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Dual Management at the Department Level

Those responsible for running a department repeatedly come up against the limits of practicability on many levels. Fixed-term projects can often be very helpful here - they allow people to familiarise themselves with a new situation and examine to what extent things have improved (or not). In this sense not only should strengths be reinforced, but above all, weaknesses should be given all the support they need to become strengths.

Also, the fact should not be overlooked that a department, as “part” of a whole, must act in the spirit of the whole and also receive instructions in this spirit. The balance between this “recipient situation” and independence in organising and implementing the tasks on behalf of the people entrusted to us is one of the key elements of department management.

Current developments in the health sector show a trend towards:

Shorter stays in acute hospitals;

An increase in age-specific illnesses (dementia etc.);

More multimorbid patients in acute hospitals;

An increase in chronic diseases and the need for care, and

A demographic shift in our society.

These changes can also be felt in the departments. The potentials of the organisation department therefore need to be utilised and developed. However, effective management and a “learning” organisation are also required.

Nurse and Doctor Cooperation

In the field of dual management at department level (doctor and nurse), the significance of the profitability dimension in management is on the rise, as are “soft skills” such as social competence and conflict resolution. Nothing new there, but the optimal cooperation of medical professional groups, especially between nurses and doctors, is indispensable. Working processes must be coordinated and evaluated on a regular basis. At the same time there should be no “taboo subjects”, potential sources of danger or actual mistakes, and the “courage to admit when you don’t know something”, must be highlighted as central themes.

Guidelines

In Vienna’s hospitals, process, structures and framework guide - lines have been recently implemented to effectively carry out shared activities between medicine and nursing. These guidelines are based on the results of the project “Improving the quality of training of trainee doctors”. The medicine and nursing framework aims to further develop and redefine the quality of medical and nursing services, as well as the form of cooperation between professional groups.

Mistakes and Minimising Risk by Applying the 4-Eyes “Hands” Principle

The aim of the “morning work” guideline is to improve patient safety in the field of medical “morning work”. The period from 7.00 to 9.00 a.m. has been defined as a potentially dangerous time. It was therefore decided that doctors and nurses should carry out their routine morning work together.

However, this 4-eyes principle is also applied as a quality assurance measure following on from morning work in potentially dangerous situations such as administering stored blood, chemotherapy and the like. These dangerous situations are determined by each department, including all relevant professional groups. This department- specific regulation is on display on the ward and should be brought to the attention of everyone. It is checked to ensure it is up to date as part of an annual multi-professional department discussion.

The 4-eyes principle makes patient safety during potentially dangerous activities the focus of attention.

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Admission and Discharge Management

The admissions discussions of nurses and doctors have been coordinated. Duplications of work are thus avoided. Patients have to be informed of the importance of their attendance at the scheduled visiting and treatment times at the informed consent discussion, provided this is not prohibited for medical organisational reasons. Each department must define the admission and discharge process in writing admissions planning and discharge management are organised on a multi-professional basis. In the case of discharge management, particular attention is also paid to the social needs of patients following their in-patient treatment. To that effect, cooperation is sought out and upheld within the established area, home-helps, rehabilitation centres and individually with family members. A gradual transition from the residential care of hospitals to the extramural supply chain is essential; to offer patients the highest possible quality of care and to make the best possible use of all associated resources.

Improving Cooperation Between Professional Groups

Planned minimum presences of employees of all professional groups should be laid down in writing and adhered to for each operational unit. In addition, multi-professional workflows are coordinated and established in a spirit of process optimisation. Team development processes are promoted (e.g. joint team meetings, joint supervision, multi-professional further training).

Target Agreements

Each year target agreement talks are held between the dual management of the departments and their colleagues in hospital management. Department and investment budgets with regard to the hospital's predefined economic plan, targets in relation to bed and staff management, possibilities for optimising methods of billing medical services, and various content-based objectives (relating to complaints management, risk management, and quality management) are discussed and agreed.

Department Budgets

The operating expenses budget for drugs and medical treatment requirements is broken down on the basis of figures and performance plans at department level. Monthly controlling overviews and close doctor, nurse and administration cooperation, allow anomalies to be identified promptly and countermeasures introduced. On top of this it is vital that innovations in treatment are planned in advance and implemented accordingly.

Internal hospital committees (e.g. committee for new medical consumables) or standardisation groups for various areas maintain close contact with the departments' dual managements. Improvements can easily be achieved here through feedback mechanisms.

Monthly controlling information and associated controlling talks with the department management are necessary to identify and fathom anomalies and jointly take appropriate control measures. Savings in the department budget are available to the department for other purposes (investments, further training, etc.). The budgetary funds saved must also be distributed and prioritised consensually per department.

Investment plans are prioritised and applied for jointly with consideration for reinvestments and new purchases in the medicotechnical sphere, amortisation projects and facilities (with regard to the "hotel components" and nursing requirements).This planned "bottom–up" budgeting is checked for plausibility internally and discussed and negotiated with the owner each year.

Bed and Staff Management

Staff deployment planning in the medical and nursing services must be planned, coordinated, and organised jointly. This is increasingly important because flexible working hour models are being pushed through, and at the same time over-long daily and weekly working hours are to be reduced. Because of the increasing flexibility, also with regard to the utilisation of operational spaces, functional bed and staff management in situ is essential.

With the support of the administration, various working hours models are being adapted to the requirements of each department and implemented accordingly. Here too it is increasingly worthwhile first planning such models as pilot projects, analysing the results and then implementing them in, where necessary, improved form.

To organise patient care as efficiently as possible, an evergrowing number of services are being offered at daily clinics (daily admissions for suitable operative or non-operative services) or at weekly clinics (service spectrum of smaller plannable treatments with no more than five-day stays in a continuous operation early Monday to Friday evening). Naturally, achieving this optimal patient mix to maximise utilisation (day patients, week patients, normal ward operation) requires a professional department and admission/ discharge management coordinated across all professional groups.

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Conclusion

The many examples cited show that managing the core tasks of hospitals' individual departments is becoming increasingly important. A harmonic and coordinated dual management scheme in collaboration with other operational centres appears essential for the benefit of patient care, patient safety and satisfaction, as well as for economic success.

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