



*Letter from Office of the Surgeon General, Department of the Army, dated May 17, 1971, deletes Pediatric Service from Department of Medicine and establishes it as the Department of Pediatrics.

APPENDIX F

POSSIBLE JOB DESCRIPTION FOR ASSISTANT EXECUTIVE OFFICER FOR NIGHT OPERATIONS, BROOKE GENERAL HOSPITAL

JOB DESCRIPTION

DEPARTMENT: Hospital Headquarters

JOB TITLE: Assistant Executive Officer for Night Operations

DUTY HOURS: Other than normal duty hours as detailed.

Job duties

Serves as the Executive Officer's representative during "other than normal duty hours." Deals with patients, doctors, relatives of patients, and other persons with special needs.

Processes death cases which occur during the tour of duty, to include notification of next of kin, casualty reporting, if required, and processing of paperwork necessary in making disposition of remains; also assists the physician in obtaining the consent for, and preparing the paperwork for, postmortum examination and removal of organs and/or tissue.

Notification of next of kin in seriously ill and very seriously ill cases to include casualty reporting if required. Also includes notification of removal from seriously ill or very seriously ill.

Is responsible for depositing patients' valuables and

currency in the Patients' Trust Fund during other than normal duty hours.

Reports equipment and facilities repairs to the proper office and authorizes emergency repair of such when deemed necessary.

Makes informal tours of the hospital to evaluate cleaniness and security, to make an administrative presence known and felt, and to serve as a communications link between the employees and hospital management.

Turns in unusual incident reports to the Hospital Executive Officer. Also turns in a report of all activities to the Executive Officer at the end of each tour of duty.

Prepares and signs emergency leaves for both patient and staff when deemed appropriate and after consultation with the appropriate commander or supervisor.

Receives emergency air evacuation requests from 5th U.S. Army Surgeon's Office and from other sources, usually civilian medical treatment facilities. After consultation with physicians requesting evacuation and physician accepting the patient, will set up the evacuation if approved.

Takes action on all of the numerous administrative problems which occur during other than normal duty hours

with special emphasis on relieving medical personnel of all administrative decisions and actions that is possible. Performs other duties as assigned.

Education, training and experience

Should have at least two years of college, but preferable a Baccalaureate Degree. Should be experienced in some phase of hospital administration, and must have a general knowledge of all phases of administrative functions within the hospital. Should be capable in problem-solving, in meeting with and counselling personnel, and in consulting with professional managers, and in establishing sound rapport with persons with a wide variety of educational, professional, and economic characteristics.

Worker characteristics

Requires a high degree of emotional stability. Must be objective, poised, tactful, and dignified in his conduct. Must have the ability to work effectively with others. Must demonstrate ability, imagination, integrity, initiative, and show an interest in self-development. Must be able to communicate both orally and in writing.

Job relationships

Workers supervised: Acts in an advisory capacity for all

departments operating during tours of duty.

Supervised by: Executive Officer.

Promotion to: (dependent upon category of personnel selected for the job).

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ABSTRACT

A STUDY OF NIGHT ADMINISTRATION AT BROOKE GENERAL HOSPITAL, FORT SAM HOUSTON, TEXAS

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirements for the Degree of Master of Hospital Administration

by
Captain William E. Ethington, MSC

August 1973 80 Pages

A copy of this document may be obtained from University Microfilms, University of Michigan, Ann Arbor, Michigan 48108.

The problem was to determine the best method of providing administrative services during other than normal duty hours to Brooke General Hospital, Fort Sam Houston, Texas.

Research methodology included a review of pertinent civilian and military professional publications; interviews with military and civilian personnel familiar with, and engaged in, providing administrative services to their hospitals during other than normal duty hours; a study of applicable Department of the Army regulations and publications; and an analysis of available statistical reports from Brooke General Hospital.

The study concluded that the best method of providing administrative services to Brooke General Hospital during other than normal duty hours is a system using permanent night administrators.

It was recommended that the hospital discontinue use of the administrative officer-of-the-day and institute a permanent night administrator system of providing administrative services to the hospital during other than normal duty hours.