IMPACT OF A CRITERION BASED PERFORMANCE APPRAISAL SYSTEM IN A 400 BED HOSPITAL IN OKLAHOMA

By

MARGARET ANNA THIELEN CHRISTENSEN

Bachelor of General Studies
Wichita State University
Wichita, Kansas
1978

Master of Education
Central State University
Edmond, Oklahoma
1984

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Graduate College of the
Oklahoma State University
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Thesis Approved:

William R. Venable
Thesis Adviser

Melvin D. Miller

Jeanine M. Rhea

James P. Key

Norman N. Durham
Dean of the Graduate College

DEDICATION

This research study is dedicated to my aunt, Miss Josephine Thielen, who by her example of lifelong learning, provided me with the inspiration, courage and fortitude to accomplish this endeavor.

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This research study is the completion of a very exciting and rewarding educational experience. It has been successfully completed only with the help and support of many special people. I would like first to express my sincere appreciation to my committee for their help, guidance and support. I want to express a special thanks to Dr. William R. Venable, my committee chairman and dissertation advisor. Thank you for your interest, support, and ability to provide the "push" I needed to complete and document this study. To Dr. Key for your belief and encouragement that this type of study could be done successfully, to Dr. Jeanine Rhea who helped me better understand the obstacles that I would need to overcome to succeed in a "man's world", to Dr. Melvin Miller for serving on my committee when a vacancy occurred and for your helpful suggestions along the way, thank you all.

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CHAPTER I

INTRODUCTION

In 1980, the Joint Commission on Accreditation of Hospitals (JCAH) established a new standard for hospital accreditation. It suggested that all personnel within the institution be evaluated according to their job descriptions. Three years later, the standard was changed to read that all nursing personnel were to be evaluated using behaviorally stated standards and criteria.

> An annual evaluation must be criteria-based and shall relate to the standards of performance specified in the individual's job description (JCAH 1983, p. 113).

In January 1987, the same standard is to be applied to all personnel within acute care hospitals.

As a result of these changes, a model criterion-based performance appraisal system (CBPAS) was developed. The system included analysis of the job, identification of standards and criteria, development of forms and a performance evaluation process. In order to utilize this system in the health care industry it was necessary to assess the effectiveness of the performance appraisal process.

Statement of the problem

The problem this study addressed was that acute care hospitals lacked data to compare the relative effectiveness of criterion based and non-criterion based performance appraisal systems.

Purpose of the research

The purpose of this study was to determine the difference in the validity, reliability, leniency, central tendency and halo effect of CBPAS and a non-criterion based performance appraisal system (NCBPAS) in the nursing department of a 400 bed non-governmental hospital in Oklahoma.

Hypotheses

This study had the following hypotheses:

Ho 1. There is no significant difference between the validity of CBPAS and NCBPAS at the .05 significance level.

Ho 2. There is no significant difference between the reliability of CBPAS and NCBPAS at the .05 significance level.

Ho 3. There is no significant difference between the leniency bias of CBPAS and NCBPAS at the .05 significance level.

Ho 4. There is no significant difference between the central tendency bias of CBPAS and NCBPAS.

Ho 5. There is no significant difference between the halo effect bias of CBPAS and NCBPAS.

Assumptions

The following assumptions were made:

1. CBPAS was implemented and managed according to written procedure.

2. Evaluation of performance was accomplished according to written procedure.

3. The department selected for study was representative of the other departments in the hospital.

Limitations and scope

The limitations and scope of the study were:

1. The population under study was limited to those persons employed by Mercy Health Center for five years or longer.

2. The population was limited to those in the nursing areas.

3. The study measured the performance recorded during the period of four years.

4. Increased frequency of evaluation from yearly in NCBPAS to quarterly in CBPAS may have contributed to the differences in the performance appraisal scores.

5. Increased number of raters from one in NCBPAS to four in CBPAS may have contributed to the differences in the performance appraisal scores.

Definitions

The following definitions of terms were furnished to provide, as nearly as possible, clear concise meaning of the terms as used in this study.

Central Tendency. The tendency to rate all subjects performance around the middle of a rating continuum.

Criterion. An item which can be observed and can indicate whether a standard has been met.

Criterion based performance appraisal system (CBPAS). A process that measures employees performance based on standards of behavior. It includes quarterly reviews of employee performance each of which is completed by a different rater.

Fiscal Year. The period of time from July of one year to the July of the next year reflected by the year date of the last July.

Halo Effect. The tendency to rate subjects' performance based on one rather than all performance dimensions.

Joint Commission on Accreditation of Hospitals (JCAH). A board whose mission is to improve the quality of care

and services provided in health care settings through a voluntary accreditation process.

Leniency. The tendency to rate the performance of all or most of all subjects above the mean.

Licensed Practical Nurse (LPN). A practical nurse who is a graduate of an approved school of practical nursing and who is licensed to practice as a practical nurse.

Non-criterion based performance appraisal system (NCBPAS). A process that defines and evaluates employee performance based on traits and value judgments. Yearly review of a employee's performance is completed by the immediate supervisor with verbal input from selected individuals.

Nursing Unit. An organized jurisdiction of nursing service in which nursing services are provided on a continuous basis and under the direction of an administrative supervisor.

Performance. How an employee accomplishes a job.

Performance appraisal. The evaluation or judgment of whether a job has been done in a way to meet the standards.

Percentage of salary increase. A percentage based on employee base salaries. This amount is awarded an employee at the completion of an evaluative period or merit year as earned by evaluation of performance. This amount then becomes a part of the base salary for the next evaluative period or merit year.

Registered nurse (RN). A nurse who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse.

Reliability. The ability of a system to consistently measure performance the same way.

Standard. Conditions that exist when the work has been done in an acceptable manner at a desired level of performance.

Validity. The ability of a system to measure what needs to be measured.

Summary

There was an organizational need to provide information regarding the effectiveness of a criterion performance appraisal system. This study was done to provide such information. It demonstrated the relative effectiveness of CBPAS as opposed to NCBPAS. The areas of effectiveness investigated were reliability, validity, leniency, central tendency, and halo effect.

CHAPTER II

LITERATURE REVIEW

This section reviews literature and previous studies regarding performance, its measurement and the effects of the process of measuring it.

Historical background

Fromm (1947, p.230) stated, "the wish to make productive use of his powers is inherent in man." Performance appraisal is one of the ways to measure this productivity.
Before 1960, performance appraisals were controlling tools used to support management (Eichel and Bender, 1984). Appraisal systems were the basis for salary administration, retention, termination and promotion of employees. Causes of unsatisfactory performances were thought to be caused by shortcomings of management and the organization itself, individual personal shortfalls of the employee and influences from outside the organization that affected the employee (Steinmetz, 1969; Nagel, 1953).

Studies by Peter Drucker (1954) brought the importance of goal setting, accountability and behavioral measurement to the fore. As management theory as a whole progressed, changed and developed, so did employee evaluation.

> The transformation of American society since the turn of the century has been breathtaking. We have progressed from a basically agrarian society to a dynamic, industrial society with a higher level of education and standard of living than was ever thought possible. In addition, our scientific and technical advancement staggers the imagination (Hersey and Blanchard, 1977, p.1).

The appraisal process broadened to include development of the individual, organizational planning, and improving quality of worklife (Eichel and Bender, 1984). Motivation of employees also became increasingly important. In his expectancy theory of motivation, Vroom's (1964, p.128) premise was the employees must expect that "their positive performance will lead to positive rewards before they will expend the effort that leads to productive performance."

In the 1980's, literature stressed that performance appraisals should increase employees' productivity, effectiveness, efficiency and satisfaction (Brinkerhoff and Kanter, 1980). The legal ramifications such as the Equal Employment Opportunity legislation and court decisions also were prevalent. Failure of appraisal systems to do what they were expected to do, appraise performance fairly, led to legal guidelines and extensive litigation (Field and Holley, 1975; Kleiman and Durham, 1981).

The National Research Council (1979), recommended that government agencies support research aimed at improving knowledge about the sources of productivity change. Recent research has identified problems that have been discussed in

the past which continue to plague management. In a classic article by McGregor (1957), it was suggested that placing major responsibility on employees for the establishment and development of the appraisal process might help overcome the difficulties found in the appraisal system. In 108 Ohio hospitals, a study was conducted that measured managerial functions and measurement as related to performance and productivity (Foreman, 1969). A variety of other studies regarding performance, its measurement and the process have been reported and are related in later sections of this review (Haynes, 1973; Conant, 1973; Stocks, 1981; Edwards, 1983; Taylor, 1984).

Performance appraisals

The purpose of an effective appraisal system provided for more than just the measurement of an employee's performance. They provided the information that identified the employee's development needs. Satisfaction was created when an employee was recognized for the good work done (Herzberg, 1966). An effective system also provided the documentation necessary to justify legal defense and appraisal fairness (Brinkerhoff and Kanter, 1980). Information for selection decisions, salary review, career counseling, and use as a tool for subordinate participation were also frequently mentioned (Stewart and Stewart, 1977; Edwards, 1983).

According to del Bueno (1977):

> Theoretically, evaluation is a positive experience. It is supposed to provide an opportunity to set goals; reinforce positive behavior; correct unacceptable behavior; and provide the basis for advancement, reward and recognition (p.21).

Reports of studies completed showed results that with most appraisal systems, the employees were evaluated by their immediate supervisor. The reasoning was that this was the person closest to the worker, knew what the worker should do and how it was to be done. The supervisor knew what the person needed to do in order for the stated goals to be reached (Henderson, 1984). However, it was found that supervisors can not objectively observe and measure the multidimensions of a person's job performance. Bedeian (1976) believes that the immediate supervisor provides an invalid source of information due to personal biases and undermines the measurement process.

Edwards and Sproull (1985) state,

> Traditional appraisal systems which require the supervisor alone to measure performance against a set of objectives, then rank individuals and distribute rewards accordingly, often result in unfair or indefensible judgments (p.28).

For this reason, many researchers encouraged the use of multiple raters and measurements (Lubben, Thompson and Klasson, 1980). This method was thought to improve fairness; improve the visibility of the quiet, shy performers; improve comparability among employees; reduce the judge-role of supervisors; and reduce rating errors (Edwards, 1985). Woods and Dillon (1985) reported that an effective system provided

honest feedback so that a person can improve individual capabilities on the job and by doing so are able to maintain and encourage higher performance levels.

Performance measurement

Productivity has been defined as, what is produced, in relation to what is consumed in order to produce it (Dobbs, 1976). Job performance was then directly related and, in some of the literature, the same as productivity. Other terms that were also intermingled in the reports were evaluation and appraisal. This review concentrates on how to measure the output of a person on the job as related to what is to be accomplished.

Fivors and Gosnell (1966) agreed that evaluations should be a constant and continuing process not just a day of reckoning which is feared. Sherman (1967) advocated that an appraisal of a person's performance stimulated the achievement of excellence. He believed that the "excellent" employee be rewarded with salary raises and promotion based on merit. The use of colleague control rather than hierarchical control was also advocated. Miljus (1970) concurred that goals may be satisfied when an environment contains realistic objectives, the necessary resources, an adequate reward structure, and the involvement of the employees. Kelly (1974) argued for operational audits which measured equipment and personnel performance against operating

standards.

Literature described the ways in which performance should be measured. Smith and Brower (1977, p.55) insisted that the "emphasis must be on performance, not personality." According to del Bueno (1979), personality traits or characteristics were not appropriate content for evaluation because validly or reliably of measurement could not be established. Henderson (1984) disagreed and stated that traits could be transformed into behaviors that could be measured.

The measurement of performance based on standards received much support (Kane, 1979; Smith and Brower, 1977; Lubben, Thompson and Klasson, 1980). Performance standards could provide action plans for achieving spending reductions and could be key tools to obtaining efficient operations (Durant, 1981). Precise and well-identified standards and criteria, coupled with a good compensation program and adequate financial controls could lead to improved performance (Sloma, 1980; Meidan, 1981; Latham and Wexley, 1981).

Kirby (1980) incorporated adult learning principles in to his appraisal system. He stated that self-diagnosis, the use of experience, and feedback are but a few of the considerations to be held when attempting to improve the measurement of performance.

Another factor that was dealt with at great length in measuring productivity was the identification of who is to

do the measuring. Fritz (1977) maintained that involving employees in performing a self-appraisal is a positive step in developing an effective system.

Stock (1981) researched the use of single or multiple measurements of performance evaluation and concluded that multiple measurements were far superior to single measurement.

These various perspectives on who was to rate the performance of employees provides ample support that the supervisor is not always the only qualified rater. Numerous studies also conclude that more than one look at a persons performance gave a more valid view of how a person was performing and provided a basis for improvement.

Performance appraisal biases

Literature regarding the problems of measurement of performance was also reviewed and the illusion of accuracy, lack of performance documentation, recency, primary effects, halo and horn effects, unclear measurement criteria and value judgment variance were but a few of what were perceived as problems with many of the systems in place today (Odiorne, 1965; Conant, 1973; Henderson, 1984).

McQuire (1980) reported that appraisal systems fail because the rater must evaluate for two audiences, the ratee and the rater's supervisor and the result satisfies neither. Rubin (1982) discussed the various errors that can occur in

the appraisal process if they are not considered when the system is designed. Leniency error is when all ratees are rated too high. Central tendency occurs when all scores are centered around the mean. Halo error is the rating that is based on one good aspect of job performance rather than an independent rating of all important aspects of the job performance. The horn effect is the opposite, the rating is based on the one aspect of job performance that was judged as poor performance. Recency effect occurs when the evaluation is based on the most recent impression. The spillover effect occurs when past ratings are reflected in the present rating.

Henderson (1984) reported on the technical problems of measuring performance. He identified the following.

1. Accurate and precise description of job content.

2. Identification and weighing performance standards.

3. Allocation of sufficient resources and other support systems.

4. Non-job-related contributions that influence productivity.

5. Measurement processes and rating instruments.

6. Use of raters who have had the opportunity and ability to rate performance.

7. Timing of the performance review.

8. Training of involved personnel.

Teel (1980) identified four problems which concerned performance appraisals. First, it was difficult to arrive

at an overall performance evaluation system. Second, getting the managers to follow the strict merit philosophy was often impossible to do. Third, obtaining employee involvement in the appraisal process took time and money the organization was unwilling to spend. And the fourth problem encountered involved reconciling developmental and administrative requirements.

The error of leniency was first described by Kneeland (1929, p.356) as "the tendency of raters to rate well above the midpoint of the scale." This phenonomon was also defined statistically as a shift in mean rating from the midpoint of the scale in the favorable or unfavorable direction (Bernardin, La Shells, Smith and Alvares, 1976; Taylor and Hastman, 1956).

There were a variety of reasons that existed that caused leniency to occur. Bass (1956) stated that the raters may feel that anyone under their supervision who is rated poorly will reflect on the raters own worthiness. He also stated that the rater may feel that the poor performers have already left the organization or it may be that the raters want to make the most politically advantageous decision.

Central tendency had many of the same causes as leniency. It was the tendency to rate all subjects around the mean of a rating continuum and not to use the extremes. This reduced the amount of confrontation that a supervisor

might have to encounter (Saal, Downey, and Lahey, 1980). Guilford (1954) concluded that central tendency errors may occur merely because the rater does not know the ratee well enough to judge the subordinate's true performance.

Halo effect occured when the rater did not differentiate among scale items, or dimensions of the evaluation, but merely rated the individual based on a global impression (Holzbach, 1978). Halo effect was also defined by several researchers as the standard deviation across dimensions of a rater's rating of a particular ratee (Bernardin and Walter, 1977; Borman, 1975; Ivancevich, 1979).

Several procedures were designed to reduce the biases that occurred in appraising the performance of employees by supervisors. Forced choice eliminated some of the rater bias by reducing the rater's control over the ratings (Cascio, 1982).

Summary

A review of literature identified that performance appraisals were a continuing and ever present concern. The factors that made an effective system and the factors that did not make an effective system were described by many authors. There was not one system that was suitable for all. This study used those factors indentified through the literature review to be important in developing an effective system when designing the criterion based performance appraisal system.

CHAPTER III

METHODS AND PROCEDURES

The purpose of this study was to determine the difference in the validity, reliability, leniency, central tendency and halo effect of a criterion based performance appraisal system (CBPAS) and a non-criterion based performance appraisal system (NCBPAS) in the nursing department in a 400 bed acute care hospital. NCBPAS was in effect during FY83 and FY84. CBPAS was utilized for the measurement of performance in FY85 and FY86. Five factors were identified as important in evaluating appraisal systems. They were validity, reliability, leniency, central tendency and halo effect (Borman, 1974; Kane and Lawler, or 1979). These were the factors tested by this study for CBPAS and NCBPAS.

Population

The subjects studied were nurses who had been employed by the hospital for five years or more. They included Licensed Practical Nurses (LPNs) and registered Nurses (RNs). The RNs were both staff nurses and those designated as teamleaders. The only function performed by the teamleaders that differed from those performed by the

staff nurses was that the teamleaders made out the daily work assignments. They did not assume any supervisory role. Table I identifies the number of nurses employed on each nursing unit. They are separated and recorded according to their job title of RN, LPN or teamleader. The largest nursing unit was the nursery followed by the pre/post surgical unit. The rehabilitation unit was the smallest.

Table II identifies the breakdown of the number of subjects included in the study. They are again identified by job title and unit. The pre/post surgical unit and the obstetrical/gynecological (ob/gyn) unit had the largest number of subjects and the rehabilitation unit the smallest. Information regarding the performance of the subjects was taken from personnel records and yearly merit review tabulations.

Non-criterion based performance appraisal system

NCBPAS consisted of a review of an employee's performance done yearly at the completion of the employee's merit year. This performance review was conducted by the employee's supervisor who solicited input from selected individuals. Examples of individuals who were selected included charge nurses, other supervisors and employees' peers. In some instances no input was requested. The employee's performance was scored based on whether various performance dimensions were judged superior, above average,

TABLE I

NUMBER OF NURSES EMPLOYED BY NURSING UNIT

Nursing Unit	RN	LPN	Teamleaders	Total
Cardiac	24	4	6	34
Ob/Gyn	25	9	10	44
Oncology	10	6	5	21
Post Surgical	7	15	12	54
Rehabilitation	5	2	0	7
Nursery	50	9	9	68
Surgery	32	2	2	36
Special Care	17	4	9	30
TOTAL	190	51	53	294

TABLE II

NUMBER OF NURSES EMPLOYED MORE THAN FIVE YEARS BY NURSING UNIT

Nursing Unit	RN	LPN	Teamleaders	Total
Cardiac	7	1	4	12
Ob/Gyn	12	4	5	21
Oncology	9	2	1	12
Post Surgical	12	11	8	32
Rehabilitation	5	1	0	6
Nursery	10	5	1	16
Surgery	12	2	2	16
Special Care	7	1	5	13
TOTAL	74	26	28	128

average, below average or poor. The supervisor assigned an amount of salary increase pay to be awarded based on the supervisor's judgment of overall performance. For the purposes of this study merit pay is referred to as percentage of salary increase.

Performance dimensions included job knowledge, attitude, judgment, adaptability, initiative and dependability. For this study all the performance dimensions but dependability were assigned points of one to five depending on how the supervisor judged the performance. Appendix B lists the parameters supervisors used when judging performance in this system. A score of one designated poor and a score of five represented superior. The dimension of dependability was based on the number of absences recorded for the employees. A score of one equalled nine or more absences and a score of five equalled no absences. Appendix C illustrates the breakdown of the interim numbers.

Criterion based performance appraisal system

CBPAS consisted of a process that reviewed employee performance quarterly. Each review was completed by a different rater. At the completion of the employee's merit year the supervisor used the points assigned by the system to figure the percentage of salary increase the employee had earned.

CBPAS used the performance dimensions of assessment,

planning, implementation, evaluation, participation and noncompliance. The performance dimensions of assessment, planning, implementation and evaluation were scored by assigning points to the percent of compliance a person attained at the end of a merit year. A score of one indicated no compliance while five was assigned for 100% compliance. Participation was scored by the number of inservice or continuing education programs attended. A score of one equalled attendance at no programs, while five equalled attendance at four or more programs.

The performance dimension "noncompliance" was assigned points according to the number of demerit points recorded for the subject during the year. Demerit points occured when there was documentation that a policy or particular requirements were breached. A score of one was assigned to a total of demerit points exceeding 15. A score of five was assigned to zero demerit points. Appendix C illustrates how the interim numbers were distributed.

Development and Implementation

A job analysis was completed for the job categories of registered staff nurses and licensed practical staff nurses working in medical-surgical nursing units. The analysis consisted of asking nursing personnel to relate what they perceived as ideal performance and to state everything in behavioral terms.

Workers were asked to contribute their time to the project which consisted of a single two-to-three hour workshop and four or five shorter meetings. The workshops were facilitated by persons who had no personal investment in the outcome. The facilitators were nursing personnel from other departments within the hospital that were not involved with the study. They also possessed active listening, interpersonal and group process skills.

Once all the tasks were listed, the tasks were reviewed and grouped into categories and a standard was developed for each. The written standards were approved by both the employee group and management. These same groups were also involved in weighing each standard. The nursing standards were established to reflect the standards as set by the Joint Commission on Accreditation of Hospitals (JCAH) (1984, p.114), "Individualized, goal directed nursing care shall be provided to patients through the use of the nursing process."

Audit and evaluation forms were developed and training sessions were scheduled to provide all employees involved with the opportunity to examine and to obtain information relevant to the entire system. A total of twenty five training sessions were held at various times of day and night.

On March 1, 1985, a pilot study was done that included selected Registered Nurses (RN). The forms were finalized

and the process was in full operation on all the nursing areas by June 1, 1985. The supervisors received a copy of the final evaluation form and four audit forms at the beginning of each employees' merit year. One audit was completed every three months for each employee. Each audit was completed by a different assigned rater. The Administrative Supervisor assigned these audits to be completed by any one of the following persons:

1. Administrative Supervisor
2. Clinical Supervisor
3. Team Leader
4. Clinical Coordinator
5. Peer from the same quad or different quad
6. Employee themselves
7. Staff Development Instructor
8. Director of Nursing
9. Vice President of Nursing

The results of the audits were tallied on the evaluation form and relayed to the employee at that time.

At the end of the employee's merit year, the appraisal points were totaled and the merit increase scale was used to determine the person's salary increase percentage.

Validity

It is difficult to compare nursing care standards. They cannot be compared between different institutions because of institutional philosophies, care delivery systems, skill mix, physical design, existing equipment, medical staff expectations and availability of support services.

A panel of experts was asked to compare the two different systems and provide input into the validity of the appraisal process to be tested. Members that made up the panel of experts were directors of either personnel or human resource departments. They were chosen from hospitals similar in size and characteristics to Mercy Health Center.

All the represented hospitals were accredited by JCAH and were members of both the Oklahoma Hospital Association and the American Hospital Association. They were all owned either by a church affiation or by some other form of a non-governmental, not-for-profit organization. All of them provided general, acute, short-term care. The size, as designated by the number of licensed beds, is listed in Table III. The name of the hospital, the city and the contacts' names are also listed.

Questions used in a structured interview were pretested by human resource department directors of similar but of smaller and larger size hospitals before being used with the expert panel. Structured interviews were carried out with each of the experts. They were each asked to give their opinion about whether they believed the CBPAS met the JCAH standard. Questions were included regarding leniency, central tendency and halo effect. The experts were asked to issue an opinion about which system they felt would most effectively reduce these biases (Appendix A).

TABLE III

NAME, CITY, SIZE AND CONTACT OF HOSPITALS PARTICIPATING AS MEMBERS OF THE EXPERT PANEL

Hospital Name	Size	Contact
Deaconess-OKC	250	Dir of Personnel
St. Marys-Enid	277	HRD Coordinator
City of Faith-Tulsa	294	Personnel Dir
Jane Phillips-Bartlesville	312	Personnel Dir
South Community-OKC	391	HR Director
MERCY HOSPITAL-OKC	432	Director of HR
Presbyterian-OKC	445	Education Coord
Baptist Medical-OKC	577	HRD Assistant
Hillcrest-Tulsa	596	Personnel Dir

Reliability

Reliability is defined in terms of consistency and accuracy of the rating technique. Reliability was established by comparing the appraisal point scores of subjects who were evaluated first under NCBPAS and later under CBPAS to the percentage of salary increase awarded the subjects under NCBPAS and CBPAS. A greater degree of reliability is indicated by a higher correlation coefficient (Polit and Hungler, 1983). Correlation coefficients were considered low if the coefficient was less than .50. The correlation coefficient was considered moderate if the coefficient was between .51 and .80. All the correlation coefficents above .80 was designated as high. All of the correlation coefficents were figured using a .05 level of significance.

The subjects appraisal scores for each fiscal year were tested by computing the Pearson product moment correlation coefficient of the appraisal points and percentages of salary increases of the different nursing units for FY83, FY84, FY85 and FY86.

To establish interrater reliability, the appraisal points for FY83 were compared to the appraisal points for FY84 and the Pearson product moment correlation coefficients were computed. The same procedure was carried out for FY85 and FY86. The higher the correlation coefficients the greater the reliability of the rater and the more meaningful

the scores of the particular system.

The percentages of salary increases for the FY83 were compared to the percentages of salary increases for the FY84 and the Pearson product moment correlation coefficients were computed. The same procedure was carried out for the FY85 and FY86. The higher the correlation coefficients the greater the reliability of the rater and the more meaningful the scores of the particular system.

Leniency

Leniency occurs when raters rate the subjects overly high. Characteristics of appraisal points and percentages of salary increase of NCBPAS and CBPAS were compared. The number of standard deviations and the width of distributions were used to determine the amount of leniency error. The greater the number of standard deviations and the wider the distribution, the lower the leniency error.

Central Tendency

Central tendency error occurs as a result of the inclination toward average scores. Again, standard deviation was calculated and compared for the appraisal points of each performance dimension. The greater the standard deviation and the smaller the error, the greater was the discrimination between performance of the subjects.

Halo Effect

The halo effect error occurs when the rater allows one characteristic or the overall assessment of the person rated to influence all dimensions to be rated. One way to determine the impact of halo is to perform a factor analysis. A within-subjects ANOVA was completed on each performance dimension. Correlations were compared among dimensions in NCBPAS and CBPAS.

The system that showed smaller correlations among performance dimension categories demonstrated less halo effect error. These correlation coefficients indicated that the appropriate performance dimensions were successfully identified. Each was sufficiently independent to measure only a single characteristic or behavior.

Summary

NCBPAS and CBPAS were compared to provide documentation regarding the effectiveness of both systems. The methods used to accomplish this included comparing NCBPAS FY83 to NCBPAS FY84 and comparing CBPAS FY85 to CBPAS FY86. Comparisons were made between the two systems in reliability, validity, leniency, central tendency, and halo effect error.

CHAPTER IV

PRESENTATION OF FINDINGS

Introduction

This study assessed the difference in the validity, reliability, leniency, central tendency and halo effect of a criterion based performance appraisal system (CBPAS) and a non-criterion based performance appraisal system (NCBPAS) in the nursing department of a 400 bed non-governmental hospital in Oklahoma. The areas of concern were validity, reliability, central tendency, leniency and halo effect. The results are reported in each of these areas separately.

General Information

The subjects who were studied were nurses who had been employed by the hospital for five years or more. They included Licensed Practical Nurses (LPNs) and Registered Nurses (RNs).

Two different types of performance appraisal systems were studied. CBPAS included behaviorally stated performance standards, quarterly reviews and multiple raters. NCBPAS utilized trait centered performance dimensions, yearly review and one rater. Performance dimensions, appraisal points and percentages of salary

increase were used to calculate the relationships between the two different appraisal systems. The dimensions for NCBPAS included job knowledge, attitude, judgment, adaptability, initiative and dependability. CBPAS used the performance dimensions of assessment, planning, implementation, evaluation, participation and noncompliance.

Validity

Content validity of the appraisal process was established by using an expert panel from hospitals of similar bed size, accreditation, association affiliation, ownership and type of care provided. Nine experts were asked to participate in the study. Seven agreed to do so. Each person was asked to respond to interview questions. A summary of the responses can be found in Table IV. All agreed that CBPAS better met the Joint Commission on Accreditation of Hospitals (JCAH) standard than did the NCBPAS. They all agreed that CBPAS was also the more objective. All but one expert felt CBPAS was more fair, reduced the tendency to rate individuals better or worse than they really were, and reduced the tendency to rate persons high in all areas if they scored high in one area.

Three experts stated that CBPAS more closely resembled the system they were presently using, while four other panel members said NCBPAS more closely resembled what they were presently using. Five experts stated that if given a choice

TABLE IV

COMPARISON OF EXPERTS' PERCEPTIONS ABOUT THE NON-CRITERION BASED PERFORMANCE APPRAISAL SYSTEM AND THE CRITERION BASED PERFORMANCE APPRAISAL SYSTEM

Question	Non-criterion based	Criterion based
The system that:		
Better meets JCAH position.	0	7
Better compares to one presently in use.	4	3
Is perceived as more objective.	0	7
Is perceived as more fair.	1	6
Is believed to better reduce central tendency.	0	7
Is believed to better reduce leniency.	1	6
Is believed to better reduce halo effect.	1	6
Better meets the overall needs of one's own institution.	2	5

they would use CBPAS. One person felt that CBPAS would take too much time and one other individual who felt it was far too rigid preferred the more subjective method of doing performance appraisals. Appendix A includes a copy of the questions asked of the participants.

Reliability

Reliability was established by comparing the appraisal points and percentages of salary increase for FY83 to FY84 using NCBPAS. The same was done for FY85 to FY86. This was done for each nursing unit separately and then together. The significance level was designated as .05 for statistical purposes.

Table V is a comparison of appraisal points and percentages of salary increase in FY83 using NCBPAS. Each nursing unit is listed separately. The correlation coefficients of the post surgical, rehabilitation, nursery, surgery and special care units were moderate while the ob/gyn unit correlation coefficient was considered high and the cardiac unit low. The correlation coefficients of the oncology and rehabilitation units were not significant using a significant level of .05. The scattergram in Figure 1 demonstrates this.

Table VI relates the appraisal points and percentages of salary increase in FY84 using NCBPAS. The calculated Pearson product moment correlation of the

TABLE V

COMPARISON OF APPRAISAL POINTS AND PERCENTAGES OF SALARY INCREASE IN FY83 BY NURSING UNIT USING THE NON-CRITERION BASED PERFORMANCE APPRAISAL SYSTEM

Nursing Unit	n	r	
Cardiac	12	.83	
Ob/Gyn	21	.88	
Oncology	12	.43	*
Post Surgical	32	.80	
Rehabilitation	6	.78	*
Nursery	16	.76	
Surgery	16	.60	
Special Care	11	.57	

* This correlation coefficient is not significant at the .05 level.

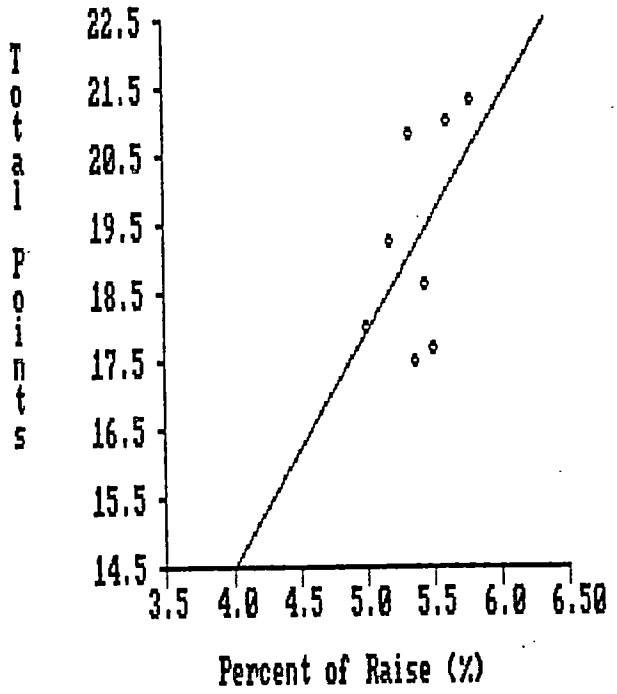

Figure 1. Comparison of appraisal points and percentages of salary increase means in FY83 by nursing unit using the non-criterion based performance appraisal system.

TABLE VI

COMPARISON OF APPRAISAL POINTS AND PERCENTAGES OF SALARY INCREASE IN FY84 BY NURSING UNIT USING THE NON-CRITERION BASED PERFORMANCE APPRAISAL SYSTEM

Nursing Unit	n	r	
Cardiac	12	.73	
Ob/Gyn	21	.81	
Oncology	12	.33	*
Post Surgical	32	.78	
Rehabilitation	6	.81	*
Nursery	16	.66	
Surgery	16	.40	*
Special Care	11	.55	

* This correlation coefficient is not significat at the .05 level.

oncology, rehabilitation and surgery appraisal points and percentages of salary increase were not significant at the .05 level. All of the other unit scores correlated at a moderate level. The scattergram in Figure 2 illustrates this.

Comparison of appraisal points and percentages of salary increase in FY85 using CBPAS is found in Table VII. Comparison of scores and percentages of salary increase of all the nursing units demonstrated high correlation coefficients. The scattergram in Figure 3 demonstrates this.

The correlation coefficients in Table VIII result from the comparison of appraisal points to percentages of salary increase in FY86 using CBPAS. There was a high level of correlation between scores and percentages of salary increase for all subjects. The surgery unit score coefficient was .06 lower for this year than FY85 but all the other scores were within .01 of the year before. The scattergram in Figure 4 illustrates this.

Table IX summarizes all four years of appraisal points and percentages of salary increase by the separate nursing units. The correlation coefficients of appraisal points and percentages of salary increase were above .87 for both years FY85 and FY86. The correlation coefficients for the years FY83 and FY84 ranged from .33 to .88 and five correlation coefficients were not significant.

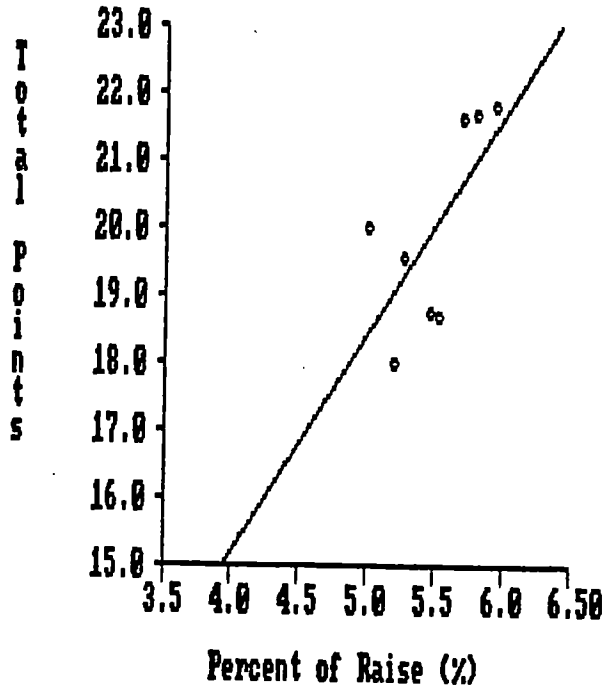

Figure 2. Comparison of appraisal points and percentages of salary increase means in FY84 by nursing unit using the non-criterion based perfromance appraisal systems.

TABLE VII

COMPARISON OF APPRAISAL POINTS AND PERCENTAGES OF SALARY INCREASE IN FY85 BY NURSING UNIT USING THE CRITERION BASE PERFORMANCE APPRAISAL SYSTEM

Nursing Unit	n	r
Cardiac	12	.92
Ob/Gyn	21	.98
Oncology	12	.98
Post Surgical	32	.97
Rehabilitation	6	.98
Nursery	16	.96
Surgery	16	.87
Special Care	11	.95

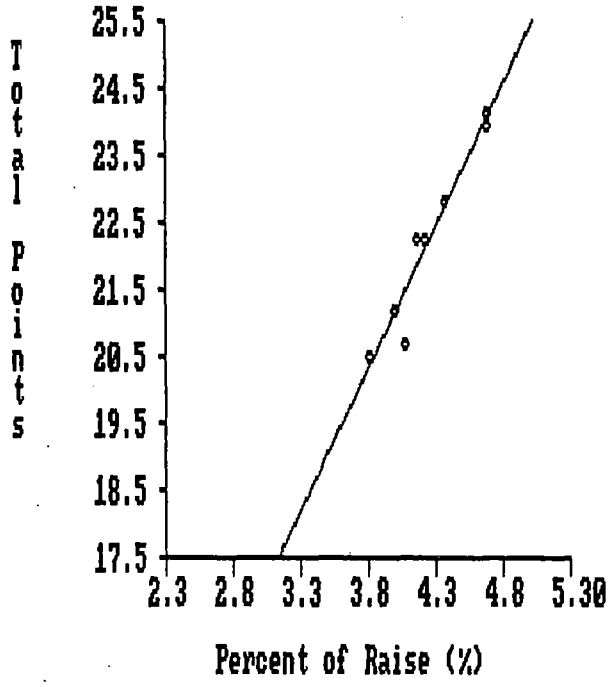

Figure 3. Comparison of the appraisal points and percentages of salary increase means in FY85 by nursing unit using the criterion based performance appraisal system.

TABLE VIII

COMPARISON OF APPRAISAL POINTS AND PERCENTAGES OF SALARY INCREASE IN FY86 BY NURSING UNIT USING THE CRITERION BASED PERFORMANCE APPRAISAL SYSTEM

Nursing Unit	n	r
Cardiac	12	.91
Ob/Gyn	21	.97
Oncology	12	.98
Post Surgical	32	.96
Rehabilitation	6	.98
Nursery	16	.94
Surgery	16	.93
Special Care	11	.95

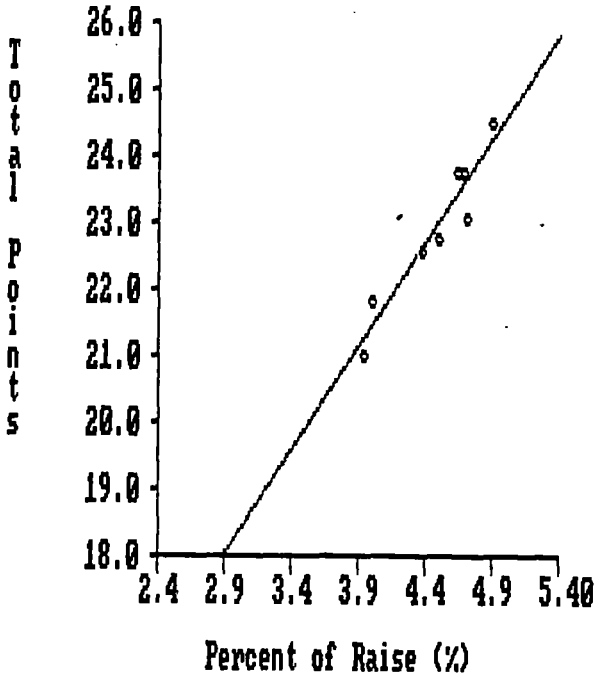

Figure 4. Comparison of appraisal points and percentage of salary increase in FY86 by nursing unit using the criterion based performance appraisal system.

TABLE IX

COMPARISON OF CORRELATION COEFFICIENTS OF APPRAISAL POINTS AND PERCENTAGES OF SALARY INCREASE BY NURSING UNIT

Nursing Unit	n	FY83	FY84	FY85	FY86
Cardiac	12	.83	.73	.92	.91
Ob/Gyn	21	.88	.81	.98	.97
Oncology	12	.43*	.33*	.98	.98
Post Surgical	32	.80	.78	.97	.96
Rehabilitation	6	.78*	.81*	.98	.98
Nursery	16	.76	.66	.96	.94
Surgery	16	.60	.40*	.87	.93
Special Care	11	.57	.55	.95	.95

* This correlation coefficient is not significant at the .05 level.

To further establish reliability, a comparison was made of the appraisal points for each year under both systems. Table X demonstrates the results of this investigation. Scores from NCBPAS in FY83 were compared to those in FY84. Scores from CBPAS in FY85 were compared to those in FY86. With the exceptions of nursery and surgery, the scores correlated at a higher level between FY85 and FY86 than between FY83 and FY84.

The percentages of salary increase given in FY83 were compared to those given in FY84 under NCBPAS. The percentages of salary increase given in FY85 were compared to those given in FY86 under CBPAS. The results of the comparison of the percentages of salary increase using NCBPAS included a perfect correlation for the scores of the oncology unit. The rehabilitation unit scores resulted in no significant difference in the percentages of salary increase given in FY83 when compared to the percentages of salary increase given in FY84. The others fell between these two extremes.

The correlation coefficients using CBPAS were less diverse and all were significant. The correlation coefficients using CBPAS ranged from .73 to .92. It was worthy to note that the correlation coefficient was the highest for the rehabilitation unit under CBPAS and lowest under the NCBPAS. See Table XI.

TABLE X

COMPARISON OF CORRELATION COEFFICIENTS OF APPRAISAL POINTS OF NON-CRITERION BASED PERFORMANCE APPRAISAL SYSTEM AND CRITERION BASED PERFORMANCE APPRAISAL SYSTEM BY NURSING UNITS

Nursing Unit	n	FY83 and FY84	FY85 and FY86
Cardiac	12	.75	.89
Ob/Gyn	21	.71	.84
Oncology	12	.78	.92
Post Surgical	32	.78	.88
Rehabilitation	6	.94	.96
Nursery	16	.88	.84
Surgery	16	.89	.82
Special Care	11	.87	.89

TABLE XI

COMPARISON OF CORRELATION COEFFICIENTS OF PERCENTAGES OF SALARY INCREASE USING NON-CRITERION BASED PERFORMANCE APPRAISAL SYSTEM AND CRITERION BASED PERFORMANCE APPRAISAL SYSTEM BY NURSING UNITS

Nursing Units	n	FY83 and FY84	FY85 and FY86
Cardiac	12	.86	.78
Ob/Gyn	21	.84	.74
Oncology	12	1.00	.83
Post Surgical	32	.80	.84
Rehabilitation	6	.32	.92
Nursery	16	.66	.90
Surgery	16	.74	.73
Special Care	11	.84	.77

Leniency

Leniency was investigated by measuring the standard deviation of the appraisal points scores and percentages of salary increase FY83 and FY84 for NCBPAS and for FY85 and FY86 for CBPAS. Table XII contains the characteristics of the appraisal points by nursing units and years.

In the cardiac, oncology, rehabilitation, surgery and special care units, the standard deviation of CBPAS was greater than that of NCBPAS. The scores from subjects in the ob/gyn, pre/post surgical and nursery units had the greatest standard deviation one of the years that CBPAS was used. Without exception, the smallest standard deviation was recorded during one of the two years when NCBPAS was in use.

The mean of the appraisal points increased in the years FY85 and FY86 under CBPAS in all of the units except the rehabilitation unit where the mean scores for FY84 and FY86 were the same.

The characteristics of the percentages of salary increase were also recorded. Each nursing unit was viewed separately and in all of the cases the standard deviation was greater during the two years of CBPAS. In calculating the figures it was also noted that the mean percentages of salary increase decreased during the years FY85 and FY86.

The ob/gyn unit recorded the least amount of difference in the mean percentages of salary increase over the four

TABLE XII

CHARACTERISTICS OF APPRAISAL POINTS BY NURSING UNIT BY YEAR

Nursing Unit / Year	Mean	Standard Deviation
Cardiac		
FY83	17.50	3.92
FY84	18.00	2.86
FY85	20.67	4.51
FY86	22.75	4.47
Ob/Gyn		
FY83	18.33	4.39
FY84	19.48	3.56
FY85	22.29	5.17
FY86	23.76	3.79
Oncology		
FY83	21.33	3.37
FY84	21.67	2.90
FY85	22.25	5.07
FY86	23.08	4.64
Post Surgical		
FY83	FY.25	3.79
FY84	FY.56	3.13
FY85	20.53	4.23
FY86	21.03	3.63

TABLE XII (Continued)

Nursing Units Year	Mean	Standard Deviation
Rehabilitation		
FY83	20.83	2.64
FY84	21.83	2.32
FY85	21.17	5.15
FY86	21.83	5.78
Nursery		
FY83	18.63	3.31
FY84	18.75	3.86
FY85	23.94	4.34
FY86	24.50	3.83
Surgery		
FY83	17.69	2.89
FY84	18.69	2.75
FY85	22.81	3.81
FY86	22.56	4.17
Special Care		
FY83	21.00	2.58
FY84	21.62	2.35
FY85	24.15	4.06
FY86	23.77	3.68

year period. Table XIII illustrates the characteristics of the percentages of salary increase by nursing units and years.

Table XIV contains a summary of the characteristics of the appraisal points by years. The overall mean was more than 10 percent greater in FY85 and FY86 with CBPAS. The average standard deviation was .9 greater for CBPAS than the average standard deviation for NCBPAS.

The comparison between the years of NCBPAS illustrates that the mean for FY84 was .63 greater than for FY84. The standard deviation was .52 wider for FY83.

CBPAS showed an increase of the mean in FY86 by .65 points. The standard deviation was .49 wider in FY85.

The summary of the characteristics of the percentages of salary increase by years is in Table XV. The standard deviation was over 50% greater for FY85 and FY86. The mean of the percentages was the lowest for FY85 and FY86.

The comparison of percentages of salary increase between the years of NCBPAS demonstrates that in FY83 the mean of the percentages of salary increase was .07 less than the percentages of salary increase in FY84. The standard deviation was .06 greater in FY83 than in FY84.

In comparing the percentages of salary increase in the fiscal years for CBPAS there was a .22 difference in the means of the percentages of salary increase in FY85 and FY86. The standard deviation was .07 larger in FY85. It

TABLE XIII

CHARACTERISTICS OF PERCENTAGES OF SALARY INCREASE BY NURSING UNIT BY YEAR

Nursing Unit Year	Mean	Standard Deviation
Cardiac		
FY83	5.36	.76
FY84	5.20	.78
FY85	4.08	1.16
FY86	4.50	1.24
Ob/Gyn		
FY83	4.88	.84
FY84	4.95	.78
FY85	4.24	1.22
FY86	4.64	1.09
Oncology		
FY83	5.79	.40
FY84	5.79	.40
FY85	4.17	1.27
FY86	4.71	1.14
Post Surgical		
FY83	5.17	.64
FY84	5.27	.55
FY85	3.81	1.12
FY86	3.94	.92

TABLE XIII (Continued)

Nursing Unit Year	Mean	Standard Deviation
Rehabilitation		
FY83	5.33	.52
FY84	5.92	.20
FY85	4.00	1.26
FY86	4.00	1.55
Nursery		
FY83	5.44	.50
FY84	5.46	.35
FY85	4.68	1.18
FY86	4.90	1.07
Surgery		
FY83	5.50	.48
FY84	5.53	.46
FY85	4.38	1.09
FY86	4.38	1.15
Special Care		
FY83	5.62	.51
FY84	5.69	.48
FY85	4.69	1.03
FY86	4.69	1.03

TABLE XIV

CHARACTERISTICS OF APPRAISAL POINTS BY YEAR

Year	Mean	Standard Deviation
FY83	FY.01	3.75
FY84	FY.64	3.23
FY85	21.98	4.59
FY86	22.63	4.10

TABLE XV

CHARACTERISTICS OF PERCENTAGES OF SALARY INCREASE BY YEAR

Year	Mean	Standard Deviation
FY83	5.30	.68
FY84	5.37	.62
FY85	4.18	1.17
FY86	4.40	1.10

was 1.17 in FY86 and 1.10 in FY86.

Central Tendency

In the investigation of central tendency, the standard deviation was calculated and compared for each performance dimension score for each year under both NCBPAS and CBPAS. The greater the standard deviation, the greater the discrimination there was between the performance of the subjects.

Table XVI lists the calculation of each of the years by performance dimensions. The standard deviations were consistently greater in both years of CBPAS than in both years of NCBPAS.

The standard deviations were greater in FY83 than in FY84 between all of the performance dimensions in CBPAS. The standard deviations were greater for FY85 performance dimensions than for FY86 performance dimensions in CBPAS.

Halo Effect

When a rater allows one characteristic to influence the overall rating of a subject it is called halo effect. The amount of this effect is determined by calculating a within-subjects ANOVA on each performance dimension. Table XVII illustrates the differences between the performance dimensions in FY83 using NCBPAS. The means of the scores of the five performance dimensions of knowledge, attitude,

TABLE XVI

CHARACTERISTICS OF PERFORMANCE DIMENSIONS BY YEAR

Year	Performance Dimension	Mean	Standard Deviation
FY83	Knowledge	3.8	.67
FY83	Attitude	2.9	.79
FY83	Judgment	3.0	.74
FY83	Adaptability	2.7	.89
FY83	Initiative	2.8	.83
FY84	Knowledge	3.2	.39
FY84	Attitude	3.1	.51
FY84	Judgment	3.6	.52
FY84	Adaptability	3.2	.57
FY84	Initiative	3.6	.52
FY85	Assessment	3.2	1.34
FY85	Planning	3.5	1.57
FY85	Implementation	4.3	1.22
FY85	Evaluation	3.3	1.54
FY85	Participation	3.3	1.76
FY86	Assessment	4.2	1.11
FY86	Planning	4.1	.90
FY86	Implementation	4.5	.67
FY86	Evaluation	3.6	1.31
FY86	Participation	3.3	1.54

TABLE XVII

ANALYSIS OF VARIANCE OF PERFORMANCE DIMENSIONS IN FY83 USING THE NON-CRITERION BASED PERFORMANCE APPRAISAL SYSTEM

Knowledge X Attitude X Judgment X Adaptability X Initiative

Mean of performance dimension

3.22	3.12	3.08	3.04	3.02

Variance of performance dimension

.256	.393	.442	.528	.550

Source	df	SS	F
Between	4	1.255	.722
Within	245	106.44	
Total	249	107.69	

The means of these performance dimensions are not significantly different at $p < .05$.

judgment, adaptability and initiative were not significantly different from one another at the .05 level of significance. The means of the scores of the performance dimensions in FY84, using NCBPAS, were not significantly different as shown in Table XVIII.

In FY85 and FY86 the analysis of variance done on the means of the scores of the performance dimensions of assessment, planning, implementing, evaluating and participating were significantly different from one another at the level of .05. The results are reported in Tables XIX and XX. The means of the performance dimensions in both years were significantly different at the .05 level for the CBPAS.

Summary

The findings of the study of NCBPAS in FY83 and FY84 and CBPAS in FY85 and FY86 were that NCBPAS was perceived by experts to be less objective and fair. Statistical data showed that NCBPAS was less likely to reduce central tendency, leniency and halo effect. The experts perceived the CBPAS to be more objective and fair. Statistical data showed that CBPAS was more likely to reduce central tendency, leniency and halo effects.

Reliability was tested by comparing the appraisal points and the percentages of salary increase given in each of the four years of FY83, FY84, FY85, and FY86. All the

TABLE XVIII

ANALYSIS OF VARIANCE OF PERFORMANCE DIMENSIONS IN FY84 USING THE NON-CRITERION BASED PERFORMANCE APPRAISAL SYSTEM

Knowledge X Attitude X Judgment X Adaptability X Initiative

Mean of Performance Dimension

3.28	3.20	3.16	3.12	3.02

Variance of Performance Dimension

.246	.326	.422	.434	.468

Source	df	SS	F
Between	4	1.85	1.22
Within	245	93.06	
Total	249	94.91	

The means of these performance dimensions are not significantly different at $p < .05$.

TABLE XIX

ANALYSIS OF VARIANCE OF PERFORMANCE DIMENSIONS IN FY85 USING THE CRITERION BASED PERFORMANCE APPRAISAL SYSTEM

	Assessment	Planning	Implementation	Evaluation	Participation
Mean	4.02	3.56	4.26	3.38	3.14
Variance	1.61	2.37	.97	2.24	2.16

Source	df	SS	F
Between	4	42.38	5.66
Within	245	458.72	
Total	249	501.10	

The means of these performance dimensions are significantly different at $p < .05$.

TABLE XX

ANALYSIS OF VARIANCE OF PERFORMANCE DIMENSIONS
IN FY86 USING THE CRITERION BASED
PERFORMANCE APPRAISAL SYSTEM

Assessment	Planning	Implementation	Evaluation	Participation
Mean				
4.10	3.64	4.22	3.50	3.72
Variance				
1.35	1.50	1.11	1.74	1.55

Source	df	SS	F
Between	4	FY.10	3.29
Within	245	355.18	
Total	249	374.28	

The means of these performance dimensions are significantly different at $p < .05$.

correlations, the scattergrams and the linear regressions that were done for each nursing department were statistically significant with CBPAS. The correlations were .87 or above. The scattergrams were on or close to the linear regression line. The slope of the line representing the linear regressions was significantly different from zero. See Table XXI.

The correlations coefficients of the scores of NCBPAS ranged from .33 to .88. In FY83 the correlation coefficients for appraisal points and percentages of salary increase within two nursing units were not significant at .05 level. In FY84, there were three nursing units which produced correlation coefficients which were not significant. In order to investigate leniency, standard deviations of the appraisal points scores and percentages of salary increase were calculated for all years. The smaller standard deviations were reported for NCBPAS and greater standard deviations for CBPAS.

Central tendency was determined by examining the standard deviations for all the performance dimensions for both systems. CBPAS had wider standard deviations than NCBPAS.

Analysis of variance was conducted on the mean scores by performance dimensions for all four years. CBPAS demonstrated statistically significant differences between the scores of the performance dimensions while NCBPAS

TABLE XXI

LINEAR REGRESSIONS OF MEANS OF APPRAISAL POINTS AND MEANS OF PERCENTAGES OF SALARY INCREASE BY YEARS

Year	T	p	df
FY83	1.578	.168	6 *
FY84	2.257	6.575	6 *
FY85	8.881	1.134	6
FY86	7.917	2.155	6

* the slope of this line is not significantly different from 0 at .05 level.

performance dimension scores were not significantly different.

A summary of the findings related to validity, reliability, leniency, central tendency and halo effect are reported in Table XXII.

TABLE XXII

SUMMARY TABLE

Tests	Non-Criterion		Criterion	
	FY83	FY84	FY85	FY86
Validity				
Total number of expert responses	14		42	
Reliability				
Correlation Coefficient of Appraisal Points and Percentages of Salary Increase by Years	.706	.634	.951	.952
Leniency				
SD of Percentages of Salary Increase by Years	.68	.62	1.17	1.10
Central Tendency				
SD of Performance Dimensions by Years				
Knowledge/Assess	.67	.39	1.34	1.11
Attitude/Plan	.79	.51	1.57	.90
Judgment/Implement	.74	.52	1.22	.67
Adaptive/Evaluate	.89	.57	1.54	1.31

TABLE XXII (CONTINUED)

Tests	Non-Criterion		Criterion	
	FY83	FY84	FY85	FY86
Initiate/Participate	.83	.52	1.76	1.54
Halo Effect				
ANOVA				
SSb	1.255	1.85	42.38	19.10
SSw	106.44	93.06	458.72	355.18
SSt	107.69	94.91	501.10	374.28
F	.722*	1.22*	5.66	3.29

* The means of these performance dimensions are not significantly different.

CHAPTER V

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS

The purpose of this study was to determine the difference in the validity, reliability, leniency, central tendency and halo effect of criterion based performance appraisal system (CBPAS) and a non-criterion based performance appraisal system (NCBPAS) in the nursing department of a 400 bed non-governmental hospital in Oklahoma. This chapter presents the summary, conclusions, recommendations and implications of this study.

Summary

In order to determine the impact of CBPAS it was necessary to identify the differences that existed in the validity, reliability, leniency, central tendency and halo effect of CBPAS and NCBPAS. This was done by investigating the appraisal point scores and the percentages of salary increase of CBPAS and NCBPAS.

A literature search was conducted that included the historical background of performance appraisals, the purpose of performance appraisals, performance measurement and performance appraisal biases. The review also included

information regarding the reliability, leniency, central tendency and halo effect. A summary of methods used to measure the different possible biases was also included in the review of literature.

The subjects in this study were nurses from various nursing units from within the same Oklahoma hospital. Appraisal points and percentages of salary increase scores of these subjects were gathered and examined from the FY83, FY84, FY85, and FY86. The FY83 and FY84 scores were obtained via NCBPAS. The FY85 and FY86 scores were obtained while CBPAS was in use.

NCBPAS had been in effect for a number of years. CBPAS was implemented and utilized for two years prior to the study. NCBPAS and CBPAS was tested for validity utilizing a group of experts. The perceptions of this group supported CBPAS.

Reliability was examined by comparing the appraisal point scores and the percentages of salary increase using NCBPAS in FY83. The same procedure was carried out using the scores and percentages in FY84 with NCBPAS. The appraisal point scores and percentages of salary increase were compared for FY85 and FY86 using CBPAS. The correlation coefficients for CBPAS were higher than for NCBPAS, indicating that CBPAS was more reliable.

A comparison was also made of the appraisal points for each year under both systems. The overall results

demonstrated higher correlations for CBPAS than for NCBPAS. The percentages of salary increase were compared in like manner. The results were statistically significant under CBPAS system but not statistically significant under NCBPAS. Scattergrams graphically portrayed the higher correlations of the appraisal points and percentages of salary increase of CBPAS. The correlation coefficients and linear regression slopes were higher in FY85 and FY86 than in FY83 and FY84.

The scattergrams also graphically illustrated the reduction in the mean percentages of salary increase obtained in the years of FY85 and FY86 utilizing CBPAS.

Leniency, the error that occurs when subjects are rated higher than their actual performance, was examined by measuring the standard deviations of the appraisal points and the percentages of salary increase. The standard deviations of the appraisal points of NCBPAS were lower by more than one point for both years compared to the two years under CBPAS. Leniency was reduced under CBPAS. A greater number of appraisal points were earned by the subjects under CBPAS even though the percentages of salary increase were lower. Subjects received credit for the performance dimensions on which they did well but received salary increase relative to the appraisal points earned. The standard deviations for the percentages of salary increase in FY85 and FY86 were twice as great as for those in FY83 and FY84.

Central tendency was calculated for each of the performance dimensions under both CBPAS and NCBPAS. Standard deviations between the performance dimensions were greater under CBPAS than under NCBPAS.

Halo effect is the tendency to rate a subject the same for all performance dimensions according to one dimension. Halo effect was investigated by conducting ANOVAs on each of the year's performance dimension scores. Under NCBPAS there was no significant difference between the scores of the various performance dimensions. The opposite was true using CBPAS. All the performance dimensions were significantly different.

The summary of findings indicated that the criterion based system was superior in reducing all of the biases tested.

CONCLUSIONS

The conclusions reached by this study are that the CBPAS performance appraisal system contained greater congruent validity than NCBPAS, was more reliable than NCBPAS, and was associated with reduced errors leniency, central tendency and halo effect in comparison to NCBPAS.

Recommendations

This study demonstrated that the impact of CBPAS reduces some of the biases that are found in performance appraisal systems. The following are recommendations made regarding

the study:

1. That the organization using CBPAS utilize the statistical methods of this study to conduct on going assessment of the system in order to insure that the biases continue to be controlled.

2. That similar studies be completed in other hospitals of the same size in various geographical locations.

3. That similar studies be carried out in industries in addition to health care.

4. That similar studies be completed in organizations where NCBPAS incorportates quarterly performance reviews.

5. That similar studies be completed in organizations where NCBPAS incorporates multiple raters.

6. That additional biases be identified and studied.

7. That continued investigation and study be made of all performance review systems so that on going improvements can be incorporated into CBPAS.

Implications

There are several implications resulting from this study.

1. CBPAS can result in cost effective measures by providing the data needed to reward only those who deserve to be rewarded for their performance.

2. By using a system that more accurately measures performance it is possible to reduce the overall percentages

of salary increase while providing a reward for the outstanding individuals in an organization.

3. By using CBPAS it may be possible to increase the productivity of individuals and groups of workers. Frequent feedback regarding observable, measurable behaviors allows individuals to improve their performance and to have the satisfaction that they know what is expected of them and how well they are meeting those expectations.

4. The results generated from the use of this criterion based system can also be utilized to better identify employee performance problems and training needs.

5. This system can be used as a quality assurance tool as well as a measurement of individual performance. By combining the scores of individuals in a nursing unit or those who work a specific shift it is possible to identify and address problems. This is also an effective a way to measure and evaluate the results of training programs.

6. CBPAS includes job analysis and observable behavioral measurements which contribute to a reduction in legal liabilities under employee discrimination cases.

7. The performance appraisal system can affect not only hospital personnel but personnel in any organizational setting. Current literature emphasizes that employees are more responsive to frequent, specific feedback than to sporadic, general feed back.

The results of this study demonstrate that an objective

view of performance is superior to a subjective one. The CBPAS is more fair, more accurate, more impartial and can be more rewarding to both employee and employers since performance expectations are spelled out.

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APPENDIX A

PANEL OF EXPERTS QUESTIONS AND SUMMARY

STRUCTURED INTERVIEW

After appointments have been scheduled a copy of the criterion based performance appraisal system and a copy of the non-criterion based performance appraisal system will be sent to each panel member.

Questions

1. Which system, in your opinion, the criterion based performance appraisal system or the non-criterion based performance appraisal system best meets the JCAH position on performance appraisals?

2. Why?

3. How does the non-criterion performance appraisal system compare to the system you are presently using?

4. How does the criterion performance appraisal system compare to the system you are presently using.

5. Which system do you perceive as the most objective?

6. Why?

7. Which system do you think is the most fair?

8. Why?

9. Which system do you believe would best reduce the tendency of supervisors to rate most employees about the same?

10. Which system do you believe would best reduce the tendency of supervisors to rate an employee better or worse than they really are?

11. With which system would the fact that a person excels in one particular performance area cause him/her to be rated high in all performance areas?

12. Given the opportunity, which one of the systems would you implement in your institution?

13. Why?

INTERVIEW SUMMARY

Structured interviews were held with human resource managers and human resource developers in seven hospitals selected based on their likeness to Mercy Health Center. Nine hospitals were contacted but two declined to participate.

Four of the individuals interviewed were titled human resource department directors, two were titled personnel directors and one was called director of human resource development and management. They all were familiar with JCAH standards and criteria based performance appraisal systems. Seven out of seven agreed that the criterion-based performance appraisal system best met JCAH standards. They stated they felt it was more measurable, more objective and based more closely to the job description.

One person did disagree with the fact that a measurable system was as useful to his organization. He felt that individuals should be rewarded based on subjective materials and stated that when they do one thing well all other performance dimensions are greater. He also thought that the tendency for scores and percentages of raises to fall in the center of a range prevented hard feeling and jealousy among the employees.

He did not think he would use it in his organization because they intend to discontinue being JCAH certified and therefor will not have to comply with their standards.

All the other respondents stated that the criterion-based performance appraisal system was superior to the non-criterion based performance appraisal system, that it did reduce halo, central tendency, and leniency because of its measurable, objective and observable qualities. They all stated that they would consider using such a system in their organization because it appeared to meet the JCAH requirements.

APPENDIX B

NON-CRITERION BASED PERFORMANCE APPRAISAL FORMS AND INSTRUCTIONS

MERCY HEALTH CENTER OKLAHOMA CITY, OKLAHOMA	PERSONNEL POLICIES AND PROCEDURES: POLICY: JOB PERFORMANCE EVALUATION SYSTEM SECTION: B-5 EFFECTIVE DATE: 2-1-76 REVISED: 2-1-82 REVISED: 3-18-82

It is the responsibility of each Department Manager and designated Supervisor to objectively measure the performance of each employee. Performance evaluation should be a constant and continuous function of each Supervisor. Reports regarding individual performance of each employee will be prepared and submitted in accord with Mercy Health Center policy outlined in the following paragraphs.

The Director of Human Resources is responsible for administering and monitoring the Employee Job Performance Evaluation Program.

Annually, at least one week prior to the employee's merit review date, the Department Manager must submit a completed Job Performance Evaluation to the Human Resources Department. Employee Job Performance Evaluations shall be processed as outlined in the Guide for Processing Employee Job Performance Evaluations and the Guide for Determining Merit Increases. (see attached)

Evaluations for part time employees are conducted on the same basis as full time employees.

MERCY HEALTH CENTER OKLAHOMA CITY, OKLAHOMA	PERSONNEL POLICIES AND PROCEDURES: POLICY: JOB PERFORMANCE EVALUATION SYSTEM SECTION: B-5 EFFECTIVE DATE: 2-1-76 REVISED: 2-1-82 REVISED: 3-18-82

GUIDE FOR DETERMINING MERIT INCREASES

This Guide should be used each time an employee is evaluated. It is intended to provide the evaluator with a means of quantifying their decisions regarding the amount of a Merit Increase. The evaluator should pay close attention to the wording describing each level of performance.

Individual departments are encouraged to use this Guide as a basis for designing their own "measuring-sticks" for Performance Evaluations. However, any departmental supplement must be consistent with this Guide and be approved by the Director of Human Resources.

PERFORMANCE	% INCREASE	DESCRIPTION of PERFORMANCE
Superior	6%	An employee whose performance always exceeds performance standards. This is a rare individual who has sustained this level of performance over a one year period. One who is rarely, if ever, absent; has never received a disciplinary warning; one who is capable of doing more with the position than is described on the Job Description; one who takes the initiative to perform duties without being asked. One who requires little or no direct supervision.
Excellent	5%	An employee who exceeds Performance Standards most of the time. One who receives no formal disciplinary counseling in a review year; one who does not violate attendance policies.
Above Average	4%	An employee who meets all performance standards and exceeds some; one who is at work when scheduled; one who performs the duties of the job as described; offers helpful ideas and contributes to the smooth operation of the department in a positive way.

MERCY HEALTH CENTER OKLAHOMA CITY, OKLAHOMA	PERSONNEL POLICIES AND PROCEDURES: POLICY: JOB PERFORMANCE EVALUATION SYSTEM SECTION: B-5 Cont'd EFFECTIVE DATE: 2-1-76

PERFORMANCE	% INCREASE	DESCRIPTION of PERFORMANCE
Average	3%	An employee who meets the Performance Standards of the job; one who is dependable and considerate. This is an employee who does little more than is required by the Job Description.
Below Average	2% *	An employee who falls short of one or more performance standards for the position; one who is less than capable of fulfilling the duties and responsibilities of the job. Requires more training; requires direct supervision. Questionable as to the future tenure of this type of employee.
Poor	1% *	An employee who does not meet the Performance Standards of the Job; one who is not able to perform all duties as described; one who does not contribute to the Department Objectives; one who requires constant, direct supervision.

* Re-evaluate possibly raise increase to 3% if work improvement objectives are met.

EVALUATION FACTORS

JOB KNOWLEDGE :	**Does this individual demonstrate acceptable depth, currency and breadth of knowledge relative to the performance of his job duties?**
ATTITUDE:	**does this individual's performance indicate an intent to be helpful to others and to be receptive to plans, programs and procedures of Mercy Health Center?**
JUDGMENT:	**Does this individual think clearly and in a manner conducive to logical and sound decisions?**
ADAPTABILITY:	**Is this individual able to maintain his work at acceptable levels even in stressful and dynamic conditions?**
INITIATIVE:	**Does this individual demonstrate a desire to attain departmental as well as Health Center goals? Does he show creativity and interest in his work?**
DEPENDABILITY:	**Has this employee met all necessary attendance requirements of the Health Center?**

APPENDIX C

SCORING FORM

STATISTICS CODES

1.	YEAR _____	
2.	JOB CODE	1 = RN 2 = LPN 3 = TEAM LEADER
3.	NURSINGS DEPARTMENT	1 = CARDIAC 2 = OB/GYN 3 = ONCOLOGY 4 = POST SURGICAL 5 = REHABILITATION 6 = NURSERY 7 = SURGERY 8 = SPECIAL CARE
4.	JOB KNOWLEDGE	1 = POOR 2 = BELOW AVERAGE 3 = AVERAGE 4 = ABOVE AVERAGE 5 = SUPERIOR
5.	ATTITUDE	1 = POOR 2 = BELOW AVERAGE 3 = AVERAGE 4 = ABOVE AVERAGE 5 = SUPERIOR
6.	JUDGMENT	1 = POOR 2 = BELOW AVERAGE 3 = AVERAGE 4 = ABOVE AVERAGE 5 = SUPERIOR
7.	ADAPTABILITY	1 = POOR 2 = BELOW AVERAGE 3 = AVERAGE 4 = ABOVE AVERAGE 5 = SUPERIOR
8.	INITIATIVE	1 = POOR 2 = BELOW AVERAGE 3 = AVERAGE 4 = ABOVE AVERAGE 5 = SUPERIOR

9.	DEPENDABILITY	1 = 9 OR MORE ABSENCES 2 = 6 OR MORE BUT LESS THAN 9 ABSENCES 3 = 3 OR MORE BUT LESS THAN 6 ABSENCES 4 = LESS THAN 3 ABSENCES 5 = NO ABSENCES
10.	ASSESSMENT	1 = 00% COMPLIANCE 2 = 25% COMPLIANCE 3 = 50% COMPLIANCE 4 = 75% COMPLIANCE 5 = 100% COMPLIANCE
11.	PLANNING	1 = 00% COMPLIANCE 2 = 25% COMPLIANCE 3 = 50% COMPLIANCE 4 = 75% COMPLIANCE 5 = 100% COMPLIANCE
12.	IMPLEMENTATION	1 = 00% COMPLIANCE 2 = 25% COMPLIANCE 3 = 50% COMPLIANCE 4 = 75% COMPLIANCE 5 = 100% COMPLIANCE
13.	EVALUATION	1 = 00% COMPLIANCE 2 = 25% COMPLIANCE 3 = 50% COMPLIANCE 4 = 75% COMPLIANCE 5 = 100% COMPLIANCE
14.	PARTICIPATION	1 = ATTENDANCE AT NO PROGRAMS 2 = ATTENDANCE AT 1 PROGRAM 3 = ATTENDANCE AT 2 PROGRAMS 4 = ATTENDANCE AT 3 PROGRAMS 5 = ATTENDANCE AT 4 OR MORE PROGRAMS
15.	NON COMPLIANCE	1 = < THAN 15 POINTS 2 = < THAN 10 POINTS BUT > THAN 15 3 = < THAN 5 BUT > THAN 10 4 = > THAN 5 POINTS 5 = NO POINTS

APPENDIX D

CRITERION BASED PERFORMANCE

FORMS AND INSTRUCTIONS

CRITERION-BASED PERFORMANCE EVALUATION SYSTEM
USERS' MANUAL

INTRODUCTION AND OVERVIEW

The Criterion-Based Performance Evaluation System has been designed to provide managers and supervisors with a tool to objectively measure their employees' performance. It also requires regular and frequent communication between the supervisor and employee regarding job performance.

The basis for the Criterion-Based Performance Evaluation (CBPE) System's validity is an accurate portrayal of each employee's job using a CRITERIA LIST. This list of criteria is the foundation upon which the remainder of the Performance System is built.

FORMS

In order to maintain a managable system, forms have been standardized and therefore paper has been conserved as much as possible. Additionally, all jobs have grouped into job families and a separate PERFORMANCE PACKET has been developed for each group of jobs. Each PERFOMANCE PACKET contains the following:

- Job Description (2)
- Performance Audit (4)
- Evaluation of Performance Standards Summary (1)
- Evaluation Totals Form (2)

For convenience, the sheets that need to be given to employees have been perforated. At the completion of an employee's Review Year, the employee has a copy of each of his/her Performance Audits as well as their Evaluation Totals. The Human Resources will place the returned Performance Packet in the employee's Personnel File. The only items remaining in the packet will be:

- Job Description (1)
- Evaluation of Performance Standards Summary (1)
- Evaluation Totals (1)

USING THE PERFORMANCE PACKET

JOB DESCRIPTION

There are two job descriptions in each packet. The Human Resource Department will write the appropriate job title, employee name and Review Date on both of them. The Manager/Supervisor must attach the appropriate CRITERIA LIST to one of the copies.

There are several circumstances in which it is extremely important to Review both the performance standards and criteria with an employee:

1. On the first day of employment, the entire CBPE system should be described and the new employee should be given a copy of the Job Description and the Criteria List.

2. Upon changing any aspect of an employee's job, the revised Criteria List should be given to the employee.

3. Upon receiving a new employee into your department by transfer, that employee should be given a copy of the Criteria List.

The employee is to sign both copies of the job description signifying their understanding of the performance standards and criteria of their job. Send one signed copy to the Human Resources Department where it will be filed in the employee's personnel file.

USING THE PERFORMANCE PACKETS, Pg. 2

PERFORMANCE AUDITS

Each packet contains four AUDIT FORMS. One of the forms is to be completed every quarter. The supervisor may assign these audits to a different person each quarter. Supervisors, peers, and employees themselves are examples of individuals who would be allowed to complete audits. The Human Resources Department will assist Managers identify appropriate individuals to complete audits if necessary.

Audits are completed using the evaluation by exception method.

All statements in an audit must be answered with either "YES" or "NO". Simply circle the appropriate response on the form. Under no circumstances should an item be left blank. In those cases when the individual has not had the opportunity to demonstrate one of the standards criteria then it is scored "YES". Score an item "NO" only when there is evidence that the standard criteria has not been met. You should use the back of the audit form to document evidence of non-compliance with a particular criteria. It is also recommended that you keep a copy of documentation and any supporting evidence (Chronologicals, problem reports, Warnings, etc.) along with the back side of the Audit Form if non-compliance is noted.

At the completion of each audit, record the scores on the EVALUATION OF PERFORMANCE STANDARDS SUMMARY in the last section of the PERFORMANCE PACKET. Review the audit with the employee and give them the Audit Form for their records.

EVALUATION OF PERFORMANCE STANDARDS

The last section of the Performance Packet contains The EVALUATION OF PERFORMANCE STANDARD SUMMARY form. Use this form to record the employees scores at the completion of each audit.

At the completion of an employee's Review Year, calculate the points and transfer the totals to the EVALUATION TOTALS form.

Sub-Total the points for each item listed. Subtract points for any non-compliance with policies and procedures and calculate the Merit Increase using the table found at the end of this Manual.

Be sure and record the totals on both EVALUATION TOTAL forms. Allow the employee to make any written comments they wish on the form. Indicate whether the employee qualifies for consideration for the Award of Excellence. Give one copy to the employee and send the second one with the rest of the Performance Packet to the Human Resource Department for filing.

JOB DESCRIPTION

POSITION: Staff R.N. **DATE EFFECTIVE:** 4/1/84

DEPARTMENT: Nursing **REPLACES:** 7/83

POSITION RELATIONSHIPS:

Supervisor: Team Leader
Positions Supervised: L.P.N.'s

JOB SUMMARY:

Performs total care on assigned patients within scope of nursing preparation and consistent with established standards of nursing practice and the goals of Mercy Health Center.

PERFORMANCE STANDARDS:

In order to provide optimal, personalized Christian family centered care, the staff R.N. will attain the following performance standards:

1. Assessment of the patient
   - 1.1 The initial assessment of the patient's condition will be documented on admission.
   - 1.2 Data relevant to the patient's care will be documented within 24 hours of admission.
2. Planning the patient's care
   - 2.1 A plan of nursing care will be written based on the patient's problems, congruent with the medical plan of care and will include:

     Identified problems
     Nursing interventions
     Measureable goals developed with the patient and family
     A teaching plan
     A discharge plan
   - 2.2 The care plan will be reviewed at least every eight (8) hours and updated as necessary. It will reflect the evaluation of care.
3. Implementation of Patient Care
   - 3.1 Care will be given in accordance to the written plan of care.

3.2 The patient's physical needs will be met.

3.3 The patient's psycho-social needs will be promoted.

3.4 The patient will be kept as physically comfortable as his condition permits.

3.5 The patient will be assured of his physical safety.

3.6 The patient and family will be taught the elements of his condition and treatment.

3.7 All care will comply with written policies and procedures.

4. Evaluation of Patient Care

4.1 The patient's response to therapy and patient teaching will be documented.

4.2 A discharge plan will be formulated and documented.

5. Participation in Hospital and Unit Activities

5.1 There will be evidence of yearly CPR certification

5.2 Documentation of twelve educational hours

5.3 Documentation of attendance of mandatory inservices.

5.4 At least three of the following will be accomplished yearly:

Conduction of patient care conferences (2 per year)

Participation in at least 75% of staff meetings held

Participation in a recognized committee or special projects

Development of a learning activity packet

Presentation of two (2) inservices.

Participation in orientation of employees.

6. Compliance with Personnel Policies. There will be no written evidence that indicates noncompliance with personnel policies.

Job Description - Page 3

POSITION QUALIFICATIONS:

Education: Graduate of accredited school of nursing

Certification, Licensure or Bonding Requirement:
Licensed to practice nursing in the State of Oklahoma

Previous Experience: Previous experience not required. Continuing education preferred. Knowledge of equipment and supplies that are necessary and related to nursing care.

APPROVAL:

Department Manager Carol Gray

Human Resources Marshall [illegible]

Administration [illegible]

PERFORMANCE AUDIT

DATE_____

EMPLOYEE_____EVALUATOR_____

ADMINISTRATIVE SUPERVISOR_____

CHART NUMBER_____ PATIENT'S ROOM NUMBER_____

Using any one of the following: chart review, direct observation, patient interviews, nursing care plan reviews, patient care conference, participation and/or quality assurance studies, complete by checking the appropriate boxes.

	YES	NO
1. The initial assessment of patient's condition is documented on admission		
1.2 Data relevant to the patient's care is documented within 24 hours of admission		
2. The written plan of care includes:		
Identified problems		
Nursing interventions		
Measurable goals developed with patient and family		
Teaching plan		
Discharge plan		
2.2 The plan of care has been reviewed and updated every eight (8) hours and reflects evaluation of care		
3. Implementation of Patient Care Includes:		
3.1 The documentation of the care given is in accordance with the written plan of care		
3.2 The patient's physical needs are being met		
3.3 The patient's psycho-social needs are being met		
3.4 The patient is being kept as physically comfortable as his condition permits		
3.5 The patient is in a safe environment		
3.6 The patient and family have received instructions		
3.7 Patient care complies with written policies and procedures		

EVALUATION OF PERFORMANCE STANDARDS

NAME_____ MERIT REVIEW DATE_____

ASSESSMENT OF THE PATIENT	AUDIT 1		AUDIT 2		AUDIT 3		AUDIT 4		PERCENTAGE OF COMPLIANCE	NUMBER OF POINTS*
	YES	NO	YES	NO	YES	NO	YES	NO		
1. The assessment of patient care will be evidenced by the documentation of:										
1.1 Initial assessment of patient's condition on admission										
1.2 Data relevant to the patient's care within 24 hours of admission										

Evaluation done by:

Chart review

TOTAL_____

*Key 100% = +5
99% - 75% = +3
74% - 50% = 0
49% - 25% = -3
24% - 0 = -5

PLANNING THE PATIENT'S CARE	AUDIT 1 YES	AUDIT 1 NO	AUDIT 2 YES	AUDIT 2 NO	AUDIT 3 YES	AUDIT 3 NO	AUDIT 4 YES	AUDIT 4 NO	PERCENTAGE OF COMPLIANCE	NUMBER OF POINTS*
2. A plan of nursing care will be written.										
2.1 The plan will be based on the patient's problems, congruent with the medical plan of care and will include:										
Identified problems										
Nursing interventions										
Measurable goals developed with the patient and family										
A teaching plan										
A discharge plan										
2.2 The care plan will be reviewed at least every eight (8) hours and will relfect the evaluation of care										

Evaluation done by:
Chart review, patient care conference participation, patient and/or family interview

TOTAL_____

*Key 100% = +5
99% - 75% = +3
74% - 50% = 0
49% - 25% = -3
24% - 0 = -5

IMPLEMENTATION OF PATIENT CARE	AUDIT 1 YES	AUDIT 1 NO	AUDIT 2 YES	AUDIT 2 NO	AUDIT 3 YES	AUDIT 3 NO	AUDIT 4 YES	AUDIT 4 NO	PERCENTAGE OF COMPLIANCE	NUMBER OF POINTS *
3. Implementation of patient care will be evidenced by the documentation of:										
3.1 The care given is in accordance with the written plan of care										
3.2 The patient's physical needs being met										
3.3 The patient's psycho-social needs being promoted										
3.4 The patient's being kept physically comfortable as his condition permits										
3.5 The patient's safety										
3.6 Patient/Family teaching										
3.7 All care complies with written policies and procedures										

Evaluation done by: Chart review, Quality Assurance Studies, Direct Observation, Patient interview, Nursing Care Plan Review

TOTAL _____

*KEY: 100 = +5
99% - 75% = +3
74% - 50% = 0
49% - 25% = -3
24% - 0 = -5

EVALUATION OF PATIENT CARE	AUDIT 1 YES	AUDIT 1 NO	AUDIT 2 YES	AUDIT 2 NO	AUDIT 3 YES	AUDIT 3 NO	AUDIT 4 YES	AUDIT 4 NO	PERCENTAGE OF COMPLIANCE	NUMBER OF POINTS *
4. Evaluation of patient care will be evidenced by the documentation of:										
4.1 Patient response to therapy										
4.2 Patient response to teaching										
4.3 A formulated discharge plan										

Evaluation done by: Chart review, Nursing Care Plan Review, Direct Observation, Quality Assurance Studies, Patient Interviews

TOTAL_____

* KEY:
100 = +5
99% - 75% = +3
74% - 50% = 0
49% - 25% = -3
25% - 0 = -5

PARTICIPATION IN HOSPITAL AND UNIT ACTIVITIES	AUDIT 1 YES	AUDIT 1 NO	AUDIT 2 YES	AUDIT 2 NO	AUDIT 3 YES	AUDIT 3 NO	AUDIT 4 YES	AUDIT 4 NO	COMPLIANCE	NUMBER OF POINTS *
5.4 Completion of three of the following: Conduction of patient care conferences (2 per year = 5 points (1 per year = 2.5 points)										
Participation in at least 75% of staff meetings										
Participation in a recognized hospital committee or special project										
Development of a Learning Activity Packet										
Presentation of inservices (1 = 2.5 points) (2 = 5 points)										
Participation in Orientation of New Employees										

Evaluation by: Educational Attendance Record, Meeting Sign-in Sheets, Orientation Schedules, Supervisor Interviews

TOTAL_____

*KEY: NO = -5
YES = +5

PARTICIPATION IN HOSPITAL AND UNIT ACTIVITIES	AUDIT 1 YES	AUDIT 1 NO	AUDIT 2 YES	AUDIT 2 NO	AUDIT 3 YES	AUDIT 3 NO	AUDIT 4 YES	AUDIT 4 NO	COMPLIANCE	NUMBER OF POINTS
5. Participation in hospital and unit activities will be demonstrated by: CPR Certification										
Documentation of 12 Educational Hours										
Documentation of Attendance at all Mandatory Inservices										

Evaluation by: Education Attendance Record, Meeting Sign-in Sheets, Orientation Schedules, Supervisor Interviews

TOTAL_____

+Key: No = -5
YES = +5

COMPLIANCE WITH PERSONNEL POLICIES	NUMBER OF POINTS
6. Compliance with personnel policies will be demonstrated by: Attendance Deduct number of absence occurances	
Promptness Deduct number of tardy incidences	
Deduct, X10 the number of documented noncompliance incidences	

TOTAL TO BE SUBTRACTED_____

EVALUATION OF PERFORMANCE STANDARDS

EVALUATION TOTALS

		TOTAL POINTS
1.	Assessment of Patient Care	_____
2.	Planning Patient Care	_____
3.	Implementing Patient Care	_____
4.	Evaluating Patient Care	_____
5.	Participation in Hospital and Unit Activities	_____
	SUBTRACT	
6.	Noncompliance with Personnel Policies -	_____
	TOTAL	_____
PERCENTAGE OF MERIT RAISE		_____

EMPLOYEE COMMENTS:

SIGNATURES _____

_____

This page to be returned to Human Resources

PERFORMANCE STANDARD

CRITERIA

1. ASSESSMENT OF THE PATIENT

1.1 The initial assessment of the patient's condition will be documented on admission.

The nurse interviews/observes the patient for assessment of problems on admission.

If the patient has physical disabilities (e.g., impaired hearing, vision, speech, etc.) they are recorded.

There is a statement about allergies written.

If the patient depends on prosthetic devices for ADL, this is recorded.

The patient's elimination patterns are recorded.

Behaviors indicative of mental-emotional patterns are recorded.

The general physical appearance of the patient is recorded.

The patient's understanding of his illness is recorded.

The patient's height is recorded.

The patient's weight is recorded.

There is a statement written about medications the patient is taking.

The diet or food preferences of the patient is recorded.

There is recorded a description of any injuries or malformations present at the time.

There is a statement about the current condition of the skin.

The respiratory rate and a description of quality are recorded.

Behaviors indicative of the current emotional state are recorded.

1.2 Data relevant to the patient's care will be documented within 24 hours of admission.

There is documentation within 24 hours of admission regarding the patient's social history.

There is a statement written indicating treatments that were initiated.

2. NURSING CARE PLAN

2.1 Plan of care will be written based on the patient's problems, congruent with the medical plan of care.

Medically prescribed treatments are included in the nursing care records.

The nursing plan indicates pertinent signs or symptoms to be observed with regard to medical treatment, medications, disease process, or possible complications.

The nursing plan indicates care to be given in relation to diagnostic procedures and will include:

Identified problems. There is a written statement about the status of the patient's current problems.

Measureable goals developed with the patient and family.

Nursing Interventions

Nursing interventions specify times and methods for carrying out therapeutic measures.

The nursing plan includes nursing therapeutic measures in regard to disease process.

The nursing plan specifies activities the patient is expected to do for himself and which activities the nursing staff should perform.

The nursing plan indicates the specific extent of ambulation.

The nursing plan specifies time and nature of care related to tubes (e.g., catheter, T-tubes).

The nursing plan includes a schedule for turning and positioning the patient.

There is a plan for providing frequent observation (every 30 minutes or more often) of a patient with threatening conditions, such as respiratory distress, bleeding or psychiatric disorders.

The nursing plan includes a schedule for deep breathing exercises when indicated.

The nursing care plan includes a teaching plan.

The nursing care plan includes a discharge plan.

2.2 The care plan will be reviewed at least every eight hours and updated as necessary. It will reflect the evaluation of care.

3. IMPLEMENTATION OF CARE

3.1 Care will be given in accordance to the written plan of care.

Records document all treatments currently being performed.

Records document the vital signs and blood pressure as ordered.

Records document the reasons for omission of medications.

Records document the reason for administration of PRN medications.

Records document the effect of PRN medications.

Records document the administration of medications including: time given, route of administration, site of injection, name of person who gave medication and dosage.

3.2 The patient's physical needs will be met.

The patient's hands are washed before meals.

Equipment or facilities are available for bathing.

Adequate equipment for oral hygiene is available.

Ostomy bags are properly cleaned and/or changed as needed.

The patient is positioned for maximal lung expansion.

The patient is told to take deep breaths before and after suctioning.

Equipment necessary for maintaining clear airway is readily available.

Equipment for supplying supplementary oxygen is properly used.

The patient is suctioned correctly.

The tracheostomy is suctioned when needed.

After an airway has been removed, the nurse checks for adequacy of respiratory efforts.

The patient ambulates the number of times indicated in the plan.

The patient is assisted with activities of daily living (ADL) when needed.

Range of motion exercises, either active or passive are performed at specified times.

Patient is informed to do (or assisted with) leg exercises in bed, unless contraindicated.

Nursing personnel are accessible to the patient during meals.

The meal is served at the appropriate time after the patient's admission.

There is a written plan for fluids for the patient who has either forced or restricted oral fluids.

The plan for oral fluids specifies: Time fluids are to be given, kinds of fluids to be given and the amount of fluids to be given.

The amount of fluid intake and output is recorded.

Bottles for Intravenous Therapy are labeled with: Patient's name and room number, kind and amount of solution, name and amount of additives and date and time, rate of flow (in drops or on time schedule label).

The IV fluid is infusing at the prescribed rate.

Fluids are removed from the patient's bedside if NPO.

The patient receives the correct diet.

The patient receives assistance with the meal tray.

Bowel function is recorded daily.

The presence or absence of bowel sounds is recorded in the post-operative or bedridden patient or patient who has a gastrointestinal disorder that would warrant monitoring.

Unusual bowel or bladder problems are noted.

The patient is assisted to the bathroom or with bedpan/urinal when requested.

Drainage tubes are patent.

Drainage tubes are properly connected.

The patient is checked for distention and retention of urine after a catheter has been removed.

Voiding or lack of voiding is checked and recorded for the patient in the first 8 hours after surgery.

There is a written statement of the care given to pressure areas on the skin.

The bony prominences are protected from pressure and irritation on bedridden patients.

The condition of the skin around the IV site is recorded.

The patient's bed is clean, dry and free of unnecessary folds which could irritate the skin.

Ostomy bags are properly in place.

Care is given to areas of skin breakdown as often as required.

The care given to areas of skin breakdown is appropriate to the stage of breakdown.

The IV solution is changed at least every 24 hours or as indicated by hospital policy.

The IV tubing is changed every 24 hours or as indicated by hospital policy.

Dressings over IV sites, including Heparin lock sites are changed every 24 hours with condition of the IV insertion site recorded.

IV sites, including Heparing lock sites, are changed as warranted by the condition of the site or at least every 72 hours.

The patient does deep breathing exercises at scheduled intervals.

The patient is turned as often as indicated in the plan.

The nursing staff assists the patient who is NPO with mouth care.

The tracheostomy tubes are clean.

Materials around the trach tube are clean and properly in place (e.g., neck strip and gauze).

The staff uses sterile technique while suctioning the patient with a tracheostomy.

Proper procedure is carried out with equipment and/or solutions for tracheostomy care.

Aseptic technique is carried out as necessary in preparing and giving injections, treatments and special procedures (e.g., catheterizations, dressing changes, IV insertions).

For dressing changes, a sterile field is maintained.

Soiled dressings are disposed of in a separate bag.

The wound site is cleansed from center outward.

Clean gloves are applied after soiled dressings are handled.

Sterile dressings are secured in place over the wound, if indicated.

The urinary catheter drainage system is closed.

The drainage tubing and bag are positioned for maximal drainage and prevention of stasis.

The equipment for irrigation meets requirements for asepsis.

The record indicates that perineal/meatus care has been given at least once daily to patients with catheters.

Dressings are changed as often as indicated in the plan.

3.3 The patient's psycho-social needs will be promoted.

The patient is contacted by the nursing staff within 30 minutes after arrival on the unit.

On admission, the patient is informed of how to call the nurse.

The patient is informed of hospital routines on admission.

Care and use of personal property is explained to the patient and/or family on admission.

The patient is informed of visiting hours on admission to the unit.

The patient is informed of availability of religious counselors and facilities on admission.

The patient is told how to use the phone.

The patient is shown necessary facilities, such as lavatory and bathroom on admission.

Safety measures, such as smoking regulations or precautions for getting in and out of bed are explained on admission.

The patient is informed on admission of the emergency call system in the bathroom.

The nursing staff members call the patient and family by desired name.

The nursing staff members introduce themselves to the patient.

Nursing personnel are courteous to the patient and his family.

The staff elicits patient's participation during rounds.

Written consent is secured prior to special procedures and/or studies.

The nurse is aware of what the patient has been told about his or her illness.

Special procedures or studies are explained to the patient.

The nursing staff informs the patient of what the plan is for his care each day.

Doors are closed for examinations, treatments or privacy.

Nursing staff members knock on the door before entering a patient's room.

There is a sign on the door to indicate that visitors shall not enter.

Nursing staff members discuss patients in private places where they cannot be overheard by patients and visitors.

Opportunity is provided for the patient to discuss fear and anxieties.

The physical dependence/independence of the patient is discussed with the patient.

The use of special equipment (e.g., inhalation equipment, suction, IV, Gomco and similar) is explained to the patient.

The nurse and patient discuss mode of living, living conditions, or occupational role in relation to his or her illness and restorative care.

An opportunity is provided for the patient or the family to evaluate care given by the nursing staff.

Nursing staff members inform the patient about activities before they are carried out.

When the patient's condition warrants, the nurse gives attention to the patient's needs for diversional activities.

Verbal communication is directed toward the severely ill or unconscious patient.

There is tactile communication with the severely ill or unconscious patient.

Nursing personnel are available to the patient during shift report.

The protocol of the patient's religion is observed by the staff.

The patient can identify a particular nurse as "his nurse"

3.4 The patient is kept as physically comfortable as his condition permits.

The water glass and pitcher are within the reach of the patient.

The patient has received attention to complaints of pain, nausea or vomiting.

Extraneous items have been cleared from the bed.

The call light is within the patient's reach.

The equipment for humidification is properly applied.

Lighting is controllable for the patient.

Measures for relief of pain are provided by the nursing staff.

The patient's position is changed.

The patient is taught to splint the incision or painful area.

Medication is given to the patient for pain.

The patient receives pain medication promptly after requesting it.

Hospital nose is kept at a minimum so it is not a disturbance to the patient.

The patient has uninterrupted periods of sleep and rest.

The patient's call light is answered promptly.

The patient is in an upright position for meals, when appropriate.

The halls and patient rooms are quiet and free of boisterous activity.

3.5 The patient will be assured of his physical safety.

The patient is wearing the approved bracelet on his person.

The patient is positioned for optimal body alignment.

The IV needle is adequately secured in place.

The patient with special equipment, such as I.V.'s or other tubing is taught precautions for getting out of bed or given assistance as necessary.

The unconscious patient with special equipment or tubing is provided with the necessary precautions for safety that he would otherwise provide for himself.

The assigned nursing staff members are informed of the patient's present status.

Medications for self-administration are labeled by name and dosage and dispensed according to hospital policy and procedure.

The bedside table, call light, bed control, and other self-care equipment are positioned within the patient's reach.

Oxygen precaution signs are posted in readily observed places.

"No Smoking" signs are posted in all areas where they are needed because of the presence of oxygen.

Side rails are up if the condition of the patient warrants.

Side rails are padded for patients on seizure precautions.

There is a written order from either a physician or a nurse for all nursing procedures currently being performed for the patient.

All wheels are locked when the patient is assisted into or out of a wheelchair.

All wheels are locked when patient is assisted into or out of bed.

The bed is in the lowest position except when treatments are being done.

All electrical equipment is at least six inches from the patient's bed frame.

All electrical equipment is grounded by an approved grounding plug.

All electrical equipment is maintained for safety.

If supports are needed (footboards, sandbags, pillows) they are being used properly.

There is a list of the patient's allergies on the front of the chart and on the Kardex.

The nursing staff follows the isolation procedure specified for each isolated patient.

The procedure for disposal of dirty/used supplies and equipment is followed.

Precautions are taken to protect the patient from known respiratory infections and other communicable diseases.

Equipment currently in use is clean.

Measures are taken for proper removal of contaminated linen.

Isolation precautions are posted outside the patient's door.

Necessary supplies (e.g., gown, gloves, mask) are available outside the door of isolated patients.

All nursing care is under the direct supervision of a registered nurse.

Actions to be taken in care of fire are known.

The patient's room is clean.

Waste has been removed from the patient's room.

All equipment in the room is being used or is on stand-by basis.

Supplies for handwashing (soap, water, paper towels) are available.

3.6 The patient and family will be taught the elements of his condition and treatment.

The patient or family is taught to report signs or symptoms (e.g., rash, pain) to the nursing staff.

There is a teaching plan for the patient.

The plan for oral fluids is formulated jointly by the patient and nurse.

There is a written statement in regard to the family's level of understanding of the patient's condition.

The nurse, patient and family discuss the family's participation in the care of the patient.

Opportunity is provided for the family to discuss fears and anxieties.

3.7 All care will comply with written policies and procedures.

4. EVALUATION OF PATIENT CARE

4.1 The patient's response to therapy and patient teaching will be documented.

Observations related to the disease process, treatment or possible complications are noted (e.g., changes in condition, observations to detect onset of complications, etc.).

Records document the side or untoward effects of current therapy.

Records document the patient's response to teaching.

Records document the patient's need for additional instruction.

The patient's performance of self-care activities (e.g., ADL, doing own treatments, etc.) are recorded.

4.2 A discharge plan will be formulated and documented.

Before discharge, the patient or family is informed of or instructed in treatments that must be performed at home.

Merit Increase Scale

R.N. Staff Nurse

Job Code 1046

- 0	=	1%
0 - 25	=	2%
26 - 50	=	3%
51 - 75	=	4%
76 - 100	=	5%
101+	=	6%

JOB DESCRIPTION

POSITION TITLE: Staff LPN DATE EFFECTIVE: June 1, 1984

DEPARTMENT: Nursing REPLACES: March, 1982

I. POSITION RELATIONSHIPS:

A. Supervisor: Team Leader
B. Position Supervised: None

II. JOB SUMMARY:

Performs total patient care on assigned patients within the scope of nursing preparation and consistent with established standards of nursing practice and the goals of Mercy Health Center.

III. PERFORMANCE STANDARDS:

In order to provide optimal, personalized Christian family-centered care, the staff L.P.N. will attain the following performance standards:

1. Assist with the Assessment of the Patient

   1.1 Physical data, relevant to the initial assessment of the patient's condition will be documented on admission.

2. Planning the Patient's Care Under the Direction of the R.N.

   2.1 A nursing Care Plan will be written

   2.2 The plan of care will be changed with additions and deletions, as the patient's needs change.

3. Implementation of Patient Care

   3.1 Care will be given in accordance to the written plan of care.

   3.2 The patient's physical needs will be met.

3.3 The patient and family will receive emotional support.

3.4 The patient will be assured of his physical safety.

3.5 The patient will be kept as physically comfortable as his condition permits.

3.6 All care will comply with written policies and procedures.

4. Evaluation of Patient Care

4.1 The patient's response to therapy will be documented

4.2 The R.N. will be informed of changes in the patient's condition.

4.3 The R.N. will be informed of changes in the medical orders.

4.4 The R.N. will be assisted in the formulation of the discharge plan.

5. Participation in hospital and unit activities

There will be documentation of attendance at 12 educational hours.

There will be documentation of attendance at all mandatory inservices.

There will be evidence of yearly CPR certification.

At least two of the following will be accomplished yearly.

-Participation in at least 75% of staff meetings held.

-Participation in a recognized committee or special project.

-Participation in the orientation of employees.

-Assist in the presentation of one inservice.

-Participate in the presentation of two patient conferences.

6. Compliance with personnel policies

There will be no written evidence that indicates noncompliance with personnel policies.

IV. **POSITION QUALIFICATIONS:**

A. Education: Graduate of an approved school of practical nursing.

B. Certification, licensure or bonding requirements: Licensed to practice practical nursing in the State of Oklahoma.

C. Previous Experience: Previous experience not required. Continuing education preferred. Knowledge of equipment and supplies that are necessary and related to nursing care.

V. APPROVAL:

Department Manager Carol Gray

Human Resources Marshall Jones

Administration Marvin Beavers

LPN PERFORMANCE AUDIT

DATE_____ DEPARTMENT NUMBER_____

EMPLOYEE_____ EVALUATOR_____

ADMINISTRATIVE SUPERVISOR_____

CHART NUMBER_____ PATIENT'S ROOM NUMBER_____

Using any one of the following: Chart review, direct observation, patient interviews, nursing care reviews, patient care conference, participation and/or quality assurance studies, complete by checking the appropriate boxes.

	YES	NO
1. Assist with assessment of the Patient		
1.1 Physical data, relevant to the initial assessment of the patient's condition is documented on admission		
2. Planning the Patient's Care under the direction of the R.N.		
2.1 A nursing care plan is written		
2.2 The plan of care is changed with additions and deletions as the patient's needs change		
3. Implementation of Patient Care		
3.1 Care is given in accordance to the written plan of care		
3.2 The patient's physical needs are met		
3.3 The patient and family is receiving emotional support		
3.4 The patient is assured of his physical safety		
3.5 The patient is as physically comfortable as his condition permits		
3.6 All care complies with written policies and procedures		

PERFORMANCE AUDIT - Page 2

	YES	NO
4. Evaluation of Patient Care		
4.1 The patient's response to therapy is documented		
4.2 Information of changes in the patient's condition are relayed to the R.N.		
4.3 Information of changes in the medical orders are relayed to the R.N.		
4.4 A formulated discharge plan is completed under the direction of the R.N.		

The following have been accomplished since _____
Date of last Merit Review

CPR expiration date _____

Number of educational hours documented _____

Number of patient care conferences _____

Number of staff meetings attended _____

Name of committee or special project chosen _____

Number of inservices presented _____

Number of employees oriented _____

Number of absence occurances _____

Number of tardy incidences _____

LPN EVALUATION OF PERFORMANCE STANDARDS

Department Number_____

NAME_____ Merit Review Date_____

ASSESSMENT OF THE PATIENT WILL BE EVIDENCED BY THE DOCUMENTATION OF:	AUDIT 1 YES	AUDIT 1 NO	AUDIT 2 YES	AUDIT 2 NO	AUDIT 3 YES	AUDIT 3 NO	AUDIT 4 YES	AUDIT 4 NO	PERCENTAGE OF COMPLIANCE	NUMBER OF * POINTS
1. Assistance with the Assessment of the patient.										
1.1 Physical data, relevant to the initial assessment of the patient's condition is documented on admission										
2. Planning the patient's care under the direction of the R.N.										
2.1 A nursing care plan is written										
2.2 The plan of care is changed with additions and deletions, as the patient's needs change										

Evaluation done by: Chart Reviews, R.N. Interviews, Care Plan Reviews.

TOTAL_____

* KEY
100% = +5
99% - 75% = +3
74% - 50% = 0
49% - 25% = -3
24% - 0 = -5

3. IMPLEMENTATION OF PATIENT CARE WILL BE EVIDENCED BY THE DOCUMENTATION OF:	AUDIT 1 YES	NO	AUDIT 2 YES	NO	AUDIT 3 YES	NO	AUDIT 4 YES	NO	PERCENTAGE OF COMPLIANCE	NUMBER OF POINTS *
3.1 Care given is in accordance with the written plan of care										
3.2 The patient's physical needs being met										
3.3 The patient and family receiving emotional support.										
3.4 The patient is physically safe.										
3.5 The patient is kept as physically comfortable as his condition permits.										
3.6 All care complies with written policies and procedures.										

Evaluation done by: Chart reviews, Quality Assurance Studies, Direct Observation, Patient interviews, Nursing Care Plan Reviews, R.N. interviews.

* KEY

100		+5
99%	- 75% =	+3
74%	- 50% =	0
49%	- 25% =	-3
24%	- 0 =	-5

TOTAL _____

4. EVALUATION OF PATIENT CARE WILL BE EVIDENCED BY:	AUDIT 1 YES	AUDIT 1 NO	AUDIT 2 YES	AUDIT 2 NO	AUDIT 3 YES	AUDIT 3 NO	AUDIT 4 YES	AUDIT 4 NO	PERCENTAGE OF COMPLIANCE	NUMBER OF POINTS *
4.1 The patient's response to therapy is documented										
4.2 Information of changes in the patient condition are relayed to the R.N.										
4.3 Information of changes in the medical orders are relayed to the R.N.										
4.4 A formulated discharge plan is completed under the direction of the R.N.										

Evaluation done by: Chart Review, Nursing Care Plan Review, Direct Observation, Quality Assurance Studies, Patient Interviews, R.N. Interviews

* KEY

100			+5
99%	– 75%	=	+3
74%	– 50%	=	0
49%	– 25%	=	-3
25%	– 0	=	-5

TOTAL _____

5. PARTICIPATION IN HOSPITAL AND UNIT ACTIVITIES	AUDIT 1	AUDIT 2	AUDIT 3	AUDIT 4	COMPLIANCE	NUMBER OF POINTS *
Participation in hospital and unit activities will be demonstrated by: CPR Certification						
Documentation of 12 Educational Hours						
Documentation of Attendance at all Mandatory Inservices						

Evaluation by: Educational Attendance Record, Meeting Sign-In Sheets, Orientation Schedules, Supervisor Interviews.

* KEY: No = -5
Yes = +5

TOTAL _____

PARTICIPATION IN HOSPITAL AND UNIT ACTIVITIES WILL BE DEMONSTRATED BY:	YES	NO	YES	NO	YES	NO	YES	NO	COMPLIANCE	NUMBER OF POINTS *
Completion of two of the following: Participation in at least 75% of staff meetings										
Participation in a recognized hospital committee or special project										
Participation in Orientation of new employees										
Assistance in the presentation of one inservice										
Participation in the presentation of two patient care conferences										

Evaluation by: Educational Attendance Record, Meeting Sign-in Sheets, Orientation Schedules, Supervisor Interviews.

* KEY No = -5
Yes = +5

TOTAL _____

COMPLIANCE WITH PERSONNEL POLICIES	NUMBER OF POINTS
6. Compliance with personnel policies will be demonstrated by: Attendance Deduct number of absence occurances	
Promptness Deduct number of tardy incidences.	
Deduct, X10 the number of documented noncompliance incidences.	

TOTAL TO BE SUBTRACTED _____

NAME_____ DATE_____

DEPARTMENT_____

EVALUATION OF PERFORMANCE STANDARDS

EVALUATION TOTALS

		TOTAL POINTS
1. Assessment of Patient Care		_____
2. Planning Patient Care		_____
3. Implementing Patient Care		_____
4. Evaluating Patient Care		_____
5. Participation in Hospital and Unit Activities		_____
SUBTRACT		
6. Noncompliance with Personnel Policies	-	_____
	TOTAL	_____
PERCENTAGE OF MERIT RAISE		_____

EMPLOYEE COMMENTS

SIGNATURES _____

_____

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VITA

Margaret Anna Thielen Christensen

Candidate for the Degree of

Doctor of Education

Thesis: IMPACT OF A CRITERION BASED PERFORMANCE APPRAISAL SYSTEM IN A 400 BED HOSPITAL IN OKLAHOMA

Major Field: Occupational and Adult Education

Biographical:

Personal Date: Born in San Francisco, California, November 10, 1938, the daughter of Dr. John B. and Catherine Scott Thielen. Married to Robert E. Christensen June 24, 1961.

Education: Graduated from Our Lady of Good Counsel High School, Fonda, Iowa, in May 1957; received a diploma in Nursing from St. Francis School of Nursing in May of 1971; received Bachelor of General Studies Degree from Wichita State University in December, 1978; received a Master of Education degree from Central State University in May, 1984; completed requirements for the Doctor of Education degree at Oklahoma State University in December, 1986.

Professional Experience: RN Staff Nurse, St. Joseph Medical Center, Wichita, KS, May, 1972 to September, 1974; Development Supervisor, St. Joseph Medical Center, Wichita, KS, September, 1974 to March, 1979; Head Nurse, Psychiatric Unit, Baptist Medical Center, Oklahoma City; June, 1979 to June, 1980. Nursing Supervisor and Staff Development Coordinator, Mercy Health Center, Oklahoma City, June, 1980 to March, 1984; Director of Management Planning and Development, Allied Nursing Care, Oklahoma City, March 1984 to August, 1985; President of Human Resource Consultants, Inc., Edmond, Oklahoma, January 1982 to Present.