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Employees Involved in Work Space Design

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What Will It Mean For Health Care?

Employees need role in design of work space

BY FRANKLIN D. BECKER

PLANNING

Program involves entire staff in the planning of changes in the working environment, with resultant improvement in morale

The people most involved with the day-to-day operation of a facility and with the direct delivery of health care services are often ignored in facility planning and management. However, increased demand by employees everywhere for greater participation and control over their work, coupled with the increasingly high proportion of total costs represented by salaries and wages, makes imperative the development of new approaches to facility planning that involve staff in decisions about their work environment and that utilize both the staff and hospital resources to their fullest extent.

The premise is simple. Hospitals are fiercely competing for patients, and patients are increasingly aware as consumers of the quality of care they are purchasing. The quality and stability of staff contribute significantly to patients' perceptions of the quality of health care they receive. Staff, in turn, want to work in situations where they feel they can comfortably and efficiently serve patients, and attain their own sense of professional standards and growth. Any program that helps staff meet these objectives is likely to reduce costs and improve the quality of care rendered to the community over the long run.

THE STUDY

To test some of the effects of a creative facility planning program involving staff in environmental decision making and to clarify some of the administrative issues related to such a program, we initiated a small-scale prototypical program in a medium-sized hospital in upstate New York.

The hospital was originally built in the 1930s as a tuberculosis hospital. Around 1950, it had outlived its usefulness and was renovated as a general hospital. The hospital now has 201 beds, 37 bassinettes, and more than 600 employees. In addition to radiology, electrocardiology, laboratory work, and two family medicine centers, it provides medical, surgical, obstetrical, pediatric, and emergency services. The interior is dimly lit as part of an effort to conserve energy, the furniture is shabby and nondescript, and walls are green and gray. Nursing units have long corridors. At the time we began the study, plans were being developed for a new hospital immediately adjacent to the existing one.

Two basic procedures were used to solicit information and ideas from staff. A questionnaire asked staff to indicate for each area of the nursing unit any environmentally related problems, the sources of the problems, and any suggestions for ideas for resolving them. All staff received these questionnaires. A smaller sample of the staff, from every level in the organizational hierarchy and from every hospital service (nursing, housekeeping, maintenance), was invited to participate in a series of approximately two-hour workshops. Persons who agreed to participate in these sessions filled out a questionnaire similar to the one other staff members received and brought it to the workshop. We deliberately separated staff into "affinity" groups (for example, nurses at one organizational level, housekeeping employees, and administration) that met separately so that staff would feel less inhibited about expressing opinions. Preliminary interviews had made clear the strong antagonisms among different staff groups.

During the workshop sessions, a series of slides of different hospital, work, and living environments was shown. Participants were asked to respond to the slides in terms of appearance, functionality, symbolism, or any other dimension that was relevant to them. The purpose of this part of the session was to make concrete words, concepts, and images that the facility planning team and hospital staff might use in similar ways but that, on closer examination, might turn out to have very different meanings or characteristics. What is "bright and cheery" to the staff person, for example, may be gaudy to the facility manager; conversely, a design that expresses "professionalism" to the facility planner may seem impersonal and institutional to the staff member.

The workshops and questionnaires, in combination, provided a forum for detailed staff feedback, drawing on

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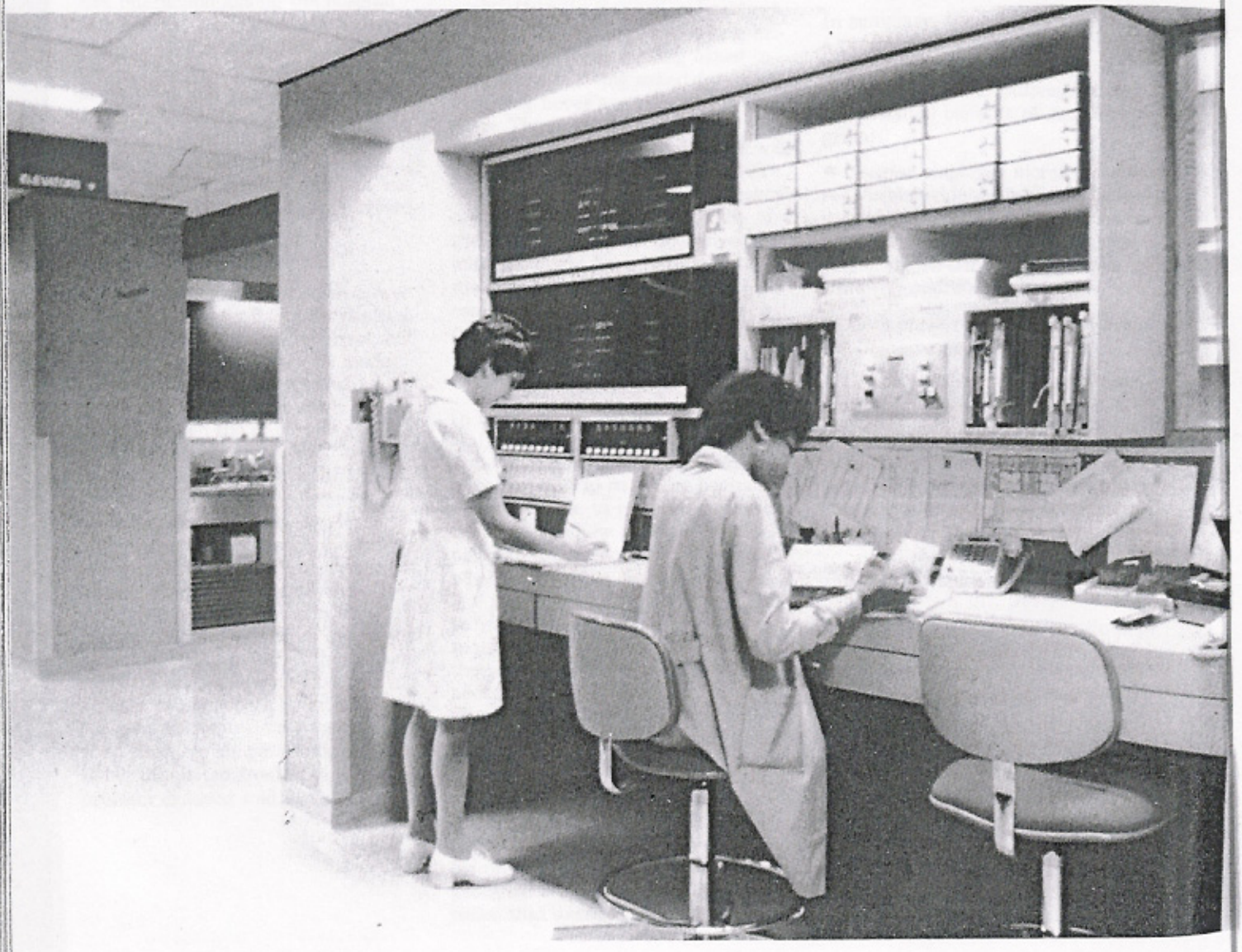
their day-to-day experience. Both the questionnaires and the information generated in the workshops were used as a basis for identifying problems and potential solutions to them. Based on information generated through these techniques, on our own observations, on available environment-behavior research, and on informal interviews with patients, staff, and visitors, our design team developed preliminary design solutions. Using color perspective drawings, the preliminary designs were then shown to the different user groups and to the hospital administration.

Decisions about what changes would be included were based on two criteria: (1) votes of department heads and (2) priority checklists filled out by patients, staff, and visitors. Very few conflicts occurred among the groups. In most cases, once the design team explained the reason for a change and showed that the problem could be solved without creating new problems, the change was accepted. Division heads worked together to accommodate staff needs.

Design changes occurred in the central corridor, the nurses' station and kitchenette, the patients' lounge, the visitors' waiting room, patients' bathrooms, and in three patient rooms. Most of the changes were cosmetic, including paint, murals, and wall hangings. Corridor lighting was changed, and the nurses' station received functional improvements: tack board space, carpeting, and shelving. Different furniture, not new furniture, was provided in the lounges and in the nurses' kitchenette.



Design changes that were made in the nurses' station, based on input from the nurses, included, among other things, more shelving and more tackboard space.

The costs of the renovation were minimal (approximately $3,000). All the labor was provided by hospital maintenance staff. Existing organizational resources (normal maintenance budgets and discarded or underutilized furnishings) also were used. For organizations and institutions with dwindling budgets our study suggests that a relatively large source of ideas, skills, and materials are untapped.

FINDINGS

The results of the assessment of the program showed that the renovation improved staff morale and reduced tension from high noise levels; made the hospital seem more progressive and modern; improved staff relationships; and, for patients, made the hospital seem less impersonal and bureaucratic. The facility management program provided a focus for positive interaction among the hospital services and facilitated cooperative problem-solving among division heads. New sets of expectations about what was possible and feasible developed. Changes in visitors' and patients' use of lounges were also observed. Not surprisingly, evaluation of the physical environment was far higher for staff on the renovated unit than on any of the others.

IMPLICATIONS

Administrators will lose some power by shifting responsibility for decision-making to the nursing unit level, but some decisions can never be made very effectively by centralized administrators. A correlation needs to be made between the importance (and to whom) of a decision and the level in the hierarchy at which different decisions are made. For example, some decisions made by top-level administrators (for instance, nurses' pants must be one inch above the top of their shoes) might easily be delegated to lower levels in the hierarchy. The point often overlooked by administrators is that these seemingly trival concerns may become significant to employees because they are constant irritations to which they often see simple solutions. Being prohibited from solving the problem or being told to work through long bureaucratic procedures not only is frustrating but becomes one of a number of clues that employees use to interpret the level of concern that they think supervisors or top-level administrators have for employees.

Our data suggest that participation may be less important for some persons than for others. Generally, those who do not expect to influence the decision-making process and who feel that their being excluded is legitimate are less concerned about participation than those who do expect to influence such decisions. Staff members generally expect to be able to influence decisions affecting their work.

This is not to say that, given the opportunity to participate, all staff will. For voluntary participation to occur, individuals must feel that the time and effort they devote will have some effect. In institutional settings, most staff members have a long history of either never being asked to participate or being asked for input that they never see reflected in decisions. The hospital in this study was no exception. While people were willing to complete a survey, they were not eager to participate in workshop sessions that required two hours of their own time. More extensive commitment might have been possible at the time the initial renovations were completed, because this was the first time staff at all levels believed that their opinions were going to be reflected in environmental changes.

In institutional settings where few staff members believe their participation will have any impact, some kind of celebration to mark the beginning of the process, to generate enthusiasm, and to allow potential participants to experience for themselves what some of the changes may be like might be useful. Because participation in environmental decision making is an integral component of the work routine, time must also be allocated to staff who want to or are chosen to participate in any kind of program. Asking them to contribute their own time conveys the impression that the effort is not sanctioned by supervisors or administrators.

CREATIVE PLANNING

No organization should wait until problems are so obviously dysfunctional that drastic solutions such as major renovations or moves to new facilities are initiated. It is essential that administrative mechanisms be created for the continual management of environmental change. Loss of productivity, lowered morale, and general dissatisfaction that accumulate over time can be addressed as the problems occur through an ongoing facility planning program. The value of an in-house program (even one supported by a network of cooperating hospitals) is that the staff has continual access to an onsite troubleshooter. The in-house facility planner trained in environment-behavior studies, who may hold other traditional responsibilities as well, becomes the liaison among all components of the hospital staff. To avoid conflict of interest, this program should not be attached to any particular staff function, such as nursing or housekeeping.

In summary, the costs of developing a program to implement solutions identified by staff, patients, and visitors may be far outweighed by the potential benefits of such a program:

- Greater employee morale as they see visible evidence in their physical surroundings that administration is listening to and responding to employee suggestions for improving working conditions.
- More creative and effective use of existing space and equipment.
- Greater patient satisfaction stemming from improved physical surroundings and a happier staff.
- Improved community image because of the responsiveness of the hospital to both staff and community input.
- More cooperation among hospital staff members.

As long as hospital costs continue to increase at an alarming rate, employees continue to demand more participation in work-related decisions, and patients continue to critically assess the relation between services bought and received, a facility planner specifically trained in environment-behavior studies should be a component of every hospital. ■