Management in the Health Services - The Role of the Nurse

A report prepared for the Commission on Nursing

By Maureen Flynn

Edited by Dr. Geraldine McCarthy-Haslam

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July 1998

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PREFACE

On March 21st 1997, the Minister for Health, Mr. Michael Noonan, T.D., established the Commission on Nursing. The terms of reference were: to examine and report on the role of nurses in the health service including:

- the evolving role of nurses, reflecting their professional development and the overall management of services;
- promotional opportunities and related difficulties;
- structural and work changes appropriate for the effective and efficient discharge of that role;
- the requirements placed on nurses, both in training and the delivery of services;
- segmentation of the grade;
- training and educational requirements; and
- the role and function of An Bord Altranais generally, including, *inter alia*, education and professional development, regulation and protection of the citizen.

As part of the preparatory work a number of reports were commissioned. This report entitled "Management in the Health Services – The Role of the Nurse" has been prepared by Maureen Flynn and edited by Dr. Geraldine McCarthy-Haslam.

Mella Carroll

Ms. Justice Mella Carroll
Chair of the
Commission on Nursing

July 1998

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INTRODUCTION

During the consultative process Irish nurses identified clear areas of dissatisfaction and concern directly relating to nursing management. In order to address the issues and to facilitate the work of The Commission on Nursing, a review of the available nursing management literature was conducted. The terms of reference given for the review were to: initially, carry out a detailed review of literature on the role of nurses in the management of health services both in Ireland and internationally. In reviewing literature on international developments the researcher was asked to concentrate on developments in the United Kingdom, North America, Europe and Australia/New Zealand, which are of relevance to the role of nurses in the management of the health services in Ireland.

The aim of the review was to identify the differing roles taken by nurses in the management of health services, nationally and internationally and from the available published material, assess the applicability of these roles to an Irish context. Due to the breadth of the subject area, the emphasis of the review was confined to the management role of nurses in hospitals. While community based health services are intricately linked to that of hospital there are distinctive aspects of their management which would require a separate examination. Systems for calculating staffing numbers and skill were also considered to be beyond the scope of this review.

As the last extensive examination of nursing in Ireland was conducted in 1980 (*Working Party on General Nursing*), the search was confined to literature published in English since that date. In total over 450 pieces of literature were identified with little published research pertaining to nursing management in Ireland. Because there is no centralised regularly updated catalogue of research conducted in Irish universities, it was difficult to identify pertinent unpublished studies. In addition, a number of postgraduate studies pertaining to the Irish situation are undertaken by Irish nurses studying in universities outside the State. The review of literature in Ireland focuses on a number of unpublished studies in tandem with major reports and policy documents. The majority of research on nursing management was found in literature from the United Kingdom (UK) and North America. Varying amounts of relevant information were also located in literature from Australia, Canada, Europe, and New Zealand. The information ranges from rigorous scientific research to anecdotal material. As the anecdotal material comments on the initiatives resulting from scientific research it was included to chart the trends in the profession's response. Management concepts and *role theory* from the theoretical framework for the review, which are presented in four chapters.

Chapter one, presents and discusses the general concepts and theories of management which can be used to understand the more particular role of the nurse manager in hospitals

and health organisations. Organisation structures, models, design, and culture are addressed. The dominant themes throughout the literature are the importance of expert management skills, decentralisation and staff empowerment.

In chapter two, the concept of *role theory* was used as a framework to examine roles within nurse management. The concept of role; set, behaviours, expectations and competencies were used to describe the various nurse management roles. The particular difficulties in role; ambiguity, conflict, overload and stress are outlined. Other pertinent issues such as leadership, strategic planning, models for nursing care delivery, profile of the workforce, quality management, education and promotional opportunities are also discussed.

Chapter three, reviews the Irish literature on the evolution of the nurse managers' role. Policy documents that have influenced the development of the Irish nurse managers role are considered. A paucity of publications on the role and function of Irish nurse managers was found. However, the available literature was used to describe current roles. Nurse managers' ability to influence policy making was discussed together with the perceived barriers to promotion in management positions.

Chapter four, gives an overview of the nursing management structures currently operational in the USA, Canada, Australia and New Zealand, Europe and the UK and examines their applicability to an Irish health care environment. The summary/conclusion gives a synopsis of the entire review and identifies areas that might require further examination.

CHAPTER 1

CONCEPTS OF MANAGEMENT

Introduction

Management has been described as the process of working with and through, other people to achieve organisational objectives in a changing environment (Douglas, 1996). No single definition of management, however, has been universally accepted. A myriad of theories exists to guide the work of managers. Theories and concepts of management can be very useful as the awareness entailed in understanding how people manage, generates ways of thinking about management, which if acted on, should help to run better organisations. Drucker, a management theorist, offers the following description for the role of the manager:

> The manager has the task of creating a true whole that is larger than the sum of its parts, a proactive entity that turns out more than the sum of the resources put into it. One analogy is the conductor of a symphony orchestra, through whose effort, vision and leadership, individual instrumental parts that are so much noise by themselves become the living whole of music. But the conductor has the composer's score; he is only interpreter. The manager is both composer and conductor (Drucker, 1954).

When considering the hospital ward setting or patient care in the home, Drucker's analogy is useful to conceptualise the nursing management function. It is very clear that the ward sister or public health nurse functions much like the conductor in integrating the services of the disparate health care teams in order to provide streamlined care.

This chapter recounts the general theories of management which can be used to understand the more particular role of managers in hospitals and health care organisations. Most management theories have evolved in particular professional domains, not all of which are relevant to the role of the nurse manager. This review will focus on management theories which provide insight into organisation structures, models, design, climate; as well as models for nursing care delivery and management issues such as strategic planning and innovation management. It begins by differentiating between the classical and modern management theories, and includes motivation theories and organisational structure. It concludes with issues related to nurse management.

1.1 Classical Management Theory

When people group together and perform different but interdependent work to meet a common objective, organised human behaviour results. *Classical* organisation theory

presents a set of traditions, beliefs, principles and techniques as a result of the study of organised behaviour in industry (Grohar-Murray and DiCroce, 1997). *Classical theory* is divided into three categories "scientific management", "administrative management" and the "bureaucratic model". Administrative management and the bureaucratic model are discussed below in relation to hospital structures.

Administrative Management

Both the "scientific management" and "administrative management" perspectives offer a group of principles – *organisational principles*. A synthesis of the main propositions and principles are; communication, unity of command, span of control, delegation of authority, and unity of purpose (Grohar-Murray and DiCroce, 1997). Communication, is defined by Boyle (1995) as "a dimension of structure in which information is transmitted throughout the organisation to provide data for decision making, to motivate employees, to exercise control, and to express satisfaction or dissatisfaction with operations" (p.11). Unity of command, specifies that "no subordinates should be responsible to more than one superior" (Loveridge and Cummings, 1996, p.11). Span of control, refers to the number of employees that one supervisor can effectively and efficiently manage. This depends on; the experience of the manager, the skill of the employees, the stability of the work unit, the volume of work and the level of morale among the employees. Delegation assigns responsibility, extends authority, and creates accountability, it makes responsibility meaningful (Boyle, 1995). Unity of purpose, is achieved through the use of definite work plans formulated on the basis of the objectives, policies, standards and work procedures previously accepted by the organisation.

Fayol (1994) one of the original management theorists formulated five functions representative of the management role, these are; planning, organising, commanding, co-ordinating and controlling. The combination of these functions together are often referred to as *classical management theory*. The functions constitute what a manager does when he is actually managing, as distinct from many other non-managerial duties which he will necessarily carry out. Fayol held that specialisation is appropriate to all levels of work, technical and administrative. Today this phenomenon is very evident in health care organisation; nurses, doctors and paramedical staff each sub-specialise within their discipline. Fayol also held that at the worker level, technical expertise is essential. However, as workers progress up the chain of command they need to add administrative ability to technical expertise to be effective and credible. This would suggest that nurse managers require both nursing and administrative skills for proficient role performance. To maintain credibility and obtain respect and acceptance, nurse managers must have a clinical background and a deep understanding of the "nursing work" in the area they manage.

Bureaucracy Model

Weber suggests that the *bureaucracy model* is the ideal organisational form to provide a rational and predictable method for organising the work of human beings (Weber, 1978). He reports that "bureaucratic" organisations have been created to a very substantial degree, through domination and calculation. The characteristics of a "bureaucracy" include: a well defined hierarchy of authority; a clear division of work; a system of rules covering the rights and duties of position incumbent; a system of procedures for dealing

with the work situation; impersonality of interpersonal relationships; employment and promotion based on technical knowledge (Weber, 1970).

A hierarchy is defined as a body of persons or things organised or classified in pyramidal or vertical fashion according to work, capacity or authority (Douglas, 1996). Weber's (1970) theory of "bureaucracy" emphasises the concepts of authority, domination, command, power, and discipline. According to Thompson (1961), the major problem of modern bureaucracies is the imbalance between ability and authority. The rights and responsibilities of the hierarchical superior and the specialised ability and knowledge to solve the problem can be vested in different people. This results in continuing confusion and conflict. Thompson contends that in this situation a supervisor often reacts with an excessive need for control and an exaggerated emphasis on rules, resistance to change, and insistence on the rights of office. This phenomenon may be witnessed in the traditional hospital structure, where nurse managers have resisted change as a form of self protection in a rapidly changing environment. The hierarchy of authority in a "bureaucracy" is essential for co-ordination of a complex organisation but often produces feelings of apathy and dissatisfaction among staff employed at lower levels of the hierarchy. This impedes identification with the organisation's objectives. Thomas suggests that close supervision can be resented and in this situation employees tend to become poorly motivated. Critics of bureaucracy state that frequently strict adherence to rules reduces spontaneity, causes rigidity, and discourages innovation (Tushman et al. 1989). Loveridge and Cummings (1996) identify a conflict inherent in the use of bureaucracies in health care organisations. When professionals are members of an organisation, the question arises as to whether their expertise and position in the hierarchy derive from their knowledge of organisational operation or from their professional discipline. The authors suggest that if the professional's expertise derives from their discipline, then allegiance is to society and not the organisation. The term bureaucracy has often been used to indicate difficulties in getting things done. In reality, many features of a bureaucracy are desirable, but the ways in which the elements have been operationalised have added to the poor perception sometimes associated with the term.

1.2 Modern Theory

Modern organisational theory represents a different way of viewing people in organisations. The emphasis is on individuals rather than concentrating on the work of the organisation. *Modern theory* is so called because of its contribution to *organisational theory* rather than its chronology. In fact, *modern theory* had its origin in the late 1920's and continues through today (Grohar-Murray and DiCroce, 1997). A number of theories are grouped under this heading. *General systems theory, contingency theory, congruence theory of organisation behaviour, structural theory* and *human relations management* are considered in this review.

General Systems Theory

A system is defined as an "organised combination of united parts or events forming a complex or unitary whole that is co-ordinated to accomplish a set of goals" (Von Bertalanfly, 1968). Three components come together to achieve the goal of a system, input, throughput and output (Kayuha, 1996). *General systems theory* lends itself to an understanding of the complexity of organisations in a way that cannot be addressed by

the conventional one-way, cause-and-effect scientific approach. *General systems theory* is one of wholeness, proposing that the whole is more than the sum of parts (Lawrence and Lorsch, 1967). A hospital or community service is composed of many elements, often divided into interdependent departments: nursing, medicine, surgery, radiology, physiotherapy, occupational therapy, dietetics, social work, catering, maintenance etc. Each department offers particular expertise but the common element among them is the delivery of quality patient care. A "social system" is concerned with an individual's participation in society and consists of "the patterned activities of people that are complementary or interdependent with respect to some common output or outcome" (Kast and Rosenzweig, 1985, p.108). There is a tendency to think of organisations as buildings, yet the essence of "modern systems" thinking recognises that people are the functioning unit of an organisation: without the patterned behaviour of the group, there is no social system and thus no organisation. An "open system" is defined as a system in exchange of matter with its environment, which emphasises the relationship between a system and its surroundings and the interrelationships of different levels of systems (Katz and Kahn, 1966). "Open" organisations depend on environmental input and feedback. Organisations learn from the interpretation of this input. *Systems theory* discusses the organisation and worker as a whole rather than as separate entities. Therefore, the output of the hospital – good quality patient care – is superior to matters related to individual departments within the hospital. In fact, many hospitals in North America have dismantled traditional departments within the hospital structure (Manthey, 1990). Similar changes appear to be taking place in Australia and New Zealand. Reports of changes in hospital structures and traditional departments of nursing have been set out in correspondence to the Commission on Nursing (see Chapter 4). Some hospitals have adopted *integrated-delivery-systems* where a team of professionals is formed for each unit, rather than working from their own specialist department. Depending on the needs of the unit, the team is comprised of : nurses, a physiotherapist, a social worker an occupational therapist, a nutritionist and others. Each professional reports to a single general manager for the unit. The unit manager may or may not be a nurse. The system offers many interdisciplinary advantages, however, it can result in reduced leadership within the professional groups, sometimes leading to a sense of isolation.

Gilles (1994) suggests that a systems approach facilitates understanding of a complex phenomenon by encouraging information "chunking" and clarifying relationships between different aspects of the phenomenon and, as such, is an important approach to nursing management.

Contingency Theory and Congruence Model of Organisational Behaviour

Contingency theory suggests that organisational performance is contingent on an appropriate fit between organisational structure and environmental factors (Lawerence and Lorsch, 1967). Formal centralised organisational structures are found in environments of certainty, while uncertain environments are associated with less formalised organisational structures. When the fit between structure and environment occurs, organisational performance has been found to be more effective (Lawerence and Lorsch, 1967). Traditionally, hospitals can be viewed as environments of certainty and as such, centralised structures for the organisations evolved. It is within these defined structures

that nurse managers operate. An extension of this theory was the development of the *congruence model of organisational behaviour.*

The *congruence model of organisational behaviour* acknowledges that "getting organisations to operate effectively is difficult" (Tushman et al. 1989, p.95). Nadler suggests that the management of organisational behaviour is central to the management task – a task that involves the capacity to: understand the behaviour patterns of individuals; groups and organisations; to predict what behavioural responses will be elicited by various managerial actions; and finally to use this understanding and predictions to achieve control (Tushman et al. 1989). The delivery of health care, whether in hospital or the community, is a very complex operation. A service company such as a hospital, like any big organisation, is composed of four major components, which Nadler describes as; "the task, the individuals, the formal organisational arrangements and the informal organisation" (Tushman et al. 1989, p. 95). For success in health-care delivery, nurse managers must be conscious of how well the four components fit together. Particular emphasis should be placed on an understanding of the informal organisation often termed the "grapevine."

Structural Theory

Kanter's *structural theory* argues that the structure of the work environment has a significant effect on work behaviour (Kanter, 1977). *Structural theory* attends to two of the critical variables in the nursing work environment: women and power. Kanter's research indicates that an individual's work effectiveness is, in part, a function of the characteristics of the position.

Positions that afford access to opportunity and power promote effective work behaviours. Individuals in positions that afford access to opportunity are more productive and in turn invest in the organisation, while those who have little access to opportunity are less effective and tend to avoid investing themselves in the organisation (Marriner-Tomey, 1990). Kanter proposed that the powerful who have connections, support and information networks, encourage staff to grow and develop their talents; but the powerless, who have limited influence, and restricted information are threatened by staff development. They become territorial and domain oriented. The area where they have a little influence becomes theirs and only theirs, with any infringements being interpreted as a threat. The result is a constrained, rigid, detail-oriented management style that causes powerlessness in subordinates. This mirrors the powerlessness the manager experiences, leading to a downward cycle of powerlessness. Kanter found that both women and men who are "stuck" in their positions exhibited ineffective work behaviours. Women are more likely than men to be in these positions. Kanter's *structural theory* holds that to alter the downward powerlessness cycle and the resultant behavioural response, a change in the organisational structure of power and opportunity rather than the individual is necessary. A study carried out by Laschinger (1996) supports Kanter's theory of "structural power" for a nurse manager population in Canada (Laschinger, 1996).

Access to power and authority is perceived to be very restricted by Irish nurses. The lack of promotional opportunities is very clearly documented (see Chapter 3). Many nurses have a real of sense of being "stuck" as a consequence. This feeling has been reinforced by the lack of visible or recognised career paths to assist nurses when considering career

development. The absence of clinical ladders compounds many nurses sense of frustration and powerlessness. Internationally, decentralisation of the nursing structure and the introduction of "primary nursing" (see Chapter 2) have been used as methods for devolving power, granting authority and autonomy.

Human Relations Management

There are a number of management theories which emphasise the necessity of interpersonal understanding for effective management which can be grouped together as human relations management. The proponents of human relations management consider *classical management theory* as outmoded for contemporary practice. It is suggested that the theory lacks certain predictive and explanatory components and neglects to recognise the role human relations play in management (Fayol, 1949). Mintzberg, in evaluating *classical theory* argues that "planning," "organising," "co-ordinating" and "controlling" tell us little about what mangers actually do. At best they indicate some vague objectives managers have when they work (Mintzberg, 1975). Mintzberg suggests that understanding their jobs as well as understanding themselves takes both introspection and objectivity on the managers" part. In a review of management research across disciplines, he found that managers played a complex intertwined combination of interpersonal, information, and decisional roles (Mintzberg, 1975). Mintzberg holds that the manager's job can be described in terms of various "roles":- organised sets of behaviours identified within a position. He describes ten roles as evidenced in Table 1.1. Formal authority gives rise to the three interpersonal roles, which in turn give rise to the three informational roles; these two sets of roles enable the manager to play the four decisional roles. The roles are interdependent and constantly developing in a spiral fashion.

The ten roles are not easily separable – they form a "gestalt," an integrated whole. For this reason, two or three people cannot share a single managerial position unless they can act as one entity. This means that they "cannot divide up the ten roles unless they can very carefully reintegrate them" (Mintzberg, 1975, p.59). Thus informational difficulties may be encountered where job-sharing of management positions takes place (see Table 1.1).

TABLE 1.1. Management Roles

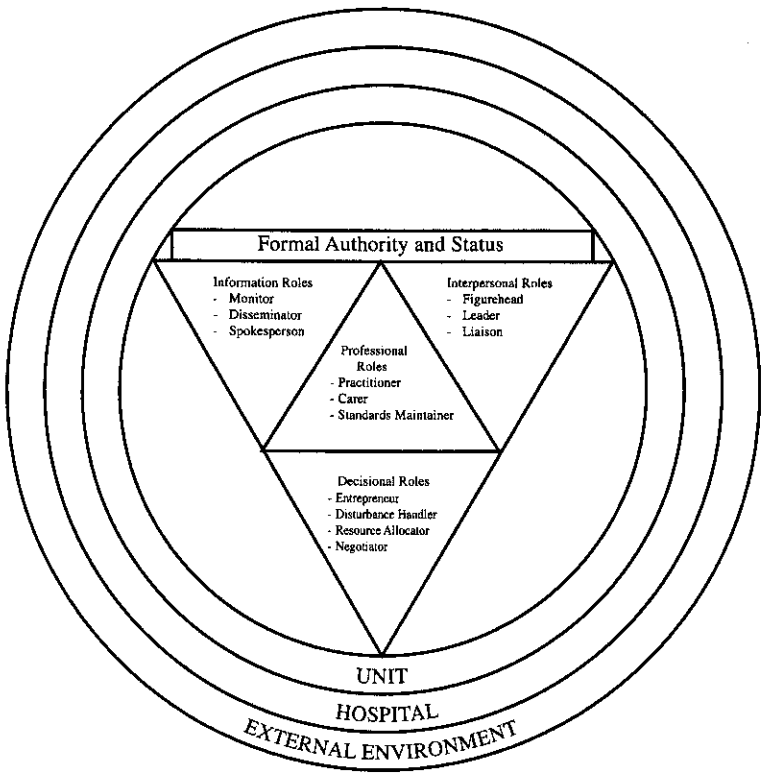
INTERPERSONAL ROLES	
Figure head role	— ceremonial duties.
Leader role	— indirect and direct leadership.
Liaison role	— contacts outside of vertical chain of command; build up external information systems.
INFORMATIONAL ROLES	
Monitor role	— scan for information, mostly verbal.
Disseminator role	— transfer of privileged information.
Spokesman role	— inform and satisfy influential people.
DECISIONAL ROLES	
Entrepreneur	— adopt to changing conditions.
Disturbance handler	— responding to high pressure disturbances.
Resource allocator	— time management, unit structure, authorisation of important decisions.
Negotiator	— commit organisational resources.

Source: **Mintzberg, H. (1975) The Manager's Job: folklore and fact. *Harvard Business Review* 53, p. 59.**

As a predominantly female profession, the issue of job-sharing in nursing is very important. In Ireland there is a tendency to divide up the role responsibilities and work practices of deputy/assistant nurse managers positions. Mintzberg's concepts suggests that substantial informational difficulties may be encountered by nurse managers when attempting to reintegrate the ten role responsibilities.

A Canadian qualitative study on the role of the nurse manager was conducted, based on interviews, with ten front line nurse managers from large acute care teaching hospitals in Ontario. Role description revealed many similarities to Mintzberg's ten managerial roles, which were grouped into three categories of managerial activities: interpersonal relationships, transfer of information and decision making (Coulson and Cragg, 1995). The nurse managers described roles, in addition to those identified by Mintzberg, that resulted from the manager's status as a nurse managing nurses. These are: practitioner, standards maintainer, and carer. Several of the managers reported internal conflict as they tried to perform the roles as both expert clinician and manager. In Figure 1.1 a model designed by Coulson and Cragg (1995) to depict the role of the nurse manager is presented. Mintzbergs work on interpersonal roles, informational roles and decisional roles was used as the basis for the illustration.

FIGURE 1.1 Nurse Manager Model.



Source: **Coulson, M. and Cragg C. (1995) Nurse Managers Perception of their Role.** ***Canadian Journal of Nursing Administration*** **8, p. 59.**

Seven key ingredients to successful management are offered by Davidhizar (1995). They can be summarised by the "seven S's":

- superordinate goals;
- an effective organisational structure;
- dedicated and supportive staff;
- ability to use the health care system;
- a positive, charismatic style;
- acquired knowledge and skills and
- a strategy plan for the future (Davidhizar, 1995, p.39).

"Superordinate" goals suggest that every successful manager needs to have a vision of how their department can support the mission of the health care organisation in its day-to-day activities. In relation to "structure", Daivdhizar (1995) contends that managers in a service setting must ensure that: written and articulated policies for personnel and nursing care are understood; guidelines for delivery of care are clearly described in procedure manuals; emergency procedures are understood and practised; orientation manuals and programmes are available to all staff; and a supervisory structure for evaluating staff instituted. The third S – "staff", suggests that for managers to succeed in meeting the goals and mission of the organisation, staff must be carefully selected, trained, monitored and socialised as necessary. Effective communication with staff, understanding of the health agency and delegation were perceived as essential aspects of staffing. Interpersonal "style" and charisma were considered important keys to successful leadership (communicating positive self-esteem, focusing on people, forming and promoting a vision and implementing the vision). "Skills" relating to both technical and creative ability and strategic planning were included in the framework. The methodology supporting the design of the framework was not reported, however it is apparent that the seven key ingredients have been informed by participative-management as suggested in *Theory Z* (see section 1.3 *theory Z*).

1.3 Motivation Theories

The basic principle of management is getting work done through others. For this reason it is vital that managers have a deep understanding of human behaviour and motivators. Several theories have been devised to assist managers in gaining an insight into the concept of motivation. The following are discussed: *hierarchy of needs theory, existence relatedness and growth theory, achievement-motivation theory, positive reinforcement theory, expectancy theory, motivation-hygiene theory and theory X, Y and Z.*

Hierarchy of Needs

Maslow first published his theory of *the hierarchy of needs*, in 1943. The hierarchy included five basic needs: physiological needs, safety needs, love needs, esteem needs and the need for self-actualisation. Each need acts as an unconscious, biological motivator for human beings. Maslow later recognised other needs that are not part of the five basic needs; cognitive needs, aesthetic needs, and growth needs (Maslow, 1966). Fuzard (1984) studied job enrichment and the path to self-actualisation for nurses. A review of the study suggests that adequate self-esteem produces confidence and capability which in turn bring about greater productivity (Marriner-Tomey, 1990). Fuszard concluded that "once the

esteem needs are met, the need for self-actualisation emerges" (Fuszard, 1984, p. 35). For self-actualisation to occur, people must not only like their job, but do the job well and strive to make it better.

Marriner-Tomey (1988) suggests the "Maslow's outline is correct in general [but] human needs are more complex than a simple listing would indicate" (Marriner-Tomey, 1988, p.196). She suggests that the hierarchy can be applied to nursing management at each level. The physiological level of needs should include adequate pay to purchase food and shelter, adequate hours for rest, and adequate breaks during the day for personal and physiological needs. She advises that a stable environment is needed for safety. Nurse mangers should encourage cohesive work groups to satisfy "love needs" and to encourage more effective work. Management plays a big role in the "esteem needs" by giving due praise and other incentives to employees. A nurse manager can contribute to nurses reaching self-actualisation by encouraging them to set goals and strive to meet them (Marriner-Tomey, 1988).

Existence, Relatedness, and Growth Theory

Alderfer's theory of *existence relatedness and growth* (ERG) evolved from Maslow's hierarchy of human needs (Aderler, 1972). The ERG theory collapses Maslow's five hierarchical levels into three. "Existence needs" are described as desires for materials that are finite in supply, such as; food, shelter, clothing, pay, and benefits. "Relatedness needs" are referred to as desires for mutual sharing of thoughts and feeling with significant others. "Growth needs" are considered as interactions between individuals and the environment in order to develop the individuals" intrinsic talents. Alderfer's model is less rigid than Maslow's and suggests that more than one need may be operative (Marriner-Tomey, 1996, p.335). In 1986, Yura suggested that the "human need theory" has considerable utility for the nurse supervisor. It consists of knowledge to assist the nurse to explain, interpret and predict the behaviour of the nursing staff, co-workers and colleagues in the work setting (Yura, 1986). When employing new staff or deploying staff to build new working teams, nurse managers should pay particular attention to the *relatedness and growth* needs of the individual team members, especially when forming interdisciplinary teams.

Achievement-Motivation Theory

The *achievement-motivation theory*, encompasses three forms of motivation; the need for "achievement," the need for "power" and the need for "affiliation" (McClelland, 1975). The theory suggests that the need for achievement involves a desire to make a contribution, to excel, and to succeed. People with high "achievement needs" are eager for responsibility, take calculated risks, and desire feedback about performance. People who have a high "power needs" want control, desire influence over others and are more interested in personal prestige and power than effective performance. People with high "affiliation needs" desire working in human environments and seek out meaningful friendships. They want to be respected and avoid decisions or actions that oppose group norms. Marriner-Tomey (1996) emphasises how important it is for nurse managers to match personnel needs with assignments. When planning project development or change in work practices, nurse managers should assess the motivational forces driving the various team members. McClelland's theory can provide a framework for such assessment. The resulting insight allows managers to select the most appropriate team member for the various roles involved in a particular project.

Positive Reinforcement Theory

In the theory of *behaviour modification,* Skinner postulates that all human problems involve human behaviour and therefore cannot be solved by physical or biological technology alone (Skinner, 1953). He contends that what is needed is technology of behaviour. "Operant conditioning" demonstrates that behaviour may be strengthened or weakened depending on what follows. Positive reinforcement strengthens behaviour, withholding positive reinforcers weakens behaviour. Punishment will help reduce behaviour, but it cannot teach new behaviours and may condition avoidance. The validity of Skinner's theory has been debated extensively in the literature. Skinner suggests that when desired results are not obtained, managers should assess the working environment for interference and check that employees have the appropriate level of training for the particular task (Skinner, 1974). Applied to nursing management, Skinner's theory suggests that nurse managers must ensure that nursing staff receive explicit positive reinforcement in relation to the quality of their work. If a nursing system is not perceived to be working correctly, the nurse-manager must conduct a detailed assessment of the work environment to identify possible barriers to reinforcement and then establish if the nursing team has been adequately prepared for the work involved in the particular area.

Expectancy Theory

Expectancy theory suggests motivation is dependent on how much people want something and their estimate of the probability of getting it (Vroom, 1964). Central to the theory is expectancy, the association between the action and the outcome. This theory suggests that to motivate personnel, managers should clarify connections between work and outcome and should reward desirable behaviour (Marriner-Tomey, 1996). In general the Irish public health-service operates on a fixed pay structure for nurses, nationally agreed. For the first time in Ireland performance related pay is being discussed for Directors of Nursing and Chief Nursing Officers of the major hospitals. Working within a fixed pay structure and personnel policies means that nurse managers do not have the flexibility to use, for example, pay, flexible working hours or educational leave as reward measures. For this reason if nurse managers were to use *expectancy theory* they need to be creative in developing explicit mechanisms to motivate and reward staff members.

Motivation Hygiene Theory

Hertzberg established the *motivation-hygiene theory* in 1959. He categories job "satisifiers" and job "dissatisfiers." Aspects which provide job satisfaction were identified as; achievement, recognition, the work itself, responsibility, and advancement (Hertzberg et al. 1959). The theory proposes that workers can be motivated allowing challenging work with specific responsibility. Aspects which provide job dissatisfaction were postulated as unfair treatment in relation to; company policy, administration, supervision, salary, interpersonal relations with co-workers and working conditions. These Hertzberg called "hygiene" factors which according to the theory need to be "cleaned up", together with the provision of adequate worker motivation. Unlike other management theorists who view pay and conditions as possible rewards, Hertzberg suggests that these only prevent dissatisfaction. Hertzberg suggests that if people are highly motivated and find their job interesting and challenging, they can tolerate dissatisfaction with hygiene factors. Using this theory, Marriner-Tomey suggests that nurses must first be attracted to the job and

then the manager must create the environment for the nurse to achieve the desired goals (Marriner-Tomey, 1990).

Theory X and Y

McGregor created a new perspective of management and organisational behaviour, when he published work on *Theory X and Theory Y* (McGregor, 1957). The two styles of management are described – X and Y. *Theory X* states that managers believe that people are inherently lazy, stupid, and unambitious. They must be moved to action by either the promise of reward or the threat of punishment (McGregor, 1957). McGregor contended that a *Theory X* managers' role was to provide security, direction and control. *Theory X* managers have the power to command, reward merit, and punish negligence and inefficiency. McGregor believed at the time (late 50's) that the majority of organisational structures reinforced these assumptions. According to McGregor, direction and control by management, whether it is hard or soft, are irrelevant and do not motivate the individual. He believed a person will work to obtain what they want. When lower level needs are met, the person immediately moves on to satisfying a higher level need.

In light of this, McGregor proposed a second more humanistic approach to managerial assumptions and practices called *Theory Y*. In this aspect of the theory the "emphasis is on realising potential, encouraging growth, removing obstacles, creating opportunities, and providing guidance" (McGregor, 1957, p. 88). *Theory Y* emphasises the average person's need to be creative, interested in their work, desiring self-direction and seeking responsibility. McGregor suggests that such assumptions should lead management to design superior-subordinate relationships in which the subordinate has greater influence over the activities involved in work and greater probability of influencing the superior's actions. McGregor advocated "participatory-management" as a means to achieve greater creativity and productivity which should result in employees gaining a greater sense of personal accomplishment and satisfaction (Mc Gregor, 1960). In a subsequent study he found that in general, people prefer being directed, often shun responsibility and continue to want security above all. In 1967 he reported that a *Theory X* style management continued to be much more widely practised than *Theory Y* (McGregor, 1967). During the current literature search the author was unable to locate a study in relation to the use of theory X and Y in nursing. However, the theory is important in establishing the style of management used by nurse managers and their potential consequences.

Theory Z

Ouchi (1981) developed *Theory Z* as a means of applying Japanese management principles to American industry. The Japanese form of "participative management" is known as *Theory Z*. Collective decision making is practised, with decisions made by consensus. Concern for the worker is apparent. The management methods derive from the executives particular underlying philosophy which incorporates the following concepts: "lifelong employment in the same firm; infrequent evaluation and promotion; nonspecialised career path; implicit control of worker behaviours; collective decision making; group responsibility for quality and holistic concern for the employee's welfare" (Gillies, 1994, p.43). *Theory Z* managers focus on the four soft S's of management; staff, skills, style and superordinate goals. Flynn (1987), a New York hospital administrator,

reports that studies examining the phenomenon of Japanese success in management all reached the same conclusion – the difference between successful companies and unsuccessful companies is the difference in the quality of the leadership through the organisation. He suggests that there were several elements of "Japanese management" that nurse managers should consider: the recruitment and training of future managers; and a mentoring system which brings the subordinates in close contact with the superior and allows them to learn the qualities that constitute competent leadership by word and example. From this he suggests that the primary focus of the director of nursing must be on the competence of the management team. He contends that all the adjusting, changing and rearranging of staff and organisation which a director of nursing may undertake will never produce successful outcomes without the support of a competent management team (Flynn, 1987). This work was published at a time of high interest in "Japanese management" styles some of which are now being treated with caution.

Summary of Management Theories

This section of the review outlined the management theories most frequently referred to in the nursing literature. It explains the theories available to nurses when considering their role in the management of the health service. The *Classical Theories* (administrative management and the bureaucracy model) describe the traditional system of nurse management in Ireland, evidence of which can still be found in many hospitals and health-care organisations (Commission on Nursing, 1997). The modern theories *(General Systems Theory, Contingency Theory and Structural Theory*) encompassing human relations management and a merge of motivational theories are considered to provide a more appropriate framework on which to base nurse management.

Many of the theories stress that an awareness of the complexity of human behaviour assists nurse managers when considering their management function. The importance of people skills is emphasised and charisma is suggested as a vital attribute for successful management. The literature highlights the responsibility of managers to focus attention on the most valuable asset within the organisation i.e. the staff. In the past, the focus of some nurse managers has been on loyalty to organisation rather than on the individuals within the organisation. The importance of individual self-esteem is highlighted throughout the literature. One of the vital functions of the nurse manager is to concentrate on challenging and assisting staff to reach the stage of self-actualisation providing for the individuals' higher needs.

A number of management theories and their application to nursing are discussed in the literature, many of which suggest that control by management, whether it is "hard" or "soft", is ineffective and does not motivate the individual. In fact, close supervision and strict, adherence to rules can, it is suggested, result in employees becoming poorly motivated and thus stifle potential innovation. Most of the modern theories advocate a move from a hierarchical authoritarian type of management, to a more open enabling form of management. In such an organisation the manager implements strategies to enable staff to be responsible and accountable for the quality of their work.

The management theories highlight the need for managers to account for the differing motivational forces of staff and imply that managers must be creative and strive to reach a balance between motivation and rewards. Management theories also suggest that the

future success of nurse management depends on the development of a strong integrated team of knowledgeable nurses producing successful outcomes of care. To maintain credibility and earn the respect of the nursing team, the nurse manager must not only have management expertise but also clinical experience and a deep understanding of the work of nursing in that particular field. The next section of this chapter examines the concept of organisational structure.

1.4 Organisational Structure

Effective management is dependent on the organisational structure in which it takes place. The structure of an organisation refers to the way in which component parts of an organisation are related to one another to accomplish the goals of the organisation (Loveridge and Cummings, 1996). The organisational structure should provide an effective work system, a network of communications, as well as identity for individuals. As a consequence, it should foster job satisfaction (Marriner-Tomey, 1996). There are two main divisions of organisational structure, the overall organisation structure within the hospital and within this, the structure for the organisation of nursing services. To some extent these overlap, however, the texts reviewed in this section focus primarily on the nursing organisational structure. Table 1.2 gives an overview of the concepts associated with organisational structure.

TABLE 1.2. Major Concepts and Definitions for Organisational Structure

Organisation:	consolidated group of elements; systematised whole.
Structure:	formation or pattern of arrangement.
Hierarchy:	a group of persons arranged by rank, grade, or class.
Bureaucracy:	administration through departments and subdivisions managed by officials following an inflexible routine.
Matrix:	the formation of cells.
Corporation:	a group of employers and employees acting as one body.

Source: **Marriner-Tomey, A. (1996)** ***Guide to Nursing Management and Leadership.*** **5th. edn. St. Louis: Mosby, p. 120.**

The key to organisational design is consistency and coherence. Mintzberg suggests five clear configurations in organisational structure; "simple structure," "machine bureaucracy", "professional bureaucracy", "divisionalized form" and "adhocracy". A brief description of each is given on Table 1.3.

For the purpose of this review, two of the structures are considered in relation to hospital organisation, "machine bureaucracy" and "professional bureaucracy." Mintzberg contends that large "machine bureaucracies" are perfect for efficient mass production but not for adapting quickly to new situations and therefore not suitable for a service organisation such as a hospital, which must respond rapidly to critical situations. It appears that hospitals require a form of professional control incompatible with the rigidity of regulation evidenced in true bureaucracies. The "professional bureaucracy" appears to best describe the ideal organisational structure of hospitals. In a "professional bureaucracy", the power base is, according to Mintzberg, at the operating core. The role

of management is to provide a support structure to professionals. It appears in reality that the level of decentralisation described for professional bureaucracies has not been achieved in many hospitals in Ireland, some of which may still be perceived to operate as "machine bureaucracies" (see Chapter 3).

TABLE 1.3. Organisational Structures

Structure Title	Overview of Structure
The Simple Structure:	is simple – not much more than one large unit consisting of one or a few top managers and a group of operators who do the basic work.
Machine Bureaucracy:	is organised around a large middle-line hierarchy overseeing the specialised work of an operating core. This structure is the consequence of the standardisation of work for co-ordination and results in low-skilled, highly specialised jobs.
Professional Bureaucracy:	relies for its operating tasks on trained professionals – skilled people who must be given considerable control over their own work. The organisation surrenders a good deal of its power not only to the professionals themselves but also to the associations and institutions that select and train them in the first place. As a result the structure emerges as decentralised.
Divisionalized Form:	a set of rather independent entities joined together by a loose administrative overlay.
Adhocracy:	a tremendously fluid structure in which power is constantly shifting and co-ordination and control are by mutual adjustment through the informal communication and interaction of competent experts.

Source adapted from: **Mintzberg, H. (1981) Organisation Design: fashion or fit?** ***Harvard Business Review*****, p. 105.**

In an average hospital, large numbers of staff are employed, and as a result, parallel hierarchies emerge. One of these may be democratic with bottom-up power for the professionals, while another may be autocratic with top-down control for the support staff (Mintzberg, 1981, p. 109). Marriner-Tomey suggests that dual management within a bureaucracy separates technical and administrative responsibilities. It has one hierarchy in which nursing professionals make nursing decisions and control nursing matters and another hierarchy in which management makes decisions about issues such as personnel and budget (Marriner-Tomey, 1996). This is the source of the differentiation sometimes attempted in nursing between the management of "nursing"; "nurses" and "general services." If the nurse manager is to operate in an integrated manner the literature suggests that the roles must not be separated.

Centralisation/Decentralisation

The literature review demonstrates that there are several ways to describe hospitals from the organisational perspective. Factors that influence the structure and therefore the nurse manager's roles are related to the type of organisation (Byres, 1997). Health organisations can be divided into those that have vertical or horizontal integration, centralisation, or decentralisation. The terms "centralisation" and "decentralisation" describe how power, authority and control are distributed throughout the organisation (Douglas, 1996). Centralisation refers to the authority of decision making remaining at the administrative level or central office, while decentralisation refers to the assignment of decision making away from the central office and close to operational level.

Authority is the "legitimate right of the superior to exact rights and obligations from subordinates" (Grohar-Murray and DiCroce, 1997), while responsibility dictates the

legitimate boundaries of work. There is a direct relationship between the two; they should exist in equal measures. Difficulties arise where managers have responsibility for a task, but do not have authority to complete the task. This is often the source of the problem for temporary or acting leaders or managers, particularly if the acting positions are long term.

Loveridge (1996) suggested that the view, often taken, of the limited role of the professional nurse has resulted in centralised decision making, in which authority is vested in the department of nursing rather than shared with the individual nurse. In this situation standardised policies and procedures replace individualised care, management replaces leadership and quality equates to adequate rather than excellent. She cautions that reliance on rules that assist in confronting complex rather than simple problems results in confusion when rapid change is required to meet uncertain conditions.

There are two ways of delegating authority. In centralised structures, line authority usually prevails, whereas staff authority is predominant in decentralised structures (Byres, 1997). Line authority is "the formal, legitimate right of superiors to exact performance from subordinates" (p.6). Brooks describes line functions as those that involve direct responsibility for accomplishing the objectives of a nursing department or service (Brooks, 1995). So called line positions may include; deputy matrons, assistant director of nursing, divisional unit managers, unit nursing officers, services managers, ward sisters and junior ward sisters. They may also include quality assurance nurse and the newly established roles of nursing practice co-ordinator. Gilles (1994) contends that highly refined nurse specialists such as chemotherapy nurse, ostomy nurse, or dialysis specialists, do not fit neatly into the chain of command. Often the explicit knowledge of the specialist far surpasses their line superiors knowledge of the topic. For this reason most nurse specialist seek support and coaching from other specialists, rather than their line supervisor. This can cause conflict within the organisation command structure.

Staff authority refers to a consultative or advisory process. Staff functions are those that assist the line staff in accomplishing primary objectives. These may include; nursing practice development co-ordinators, education and research officers, directors of quality control and specialist nurse advisors, among others. Centralised authority means that all of the decision making stays at the highest level, this is evidenced in nursing, in hospitals where the director of nursing/matron still retains overall power.

Decentralised authority eliminates the need for levels of management because the head nurse (at unit or ward level) assumes responsibility for managerial decisions that influence both the patients and staff. An example of a decentralised organisational structure is that of primary nursing (see Chapter 2). Wells contends that decentralisation is now synonymous with effective nursing management and high employee morale (Wells, 1990). Manthey (1990) suggests that decentralisation differs from participate-management, in that staff members have not just some opportunities to recommend, but definite authority to decide. She offers three simple rules for effect management:

- base the organisational structure firmly on the principles of decentralisation;
- give decision-making authority to the individual or groups whom the decision most directly affects; and
- having assured yourself that the group uses a healthy decision-making process, trust that their decisions will be superior to any that you could devise (Manthey, 1990).

Power is described as a force to meet goals and get things done (Grohar-Murray and DiCroce, 1997). There are many forms of power: coercive, reward, legitimate, expert, referent, information, and connection power. Empowerment is one of the main objectives of decentralising systems. Manthey and Miller (1994) highlighted how the term can be misinterpreted by nurse managers. They describe the problem as follows – for some nurse managers it means "you can make decisions as long as I agree with them," to others it means "solve your own problems, but don't rock the boat" and to others it really means "you get to make decisions whether I agree with them or not and even if they do rock the boat" (Manthey and Miller, 1997). Another issue for nurse managers identified by Manthey and Miller when considering empowerment is the reluctance many people have to take responsibility. This may be particularly true in the Irish situation where most nurses have been educated in the traditional manner and not encouraged to think for themselves. It is a very great assumption to expect that all nurses may function well if suddenly expected to do so in a decentralised system. Miller advises that clarity in levels of authority is critical in establishing shared-governance, self-directed work teams, and other forms of employee empowerment. This important issue must be considered when introducing new forms of decentralised organisational structure in nursing.

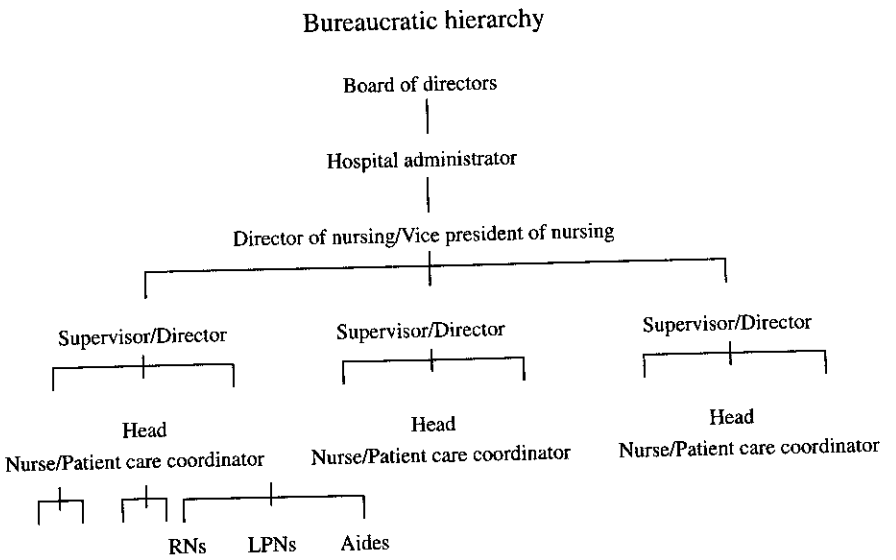
In a Canadian study, 200 first-line managers (71.9% response rate) were surveyed to investigate the relationship between decentralisation, professional autonomy, job satisfaction and organisational commitment. Decentralisation was found to be the most important factor because it affected organisational commitment directly, as well as indirectly, through professional autonomy and job satisfaction. Job satisfaction was also found to be an important predictor of organisational commitment (Acorn et al. 1997).

Organisational Models and Culture.

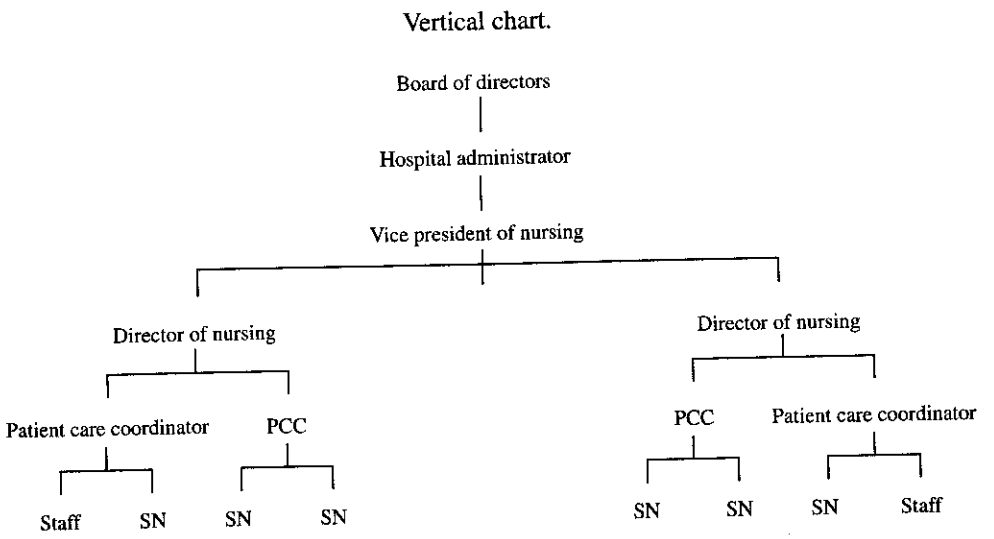
Organisational models are important and can be used by nurses in management to gain an understanding of the nursing function within an organisation. The following organisational charts represent the formal organisation structure and diverse relationships which may exist. The charts provide a visual representation of the chain of authority, division of work, levels of management, and functional communication patterns. Structures of organisations may be categorised as horizontal, vertical, matrix or hybrid. Structure can also be viewed as organic (informal) or mechanistic (bureaucratic) on three dimensions of vertical participation, horizontal participation, and formalization. Vertical participation is the degree to which supervisors and subordinates consult together concerning job-related tasks and decisions. Horizontal participation is the degree to which individuals are involved with peers in decision-making and defining tasks. Formalization is the extent to which rules, procedures and instructions exist and are used (Alexander and Randolph, 1985).

The tall or vertical organisation structure (Marriner-Tomey, 1996) arises when the span of control is small and may also be referred to as a pyramid or a bureaucracy (see Figure 1.2). This arrangement produces a hierarchical structure represented by regular assigned activities, written directives, and policy guidance for behaviour (Grohar-Murray and DiCroce, 1997). Each level of manager has a small number of staff to manage. The traditional Irish nursing structure can be described as vertical. This structure provides for control of the activities of employees.

FIGURE 1.2 Tall or Vertical Organisational Structures.



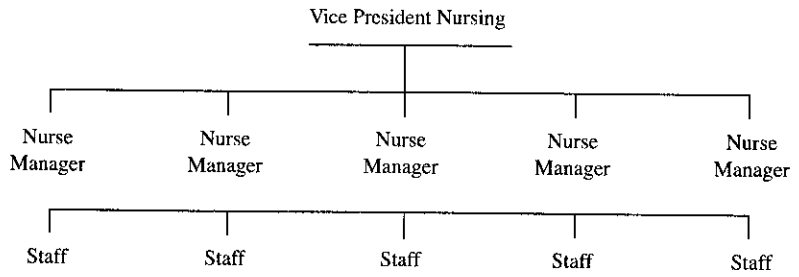
Source: **Marriner-Tomey, A. (1996)** ***Guide to Nursing Management and Leadership.*** **5th. Edn. St. Louis: Mosby, p. 121.**



Source: **Marriner-Tomey, A. (1996)** ***Guide to Nursing Management and Leadership.*** **5th. Edn. St. Louis: Mosby, p. 136.**

A flat or horizontal structure forms when the span of control is wide and a large number of employees report to one manager (Wise, 1995). Participatory-management involving the delegation of decision making to the professionals doing the work, is the primary characteristic of flat organisational structures (see Figure 1.3). The term flat signifies the removal of hierarchical layers granting authority to act and placing authority at the action level. Decision making regarding nursing work methods, individual patient's nursing care, and conditions under which nurses work are made at unit level. This structure is extremely empowering for the first-line manager and the nursing team.

FIGURE 1.3 Flat or Horizontal Organisational Structure.



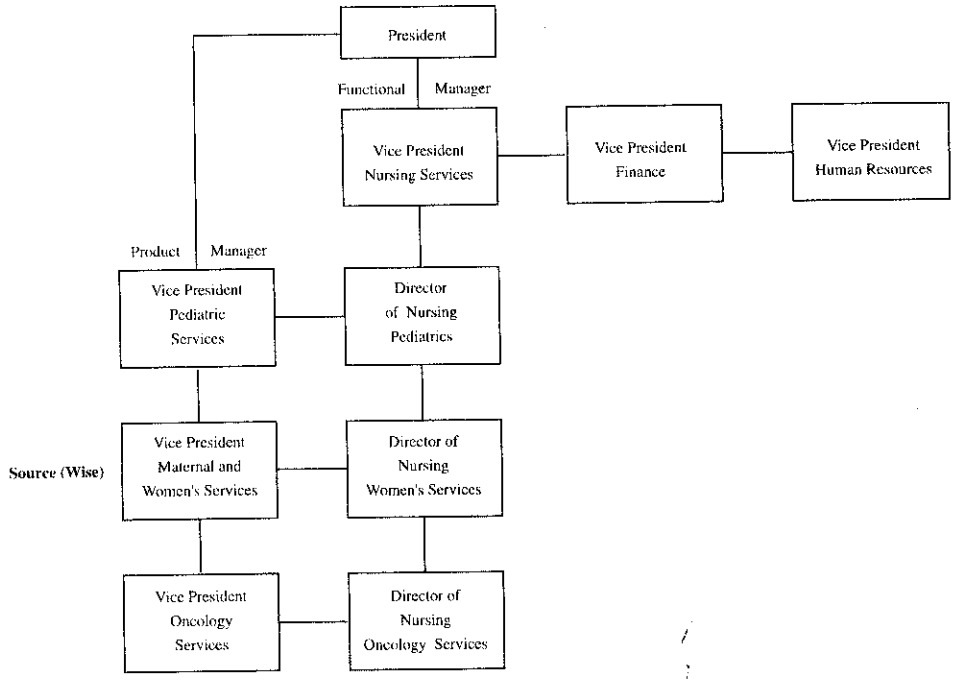
Source: **Wise, Y. (1995)** ***Leading and Managing in Nursing.*** **St. Louis: Mosby.**

The matrix structure creates groups within the organisation that belong to different departments but share common goals which affect the organisation as a whole (see Figure 1.4). The structure creates departments within a structure because the needs or goals of the organisation require specialised and diverse work (Grohar-Murray and DiCroce, 1997). Matrix structures are designed to focus on both product and function. In an acute-care organisation the desired "product" is a satisfactory outcome to the patient's presented problem, while the "function" is defined as all the action required to produce the "product." Characteristics of this design include the distribution of authority and resources to the operational level of the organisation, dual reporting and accountability channels (to functional divisions and service lines) and multidisciplinary membership (Loveridge and Cummings, 1996). In a "matrix" organisation, the manager of a unit such as a ward, is responsible for a service – nursing – and reports both to a functional manager (Director of Nursing) and product manager (Chief Executive Officer). Dual channels of authority can be confusing to both managers and employees and can lead to interpersonal and role conflict. Loveridge and Cummings (1996) advise that if this model is to be successful for nursing, it is imperative for nurse managers to negotiate their role responsibilities with the persons to whom they are to report.

Hybrid is a term applied to organisational structures that operate with characteristics of different types of structures. Problems with letting go of centralised control, and of senior managers changing from "boss roles" to facilitator roles, are partially responsible for the development of hybrid structures. Such structures can be used in times of transformation and organisational redesign (Wise, 1995). When used for this reason hybrid structures are a temporary measure.

Drucker (1970) claims that a complex institution needs a complex organisational structure. He defines the ideal organisation as one that permits movement on two or three axes, thus allowing lengthening or shortening of the chain to accommodate internal or external conditions, lateral expansion to encompass additional staff officers, and deepening of the primary work group adding clinical specialists to the base of the hierarchy. Mintzberg (1997) reports that hospitals are constantly reorganising, and suggests that this exercise is undertaken in the belief that by rearranging authority relationships, problems will be solved, reflecting the frustration of managers in trying to effect real change in clinical operations.

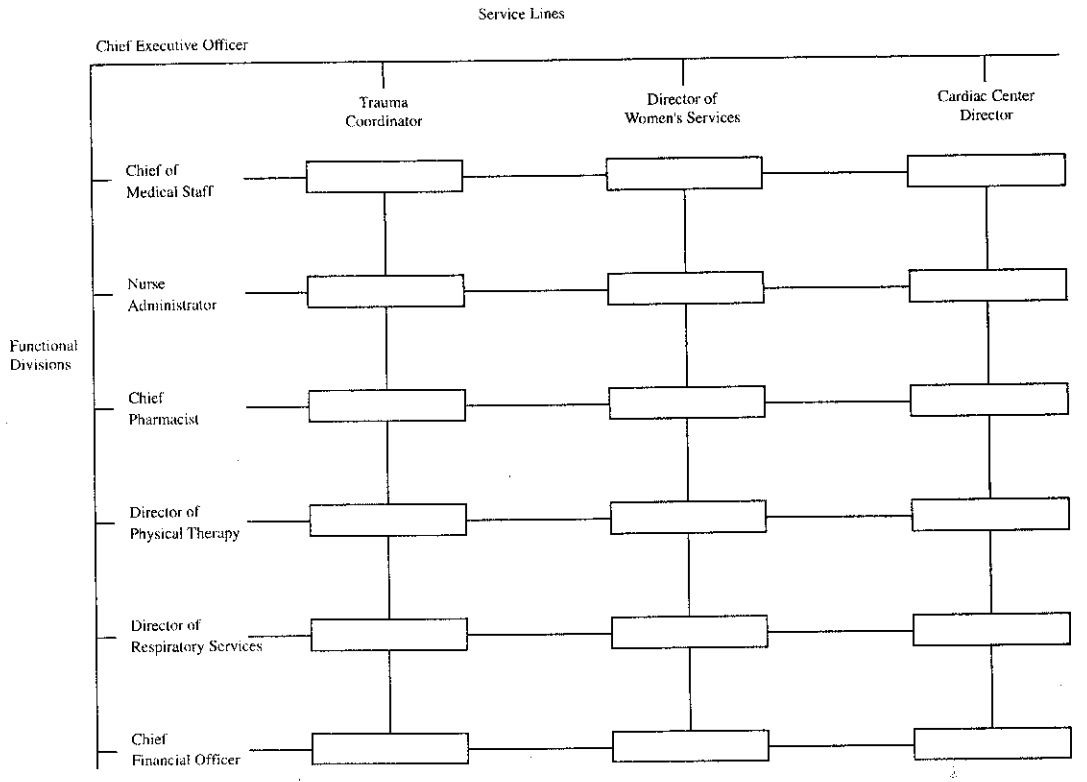
FIGURE 1.4 Matrix Organisational Structures.



Source (Wise)

Matrix organisational structure.

Source: **Wise, Y. (1995) *Leading and Managing in Nursing*. St. Louis: Mosby.**



Source: **Loveridge, C. and Cummings, S. (1996) *Nursing Management in the New Paradigm*. Maryland: AnAspen Publication, p. 14.**

Levels of Nursing Management

The organisational models for nursing management described above present many different levels of nursing management. The role function of managers in each level differs across organisations as does the actual number of managerial layers. In a recent text on Nursing Leadership and Management, the levels of nursing management have been grouped into three broad categories (Grohar-Murray and DiCroce, 1997). These are first-line/front-line managers, middle managers and top managers. Table 1.4 shows an adaptation of the model to equate the positions described with those operational in Ireland. The table gives an outline of the responsibilities attributed to each level of management. Front-line managers are responsible for operational issues in the day-to-day delivery of patient care at unit level. Middle managers are responsible for nurses and the nursing services delivered across units, much of their work is administrative. Top managers have global responsibility for all nursing issues within the hospital. They represent nursing at the highest level within the organisation and much of the work involves strategic planning and policy formulation. The framework presented in Table 1.4 is a simplistic representation of what is a very complex issue. Advisory and support staff are not included in this model. While it is based on an American model, the framework does provide a basis for examining the array of nurse management roles operational in Ireland. A more detailed explanation of the role and function of individual nurse managers in Ireland and internationally can be found in chapter two and three of this report.

TABLE 1.4. Levels of Nurse Management

Level of Management	Post Holder	Outline of Responsibility
Top/Senior	Most senior nurse in the organisation Matron, Director of Nursing	Overall responsibility for nursing Strategic planning, managing managers, ensuring quality service.
Middle	Divisional Heads Assistant Directors of Nursing Unit Nursing Officers	Manages front line managers Operational and administrative management across units.
Front-line	Unit Managers/Ward Sisters	Operational managers – head nurses who manage staff employees and the delivery of the nursing service.

Source adapted from: **Grohar-Murray, M. and DiCroce, H. (1997)** ***Leadership and Management in Nursing*****, 2nd. edn. Stamford, CT. Appleton and Lange, p.139.**

The role of the nurses in middle management depends on the type of organisation in which they operate. In some settings the organisation is decentralised to the point of allowing nurse managers great freedom in adopting their preferred management style, in other organisations, roles and behaviours are more standardised according to function and there is less responsibility and accountability for middle nurse managers (Kerfoot, 1995). There is an international trend to remove the middle layer of management. In 1990 Manthey asked "what has happened to middle management positions in nursing?" as the role is infrequently written of in the literature. She suggests that middle management was in the USA effected by two major trends (at unit level nursing) the restructuring of nursing support and administrative systems and the professionalisation and specialisation of the average staff nurse (Manthey, 1990). Head nurses, Manthey suggests were developed into

administratively sophisticated managers of the clinical workplace and its personnel. They have assumed more comprehensive responsibility for co-ordinating and accounting for nursing activities around the clock and throughout the fiscal year. In light of this development, there was in the USA, a diminished role for middle managers. Townsend (1990) reports of reducing administrative levels from four to three, adding a totally new nursing management role to the institution (Clinical Nurse Specialist) and redefining all remaining first and second-line management positions in a 280 bed community hospital in the USA. She described the value of the participative process used in the reorganisation project. In the new organisational structure a Nursing Department Administrator (NDA) and Clinical Nurse Specialist (CNS) shared responsibility for each unit (Townsend, 1990). Shamian and Chalmers (1996) lead a project on behalf of the World Health Organisation in which they reviewed the international literature on *Nurse effectiveness: health and cost-effective nursing services*. They identified a trend in many countries to remove senior nursing posts at government and organisational level and cautioned that this action is quite likely to eliminate nursing expertise from the policy making table, with resulting deleterious effects on the standard of health-care delivery. They suggest that senior nursing support at policy level can enhance health policies (Shamian and Chalmer, 1996).

Culture and climate are an aspect of any formal organisation. In an organisational context climate concerns behaviour, attitudes, and feelings of personnel. Managers and leaders strive to create a climate that promotes job satisfaction. "Culture refers to more deep-rooted assumptions beliefs and values" (Douglas, 1996, p.12). The use of the term culture, in the context of health-care organisations has become commonplace, however, the exact meaning intended when the word is used is not always clear. Schein defines organisational culture as follows:

> Organisational culture is the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems (Schein, 1984, p.4).

Hewison (1996) identified the dimensions of the concept as instrumental; cognitive and interpretative. Hewison argued that when clearly defined and appropriately applied, culture can be a useful concept for nurse managers in that it: "stimulates new ways of thinking about organisations; can indicate ways of managing the culture if desired; and increases understanding of and thereby contributes to the effective management of complex health-care organisations" (Hewison, 1996, p.9). It is suggested that it may be more fruitful to think of organisations as collections of sub-cultures rather than attempting to manage a single culture that in reality can ever really exist. Culture must be understood as an active, living phenomenon through which people create and recreate the worlds in which they live. When considering the role of the nurse executive, Byers (1997) suggests that the senior nurse who has a deep comprehension of culture can influence an organisation at its core. Opportunities for advancing patient care practices, expanding nursing roles, or developing new patient services become easier to identify if managers are conscious of the pervading culture.

Handy (1991) presents a framework for classifying organisational culture based on management style. He uses a number of the Greek Gods to illustrate cultural management styles (see Table 1.5).

O'Shea (1995) reported that the predominant culture in a large Irish hospital was very much in the Apollo mode, where predictability and stability are treasured and encouraged and the organisational form is bureaucratic. However, she identified a second, but very dominant sub-culture, that of the Dionysians – The Consultants and Doctors – expert, stars and masters in their own fields. She points out that they consent to the need for some form of management but berate its importance. O'Shea expressed concern about this juxtaposition and the apparent emerging dominance of one over the other within the clinical directorate system which is doctor lead (O'Shea, 1995).

TABLE 1.5. Handy's Culture and Management Styles

The Culture	Management Style
The Club (Zeus)	Dynamic entrepreneur who rules over companies of the club culture with speed of decision and rapid intuitive communication.
Role (Apollo)	Patron of order and bureaucracy, based not on personalities but on definition of the jobs to be done. Predictability and stability are treasured and encouraged.
Task (Athena)	Respect for craftsmen recognises only expertise as the basis of power and influence.
Existential (Dionysus)	The organisation is dominated by artists and professionals people who owe little or no allegiance to a boss. The members of the organisation are experts" stars and masters in their own fields who berate the importance of management.

Source adapted from: **Handy, C. (1991) *The Gods of Management.* 3rd. edn. London: Arrow.**

Summary Organisational Structure and Culture

The most recent literature suggests that when describing nurse management, three levels are mainly referred to; first-line, middle and senior (top) nurse management. This section of the review suggests that health organisations can generally be divided into those that operate centralised structures and those who maintain decentralised systems. The organisational chart can act as a useful guide when determining the type of structure for a particular organisation.

Centralised authority means that most of the decision making stays at the highest level. In this situation, nurse managers supervise several levels of employees, and often rely on an authoritative style. They often believe, because of an overwhelming sense of responsibility that control is necessary.

From the literature presented, a change in the role of nurse manager with the introduction of decentralised systems is apparent. Internationally, the middle management level in nursing structures has been dramatically reduced. Downsizing and flattening of organisational structures appear to have stimulated a reconceptualization of the nurse managers role. Instead of controlling staff behaviour, managers are now expected to help staff be responsible for their own behaviour. This raises the issue of re-training and upskilling for Irish nurse managers. Nurses who may have trained in the traditional apprenticeship programme may not have the necessary skills or knowledge required to facilitate a participative style of management. The importance of maintaining an integrating approach to nurse management is illustrated. Nurse managers must be given the necessary autonomy, power and authority to manage both nurses (the staff) and nursing (the service).

In selecting an organisational structure and management system, nurse managers must consider what is best for a hospital's efficiency and effectiveness in relation to its purpose

and overall goals. An awareness of the organisational system in operation is important in selecting appropriate management styles. Attempts to utilise participative-management strategies might not be successful in a centralised system. Developing an organisation includes designing jobs, forming departments and work units, creating a hierarchy, developing a span of control and co-ordinating and integrating activities. According to Mintzberg effective organisations are those which achieve a coherence among their component parts, and do not change one element without considering the consequences to all others. Spans of control, degrees of job enlargement, forms of decentralisation, planning systems, and matrix structure should not be picked and chosen at random, rather they should be selected according to internally consistent groupings (Mintzberg, 1981). The culture of the organisation will have a large part to play in determining the success of any new organisational design or structure. Johnson in relation to hospital organisational structure advises that "we can either create our own reality, or we will live in someone else's" (Johnson, 1992).

1.5 Organisational Design

Internationally a number of initiates have been taken in designing alternative organisational structures. The main designs discussed in the literature are shared-governance, clinical directorates, managed care, community design and organisational re-design. These initiates create new structures by integrating systems, the relationships within the systems and the individual management roles, an outline of each of the initiatives is given in the following section of the report.

Shared-Governance

Shared-governance is the term used to describe an organisational structure in which accountability directs the relationships of communication, co-ordination, coaching and counselling, (Porter-O'Grady, 1990). The concept of shared-governance is a new concept for health-care professionals, originating from the development of participative-management structures in automotive plants (Wellis, 1991). It reduces the emphasis on hierarchical relationships and highlights the professionals right to be involved in governance of the profession (Stichler, 1992). In the 1980's in the USA, nursing professionals adopted shared-governance as a means of obtaining more control over their working environments (Porter-O'Grady, 1992). The intent of shared-governance is to enhance the practice of health care professionals by involving them in determining standards of practice; evaluating, monitoring and improving practice; and ensuring that a single standard of care is provided to all patients. Grievances, labour disputes, wages and rates of pay, hours of work, or working conditions are not issues dealt with in shared-governance. Through shared-governance, the unit nurses set standards for clinical practice, quality of care, staff competence, peer review, peer relations, and professional practice policies (Porter-O'Grady, 1992). The Council of International Hospitals (UK) identified thurty publications over the last six years relating to models of shared-governance in nursing. The rationale for the adoption of such models is to enhance the professionalisation of nursing. Each article presents reviews of nurses' experiences during and after the introduction of systems of shared-governance. This concept is widely accepted internationally but has not received much attention in the Irish nursing literature.

A detailed examination of shared-governance may indicate useful suggestions for nurse management in Ireland.

Self-governance is a very different concept to that of shared-governance. Self-governance goes beyond participatory-management through the creation of organisational structures that allow nursing staff to govern themselves with no identifiable line manager. The term can be used to describe flat structures (Wise, 1995). Accountability forms the foundation for designing self-governance models. To be accountable, authority to make decisions concerning all aspects of responsibilities is essential (Wise, 1995, p.178).

Jannotta and Maldonado reported the introduction of a system of self-management for nurses at a 119 bed hospital in the USA (Jannotta and Maldonado, 1992). They described the role and training required for self-managed nurses as well as the organisational changes. The organisational structure described, involved no first-line management and limited middle management. Positions included were; senior administrator for the three sites, associate administrator for two sites, and for each of the three hospitals involved, directors of nursing and registered nurses (patient care managers). The authors described the model as in a state of constant evolution, as the hospital adapted to dramatic changes in the economic and technological climate. While describing the project as successful, they reported that, due to corporate decisions, the model has changed to a degree that it could no longer be considered representative of the self-management model (Jannotta and Maldonado, 1992).

When considering shared-governance in the Irish context, it must be remembered that there is a long tradition of highly centralised bureaucratic management in nursing. A change to shared-governance could be considered as a model for enabling a change in management style. However, if the further step of self-governance was to be taken shared-governance would already need to be firmly established in the Irish nursing workforce.

Clinical Directorates

The term clinical directorate is widely assumed to be modelled on experience at the Johns Hopkins Hospital, Baltimore, USA. In the late 1970's the hospital introduced the concept of decentralised management by creating a number of functional units. A Chief Executive Officer (a clinician), was appointed for each unit, supported by a Chief of Service (Business Director) and a Director of Nursing. The theory was that each of the functional units could buy any required service from central sources within the hospital or from another provider if the service or product was available at a lower price with equal quality (Kearney, 1998). The establishment of clinical directorates is based on budgeting and budget management, the system decentralises both revenue and expense budgeting. This approach recognises that the majority of hospital expenses are generated by doctors – whether in admitting patients into hospital, prescribing, diagnosis, treatment or discharge. Decentralised management therefore gives institutional responsibility for these decisions to the people who make them. A similar development has taken place in the UK. The Griffith report in 1983 emphasised the need to involve hospital doctors in the management process. Some form of directorates model is now assumed to be the norm in acute general hospitals in the UK (Royal College of Nursing, 1991). In Ireland, the Department of Health and Children is currently piloting the directorate system in acute general hospitals (see Chapter 3) The Department describes the clinical directorate model in an Irish setting as, "one where hospital consultants head up directorates and have

executive power and authority with respect to planning and developing services for and controlling resources used and consumed by their directorates."[1]

The Department recognises that there have been concerns and reservations expressed by some members of the nursing profession in relation to the introduction of the clinical directorate model. These related primarily to professional standards within the directorate. O'Shea (1995) described clinical directorates as a "model for clinical management where a hospital is divided into coherent manageable sections, each of which is lead by a doctor with support to manage the directorate" (O'Shea, 1995, p.42). The directorate management team usually consists of a clinical director, nurse manager and business manager, referred to as triumvirate management. Resource management forms the core of clinical directorates.

Taaffe (1996), when commenting on triumvirate clinical directorates in Ireland, cautions as follows "flexibility to rearrange and interchange the three people can be both valuable and dangerous." The size and activity of directorates vary, and as such a full time nursing and business manager may not always be needed. Taaffe (1996) suggests that the nurse manager or business manager may work across two directorates but makes it clear that from her perspective it is never acceptable for one person to perform both roles. She advises that implementation, training and motivational factors in addition to information technology are crucial to the success of directorates and suggests that more imagination is needed to improve on present efforts.[2] The Irish Office for Health Management (1998) recently arranged a video conference *Clinicians in Management*, at which personnel from four hospital management pilot sites presented developments in management based on a variation of the clinical directorate model.

The Royal College of Nursing (RCN) suggests that the reorganisation of hospitals into clinical directorates has major implications for nursing, consideration of which has often been secondary to issues of medical involvement and resource management. They warn that unless nursing implications are taken into account the system will fail. The RCN offer the following three important starting points when considering clinical directorates:

- Management of nurses is not the same thing as management of nursing: both issues must be considered separately, as well as together.
- Management (whether functional or general) is not the same thing as leadership and in a profession, leadership may be a more potent motivating force than management.
- Management encompasses far more than the control of money and people through line authority (Royal College of Nursing, 1991, p.2).

The RCN draw on the experience in the UK and the Johns Hopkins Model (USA) when describing the very important role of the director of nursing in the model. They outline this as:

> setting nursing care standards, reviewing nursing practice, directing nurse recruitment – along with other senior managers – reviewing and approving unit budgets and plans, providing institutional leadership for professional nursing by participating in all key central decision making and by setting the tone for nursing practice through the hospital (Royal College of Nursing, 1991, p.4).

[1] Nursing in Ireland, background information supplied to the Commission on Nursing from the Irish Department of Health and Children, July 1997.

[2] Unpublished paper prepared by Ms. Peta Taaffe (formerly Director of Nursing, St. James's Hospital) The Clinical Directorate structure in Irish Hospitals – some reflections and points for discussion, January 1996.

From the RCN perspective the nurse manager in the clinical directorate occupies a middle management role and reports to top management at director of nursing and chief executive level. The directorate nurse manager is accountable to the director of nursing for, "ensuring the actual standards of nursing within the directorate conform with agreed standards; ensuring compliance with statutory nursing obligations; facilitating the development of nursing practice; and ensuring the development and continuing education of all nurses working within the directorate" (Royal College of Nursing, 1991, p.4).

Since the majority of the staff in a directorate are nurses the service manager must be a nurse. The RCN suggest that the role of the senior nurse (directorate nurse manager) within the clinical directorate is critical and needs to be defined very carefully, especially in relation to any business manager role. The RCN outlines the parameters of the senior nurse's role as follows. The senior nurse must:

- not only mange nurses but must also have the authority to control support;
- have appropriate specialist support staff;
- have access to professional advice and support of Director of Nursing at board level;
- be involved in agreeing and ensuring compliance with level of workload which is compatible with available resources; and
- monitor the individual ward activities for which Ward Sisters should have 24 hour responsibility of staff and budget (Royal College of Nursing, 1991, p.6).

The RCN suggests that planning for succession of senior nursing positions within directorates is vital.

In a review of the nurse's role in managing the nursing service in clinical directorates, Batehup (1992), highlights serious issues which may arise for nurses. She suggests that in a directorate model, the energies of the senior nurse manager can be focused on reactive activities (staffing, budgets, recruitment, discipline, complaints, bed-management etc.) rather than an involvement in business planning and future developments of services in the directorate. She proposes that with these responsibilities, there is little or no time to concentrate on the management of the nursing service within the directorate. This implies that the ongoing development of nursing practice and advanced clinical roles that are increasingly needed to meet the changing health care needs of the future, as well as the facilitation of quality monitoring and evaluation of services, are in danger of neglect.

Batehup cautions that the opportunity to develop participative team-work between the three management roles within the directorate can be hampered by the hierarchical structure allowing old-style bureaucracy to predominate. She contends that the clinical director has varying degrees of power and influence, which may be related to his/her commitment to the role of manager and competition with clinical responsibilities. There is the possibility that business manager posts can be seen as developmental, short term and a means for gaining a higher post. This can cause instability, particularly when the director's role is part-time (Batehup, 1992). She cautions that in the clinical directorate system the management of nursing needs to be strong, effective and able to withstand the loss of direct management control by nurses over the nursing workforce. In work redesign, Batehup suggests that senior nurse managers need to retain the people development part of the role, becoming coaches, facilitators and entrepreneurs, the driving influence to develop and show how a nurse's care influences a patient's outcomes. She recommends that someone else take on the purely administrative functions within the directorate.

The Council of International Hospitals (UK) in 1996 compiled a review of the Role of Nurses in Management in clinical directorates. The complete document gives copies of thirty recent publications pertaining to clinical directorates and gives a brief overview of the nurses position in the management structure of five hospital trusts in the UK. This document forms a valuable resource for anyone considering the introduction of clinical directorates (Council of International Hospitals, 1996).

Managed Care

Managed Care was introduced in North America in the 1980s as a result of spiralling health costs. Managed Care encourages an integration of cost containment and quality by linking providers and insurers into one system designed to control quality, utilisation, and cost (Barter et al. 1995). In the USA, the Social Security Amendment Act of 1983 included the establishment of a prospective payment programme known as Diagnostic-Related Grouping's (DRGs) (Shaffer, 1983). DRGs are targeted towards hospitals being reimbursed through Medicare funding. Arkell (1997) reviewed the benefits and implications of managed care for clinical practice. She provides a concise overview of the terminology used in relation to managed care (Arkell, 1997). Managed care is described as:

> quality cost-effective care that is patient focused; it is achieved through multidisciplinary collaboration and teamwork. Particular case types, often termed "diagnostic related groups" (DRGs), are identified by members of the multidisciplinary team, and the care and treatment required to achieve previously determined outcomes within a specified time-frame are documented (Laxade and Hale, 1995, p.290).

The information produced is incorporated into a managed care tool known as a multidisciplinary care pathway. The toolspathways, anticipated recovery paths and care maps (Laxade and Hale, 1995).

A critical path is a structured, multidisciplinary, patient careplan, in which diagnostic and therapeutic interventions performed by physicians, nurses, and other staff for a particular diagnosis or procedure are sequenced on a timeline. All the tools have similarities but care maps differ in that they identify patient outcomes which are linked to the activities of care detailed in the pathway. Conventionally, the pathways use eight categories with which to group events: consultations or assessment; tests; treatments; medications; diet; activity; teaching; and discharge planning. Variance analysis is used to determine the reasons for not achieving, (or achieving earlier than expected) certain patient outcomes and activities within the specified time frame.

To ensure the programme operates successfully it is suggested that a system of either case management or care management is adopted. A person is appointed in each system to take overall responsibility and accountability for implementing the managed care programme. In acute settings the case manager is usually a nurse, but there is no reason why other health professionals should not undertake this role. Because nurses have a tradition of delivering skilled and compassionate care throughout the 24-hour period they are in an ideal position to help produce and implement managed care programmes. The case manager has responsibility for monitoring variance analysis. Care management is similar to case management except that the authority and accountability of the care manager is restricted to the ward in which the patient remains during a hospital stay. The care manager could be a primary nurse, a named nurse or a team leader, depending on

the organisation of patient care used. Arkell (1997) reports the benefits of managed care as:

- decreased length of hospital stay;
- increased intensity in direct nursing care during the early stages of hospitalisation;
- improved or maintained quality of care;
- potential to reduce the number of clinical negligence cases;
- financial savings by preventing the provision of marginally useful or useless health care;
- knowledge of what is expected and how treatment/care will progress;
- proactive thought about care plans; and
- constant evaluation of care (Arkell, 1997, p. 232).

The implementation of managed care in the USA is financially driven as the majority of health care is privately funded and largely controlled by health insurers. In the USA it is recommended that the patient's treatment regime is provided at the level negotiated in the managed care contract. If more treatments are provided than are defined in the contract then the provider incurs a financial loss. While managed care is being considered in the UK, Arkell suggests that there are several issues to be considered in order to avoid problems, these are:

- a lack of good quality research to substantiate the benefits claimed to be derived from managed care;
- if managed care programmes become unrealistic because of changing practices or reduced resources, then they should be withdrawn;
- as the concept of competition establishes itself it could mean that in managed care, quality and individualised care could be sacrificed for financial saving – leading to moral or ethical dilemmas for the team;
- DRG guidelines should not be applied automatically or rigidly to each category because guidelines are not a substitute for professional judgement;
- within the current system it may not always be possible to provide the services stated in the negotiated contract. This may lead to the risk of litigation for care providers;
- managed care is often criticised for not focusing enough on the needs of the individual; and
- the quality of patient care is only as good as the nurse who is providing that care with or without managed care (Arkell, 1997, p. 234).

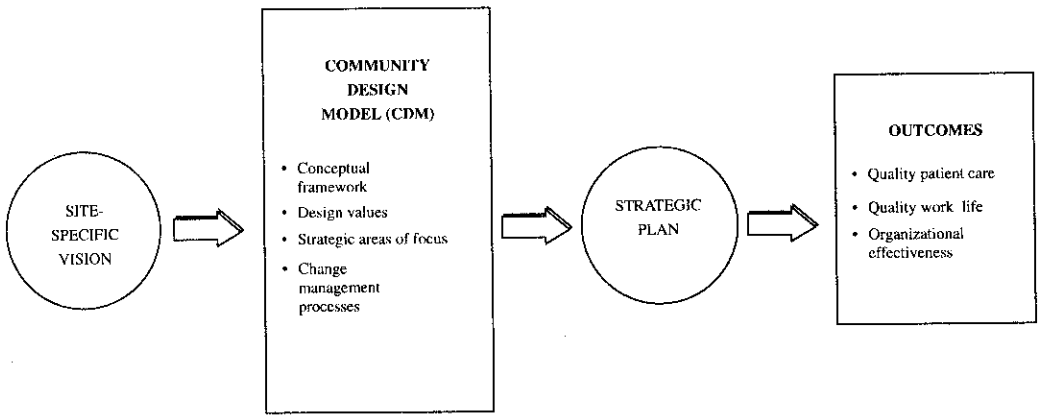
Managed care is firmly established in the USA, has been adopted by some hospitals in Canada and Australia and is being considered in the UK. Cost containment is the driving force behind managed care and for this reason it is not inconceivable that an adaptation of the model might be considered by the Irish Department of Health and Children. However, careful note should be made of the issues raised by Arkell in relation to the introduction of managed care.

Community Design Model

Traditionally schools of medicine and nursing have emphasised individual expertise and independent decision making. Byers (1997) reports that this style of interaction is becoming increasingly dysfunctional in an era of co-operation and teamwork. She uses the *Community Design Model* (CDM) to illustrate how the problem can be circumvented. *The*

Community Design Model is an organisational design that was developed at Harbour-UCLA Medical Centre USA (1992) see Figure 1.5.

FIGURE 1.5 The Re-engineering Process using the Community Design Model (Harbour-UCLA Medical Centre)



Source: **Byres, A. (1997)** ***The Executive Nurse: Leadership for New Health Care Transitions.*** **Albany: Delmar Publishers, p. 88.**

The model presents structural innovation that can be initiated by senior nurses. It has four key components; a conceptual base, strategic directions, outcome indicators, and strategic management processes. The conceptual base is built on the assumption that success requires creating an internal sense of community in combination with the expectation that every stakeholder is a leader. The areas of strategic focus are: creation of a community initiative; establishment of a leadership culture; development of a user friendly environment that empowers stakeholders and development of systems to facilitate transitions. Outcome indicators reflect the organisational vision and are the focus of measuring and evaluating strategic plan elements. The model outlines various processes that support restructuring through re-engineering. The critical attributes of the model include a focus on teamwork, empowerment, a sense of belonging, decentralised decision making and the development of human potential (Byres, 1997).

A strength of the model is that it was collaboratively designed by a group involving practising nurse managers. The project was grant funded and tailored to the American culture and health care delivery system and as such, may not have direct applicability to an Irish environment. However, the concept of building "community people" certainly does apply and nurses as the constant force in hospitals have a key role to play in this process. The community approach offers to bring people together to achieve a common goal without compromising diversity or individual identity.

Organisational Re-design

Work organisational re-design is discussed extensively in the North American and to a lesser extend in the UK literature. Work redesign is a multidisciplinary approach to restructuring the work environment for nursing (Tierney, 1980). The aim is to eliminate fragmentation and duplication (Armstrong et al. 1987). Gelinas and Manthey (1995) report on a study which they conducted on behalf of the Veterans Hospital Association (VHA) to examine the impact of work redesign on the roles of hospital executives. Thirty

six in-depth telephone interviews were conducted with executives at thirteen VHA healthcare organisations (Gelinas and Manthey, 1995). Almost all respondents reported that the motivation for change was the need to restructure for future success. A few began the change process because of severe operating shortages – dollars in one case, and nursing staff in another.

Armstrong et al (1987) indicate that clinical integration through the alignment of functional or cross departmental activities is crucial in designing new streamlined processes. Studies report that the culture change needed to eliminate professional boundaries and departmental competition was enormous (Gelinas and Manthey, 1995) and (Kohles, 1997). The interviewees in Gelinas (1995) study, reported that the only way to succeed is to decentralise the process using empowered employees. As a result of this study the authors offer the following advice to nurse managers involved in work redesign:

- Be involved if you really want it to happen.
- Creative change is hard.
- Change is like taxes: it's OK for someone else, but not me.
- People cannot be empowered by telling them to be. They need coaching, help and a safe environment.
- Don't make the change at Christmas time or at the beginning of the fiscal year.
- Don't have a time line that is too long.
- Know it's going to be painful.
- People really need to be supported. Give them training.
- Be honest.
- Get a coherent message to all levels about where you are going and why.
- Paint the vision and help people see it day-after-day after day.
- Be prepared to be tested and challenged (Gelinas and Manthey, 1995, p.61).

Kohles reports that nurse management is often based on the pillars of a highly centralised, autocratic and vertical organisational culture. The common principles of practice within this culture are to control things, coerce people, give directions/commands from a centralised focus and sometimes support blame, low risk taking and fear (Kohles, 1997). Kohles reported in-depth, on the experiences of four nurse managers who used the principles of interactive planning, system thinking, continuous quality improvement, and learning organisations to redefine their management practice. The managers interviewed advised that nurse managers involved in redesign, focus their attention on: information, relationships, vision, teams, systems thinking, financial realities, evaluations and continuum of care. The nurse managers studied concluded that formerly, they had managed the care of sick people by directives rather than involvement. They transformed their roles to offer effective, affordable, options across the entire health-care continuum, through collaboration with many other disciplines for the improvement of patient services. Their experiences changed their management practice, focusing on interactions and relationships while realising a strengthened accountability for quality service and cost (Kohles, 1997).

Summary Organisational Design

The common thread in the five organisational designs discussed (shared-governance, clinical directorates, managed care, community design model and organisational redesign) is the degree of devolvement of power from centralised management to groups or individual nurses, resulting in professionalisation and empowerment of nurses. The literature demonstrates that international changes in health-care management have been shaped by consideration of finances especially in terms of health insurance. The designs discussed in this section have been shown to provide gains in relation to cost effectiveness as well as quality of care delivered. The review indicates that the implementation of new designs has been facilitated by the imaginative problem-solving ability of nurse managers when faced with scarce resources. If any of the organisational designs are considered for general use in the Irish health service, careful consideration must be given to the existing organisational structures, health environment and staff expectations of management. The importance of achieving a fit between organisational structure and environment is highlighted by *contingency theory* (see section 1.2).

Summary

The literature search revealed a large body of information on management theories and organisation. A number of these have been shown to have proven application to nursing management. The author is aware of the American bias in the information presented in this section but nurses writing about management concepts appear to have drawn extensively on the writings of American management theorists as this is where the main theories emerged.

This chapter reviewed the *classical, modern* and *motivational* management theories. Through an understanding of the theories nurse managers may gain an insight into ways of thinking about management. A realisation of the breadth and variety of management styles releases nurse managers from dependency on a single management method and allows diversity of perception. Literature on organisational structures, designs and culture allow nurse managers to identify the type of organisation they are working in and through informed choice participate in decision making about the organisation as a whole and nursing in particular.

The dominant theme in the literature has been the importance of a shift from the bureaucratic mechanistic form of management to a more open enabling and empowering management style. Nurse managers have a significant role to play in empowering the nursing workforce within an organisation to effect change for the betterment of the organisation and the staff working within the facility. Strategies such as decentralisation, participative-management, shared-governance, and professionalisation of nursing are offered as examples of how this might be achieved. The literature demonstrates how the clinical directorate model has been used by progressive nurse managers to empower and lead the nursing staff. This chapter explored the concept of management. The following chapter examines the specific role of the nurse manager in greater detail.

CHAPTER 2

ROLE THEORY: THE ROLE OF THE NURSE MANAGER

Introduction

Current economic forces and technological change have dramatically influenced the practice of nursing management. Nurses, who comprise the largest individual group of hospital employees, are managed by directors of nursing/matrons in Ireland. Internationally nurse-managers are now expected to possess a business mind-set with regard to delivering patient care, as well as financial acumen and knowledge of economic trends and health policy (Miller, 1987). The increasingly complex environment in which first-line managers function, has significantly altered their role (Duffield, 1991). Nurse managers play a vital role in balancing clinical practice and business-related outcomes (Mateo et al. 1997). In order to explore the particular role of the nurse-manager in health services management, this chapter begins by reviewing the concept of role using *role theory* as a framework. The role concept (job titles), role expectations (job descriptions), role set (interdependency group) and role behaviours (role competencies) reported for nurse-managers are discussed from an international perspective. Nurse management role difficulties are identified and issues central to nurse management roles, such as leadership, strategic planning, innovation management, models for nursing care delivery, profile of the workforce, quality management and education, are discussed.

2.1 Role Theory

Role Theory provides a framework to examine and discuss many social issues. George Herbert Mead's (1934) interest in mind, self and the understanding of human nature in terms of group and society, forms the origins of *role theory*. The theory explains roles by presuming that persons are members of a social position and hold expectations of their own behaviour and that of other persons. He proposed that individuals could shape society by working together. Banton, provides a succinct definition of role as "a set of norms and expectations applied to the incumbent of a particular position" (Banton, 1965).

Role theory represents a "collection of concepts and a variety of hypothetical relationships that predict how actors will perform in a given role, or under what circumstances certain types of behaviours can be expected" (Hardy and Conway, 1988, p17). The theory is based on several underlying propositions. These are as follows:

- Some behaviours are patterned and are characteristic of persons within contexts (i.e. form roles).
- Roles are often associated with groups of people who share a common identity (i.e. who constitute social positions).
- Persons are often aware of role, and to some extent roles are governed by the fact of their awareness (i.e. by expectations)
- Roles persist, in part, because of their consequences (functions) and because they are often embedded with larger social systems.
- Persons must be taught roles; they must be socialised and may find either joy or sorrow in the performance thereof (Biddle, 1986, p.8).

Role Theory addresses the structures of the organisation, the environment and their interaction. Biddle contended that roles are linked to structural positions within an organisation. Byres (1997) proposes that nurse management roles are defined by relationships within the health care organisation. She suggests that "who one reports to and who one's peers are, define the level and scope of the role" (p.7). Regardless of the level or scope of the role, nurse-managers are ultimately required to play multiple roles; carer, leader, educator, manager, administrator, counsellor, financial controller etc.

The concept of role has been used to denote prescriptions, descriptions and evaluations of actions. Psychologists view role on a personal micro level, while sociologists and anthropologists focus on the overt, macro and societal elements of a role. Nursing work roles are mainly viewed at a public macro level. Equally important are the elaborate psychological and very personal demands related to a nurse-managers work role, which appear to be poorly understood.

Linton's (1945) simple two-fold classification divides roles into those which are ascribed and those which are achieved. This classification is based on the mode of allocation of roles, "ascribed roles are assigned to individuals without reference to their innate differences or abilities while achieved roles are left open to be filled through competition and individual effort" (Linton, 1965, p30).

Society ascribes roles within the societal order. However, the individual normally has the opportunity to develop and ascend to achieved roles which may provide a greater sense of self-fulfilment. The organisational structure within health-care organisations ascribe (prescribe) levels of nursing management but the role players (nurse-managers) determine what can be achieved through the role. Within traditional hierarchical hospital structures, individual nurse managers have little or no control over their ascribed roles but have more freedom in the selection of appropriate roles to be achieved through their role performance and career development. The stereotypical image of nursing management (Matron) popularised by the media, serves to enforce the fixed role and image allocated to nurse managers in the health-care hierarchy.

Hardy and Conway (1988) describe two major perspectives from which roles and role performance can be studied, namely the functional/structural and the interactionist/ symbolic approaches (Biddle, 1986).

Functional/structural perspective
Assumes that roles are fixed in society and have certain expectations and demands attached. The focus is on the characteristic behaviour of persons who occupy a social position within a stable system. Sanctions serve to enforce the behaviour individuals engage in and limit options for alteration of behaviour.

Symbolic/interactionist perspective
Stresses the role of individual actors, the evolution of roles through social interaction, and various cognitive concepts through which social actors understand and interpret their own and others" conduct (Biddle, 1986) & (Hardy and Conway, 1988, p.18).

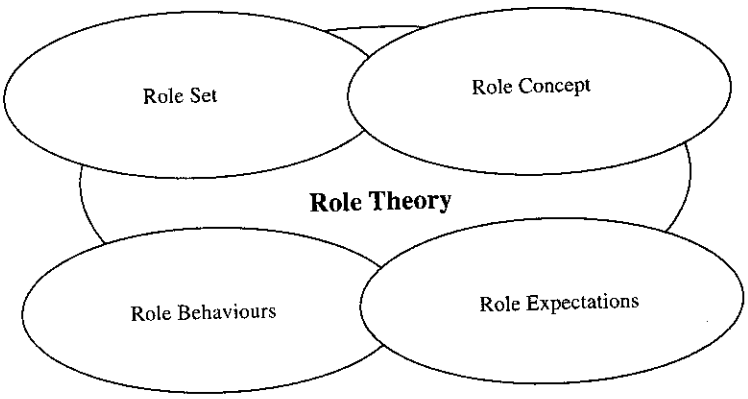
The major difference in the two perspectives is that the functional perspective conceives of social action as learned responses that are communicated during the process of socialisation and reinforced in the individual by the approval or disapproval of significant others. Traditionally, nurses in Ireland have been socialised through initial nurse training programmes and have been initiated into management by older nurse managers. As nurses became managers the process is continued. Control and command have historically been evident (McCarthy, 1997). This control was often maintained by the operation of sanctions. The traditional hierarchical systems of nursing management have for many years ascribed to the functional perspective of role.

Symbolic interactionism has ordered its priorities in the opposite direction to functionalism. The symbolic interaction perspective holds that the individual engages in interactions with others and selects certain cues for actions which have more relevance than others. Symbolic interaction acknowledges society and its institutions as a framework within which actors make roles explicit. As the concept of decentralisation and empowerment increases, the interactionist approach is becoming more important to nursing, particularly to nurse managers.

Role Theory Model

Role Theory provides a framework to examine work related activities and their consequence. A number of role related terms are used; role concept, role expectations role set and role behaviours (see Table 2.1). From available literature it is apparent that these are the most commonly used terms to describe a particular role.

FIGURE 2.1 Representation of Role Theory.



Source: **Flynn, M. (1995) The role and educational preparation of anaesthetic nurses in Ireland, unpublished M.Ed. Thesis, Trinity College Dublin.**

TABLE 2.1. Role Theory

Role concept:	the concept makes it possible to identify and analyse the objects of study thus making communication in relation to the subject possible.
Role expectations:	each member of a person's "role set" depend upon his/her performance in some fashion, in order to perform their own tasks. Because they have a stake in others performance, they develop beliefs and attitudes about what a person should and should not do as part of their role.
Role set:	because of the nature of organisations, (systems of interdependent activity) the occupation of any given role is interdependent with others. These other roles constitute the "role set."
Role behaviours:	these are anticipated behaviours, actions to be performed by individuals who are engaged in a certain role within society. A form of energy exchange which includes inputs, throughputs, outputs, feedback and goal direction.

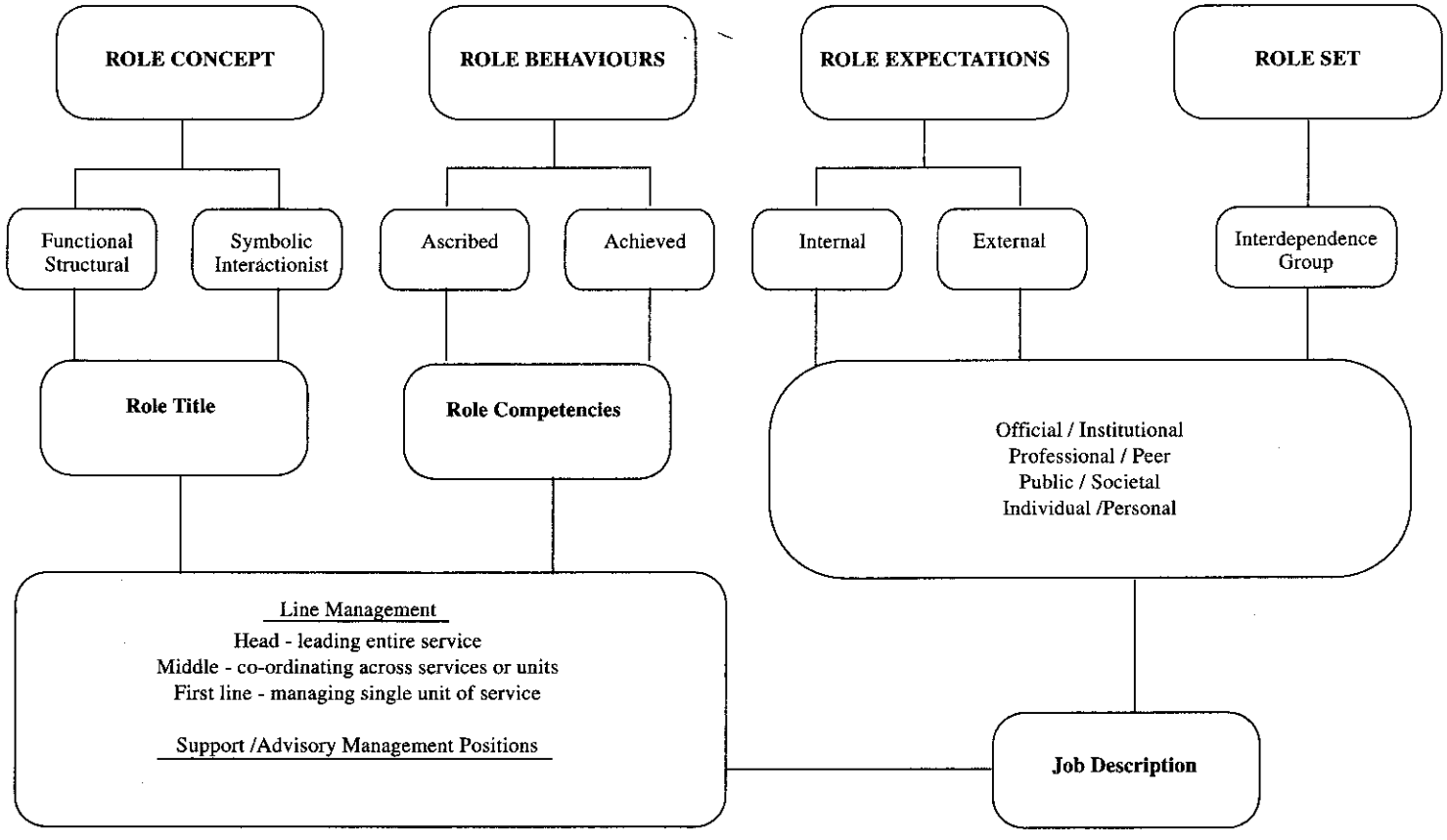
Source adapted from: **Hardy, C. and Conway, M. (1988)** ***Role Theory Perspectives for Health Professionals.*** **2nd. edn. Norwalk: Appletin and Lange.**

Role Theory terms can be used as a four point framework for examining a particular role (see Figure 2.1 and Figure 2.2). The particular role concept can be appreciated by examining the title given to the position e.g. Matron, Director of Nursing, Vice-president of Nursing, The title can be viewed either from a functional or symbolic perspective. Role behaviours (actions) can be divided into those which are required (ascribed) and those which are achieved. Whether the role behaviours are ascribed or achieved, a particular set of role competencies is necessary for successful role performance. Expectations of a role are formed as a result of beliefs and values held by the individual role occupant, other members of their reference group or the wider public. The institutional expectations of nurse-managers are made explicit through job descriptions. Role set refers to the individuals and groups with whom nurse managers interact and depend on in role performance. The particular role concepts, behaviours, expectations and set are distinct for each level of nurse management, first-line, middle and senior management. The next section of this review uses the role theory framework to summarise the literature on nurse management roles.

Role Concept

Traditionally the role of the nurse manager has been to ensure efficiency in the nursing services in hospitals, which was often achieved by the use of firm control. Power was maintained by: "position; management focus; (centralised planning, direction, control and discipline); autocratic (top-down), rigid processes; fiscal focus; and rewards/punishment" (Adalen et al. 1997, p.97). This role was ascribed by hospital authorities, doctors and the public and was often functional in orientation. Coulson and Cragg (1995) suggest that today's nurse-managers have a unique and complex role that requires the blending of two professions: management and nursing. It takes the appropriate culture, the right people and the continuous improvement of processes to create a high performance team. It is the role of the manager to create the appropriate culture; to hire, motivate and retain the right people; and to facilitate the creation of processes that will enable staff to succeed. This team is the crucial component in determining organisational success (Shendell Falik and Soriano, 1997).

FIGURE 2.2 Framework for Examining the Nurse Managers Role



This figure has been constructed by the author of the report.

A distinction is made in the literature between the terms "nurse-manager" and "nurses in general management." In one the nurse functions as a nurse (as a nurse-manager), in the other the nurse moves beyond nursing into a general health management position, see Table 2.2. The International Council for Nurses (ICN) believe that there is a need for nurses in health-care management both as nurse-managers and nurses in general health management.

TABLE 2.2. Nurses Management Functions

Nurse Manager:	has management roles and functions, primarily related to nurses, nursing or nursing services. The position is required to be filled by a nurse on the basis that nursing knowledge and judgement are pre-requisites to the management functions of the position. The position is seen as essential to contribute to the goals of the organisation. The nurse manager has accountability for the functions related to nursing and sometimes to nurses, or to a combination.
Nurse in General Management	has management roles and functions primarily related to the broader field of health care management, where the position is not required to be filled by a nurse. The manager is therefore not functioning as a nurse but can have much to contribute to the position from their nursing background.

Source adapted from: **International Council of Nurses (1990)** ***Preparation of Nurse Managers and Nurses in General Health Management: guidelines for national Nurses" associations and others.*** **Geneva: ICN, p. 65.**

The term nurse-manager itself is clarified to expand on the difference between management of nurses, and management of the nursing function (International Council of Nurses, 1990, p. 5, see Table 2.3). The difference in the two functions and the feasibility of dividing the two roles is debated in the nursing literature. It appears that the management of nurses attracts greater attention as a major component of the hospital budget is spent on the employment of nurses. Therefore managers of nurses have substantial influence within an organisation, while senior nurses who purely manage nursing may not have the same level of influence.

TABLE 2.3. Scope of Nurse Managers

Management of Nurses:	management roles and functions related to nursing staff, e.g. recruitment, orientation, allocation, activities, leave, etc.
Management of Nursing:	management roles and functions related to the development of professional nursing, its practice and its standards, appropriate to health needs (sometimes referred to as management of the nursing function).
Management of Nursing Services:	management roles and functions related to nurses, nursing (the nursing function), or a combination of both, whatever is most appropriate to the particular health structure and country concerned.

Source adapted from: **International Council of Nurses (1990)** ***Preparation of Nurse Managers and Nurses in General Health Management: guidelines for national Nurses" associations and others.*** **Geneva: ICN, p.68.**

Management of nursing services seems to be the most encompassing descriptor for the role of the nurse-manager as it involves both the management of nurses and nursing. The reader is cautioned not to become excessively entwined in the semantics of language and lose sight of the true role of the nurse-manager.

Sometimes the weighting of the nurse-manager's role has been on the management and supervision of nurses, with the management of the nursing function receiving lesser

attention. In such cases, nursing management has neglected to demonstrate the advantages of retaining roles and functions that relate to management of the nursing function.

Balogh and Bond (1993) suggest that some nurses may be more comfortable with the term nursing manager than nurse-manager. The reason offered for selecting the title nursing manager was to convey a distinction between the wider brief of managing resources and the more narrow supervisory role of managing nurses through the nursing officer line. Behind the distinction the more profound question with deeper professional implications is the possibility that non-nurses might be recruited to manage nursing resources and thus undermine the existing supervisory process of professional accountability (Balogh and Bond, 1993).

The most powerful way for managers to maintain professional status is through clinical involvement and it is suggested that this remains possible for the medical profession. In a survey of sixty-six senior nurses (UK Northern Regional Health Authority) 29% said they would like to maintain a clinical caseload within the remit of a management post. Several nurses argued that this was an essential prequisite for the development of the professions knowledge base and clinical leadership (Balogh and Bond, 1993). It appears that the evolving general management models described in the literature could preclude the development of nursing roles with a clinical element at senior management levels. Nurses in management therefore have a dilemma.

Chapter one, of this review identifies three particular trends in organisational design in hospitals: the introduction of general management; decentralisation and devolution and the development of flatter and leaner structures. In some organisational changes, management positions are no longer automatically filled by health professionals but by people (who may include nurses, doctors, etc.) who are chosen primarily on the basis of management skills and ability. There is a fear amongst nurses that this change may erode the control of nursing services which nurse-managers have had in the past. In 1990, the International Council of Nurses (ICN) advised that as a matter of urgency nurses should examine new types of nursing roles and positions. The ICN also suggested that managers need to ensure that the new organisational structures will facilitate nurses to: retain control over the nursing function and professional practice; set and implement standards; and influence health planning, policy development and resource management (International Council of Nurses, 1990).

The ICN cautions that many arguments made by nurses (on the basis of the size of the nursing workforce, their close client contact etc.) for involvement in senior health management often irritate executive hospital managers and may be counter productive. Nurses must be able to demonstrate their effectiveness; evidence and documentation is required to make convincing statements. The ICN report that nursing management positions have been eliminated in some countries and suggest that this was probably because relevance, achievements and effectiveness were not demonstrated in relation to the posts. The ICN offer general guidelines to nurse-managers which state that: "if nurses are the experts on patient care, then decisions on staffing; quality of nursing practice; implementation of changes in nursing practice within set budget parameters could be decentralised to them" (p.18). In this model the ICN suggests that the senior nurse-manager would retain central control over such matters as planning, determining overall outcomes within budget, and ensuring evaluation of standards of nursing practice. What is important is for the senior nurse-manager to define where accountability lies, and then provide the structure and support in a way that allows for other staff to have that accountability.

The availability of full time professional advisory roles to line managers is a new nursing development in many countries. Strong leadership is required to develop these positions and to demonstrate their benefits to both nurses and general managers. There are various titles reported for such roles – Director of Nursing, Senior Nurse Advisor, Consultant Nurse Advisor and Clinical Nurse Consultant. The ICN outline the professional nurse-advisory role functions and activities as follows:

- Providing leadership and direction for nursing.
- Professional head of nursing.
- Facilitating nursing research and the integration of professional knowledge into practice.
- Ensuring an effective workforce to meet health service needs.
- Interpreting legal and professional matters relevant to nursing practice.
- Monitoring, evaluating and promoting nursing standards.
- Advising on nursing service delivery.
- Establishing and maintaining networks.
- Providing advice on nursing and nursing issues.
- Providing nursing input and advice into the organisation's senior management team.
- Helping foster a sound environment for quality patient care.
- Articulating health concerns within management.
- Involvement in organisation-wide task groups or projects (International Council of Nurses, 1990).

The title allocated to a management position gives an indication of the underlying role concept, the next section of the review examines a sample of international nurse management titles.

Nurse Management Titles

The titles assigned to particular nurse management roles give an insight into the remit and expanse of the role. As described in chapter one, nurse management roles can be divided into three broad line-management categories; senior, middle, first-line as well as a fourth advisory category. Appendix one, presents a comparative table of the titles given to nurse management roles in Ireland, UK, USA, Canada, Australia and New Zealand. This table was constructed on the basis of available literature and communications from nurse-managers, it is not exhaustive and intends to be purely illustrative.

Ireland is the only country to report the use of the title "Matron." Most other countries appear to use the title Director of Nursing with some countries introducing a level above Director of Nursing called Chief Nurse/Vice-president of nursing. The title Director of Nursing often has a qualifier – quality assurance/patient services/services or a services title e.g. paediatrics. The qualifier gives a greater insight of the role concept. Some of the newer Director of Nursing positions are removed from line-management and are advisory in orientation, with a focus on nursing leadership within an organisation. Because of this, a simple review of literature on role based on titles may be misleading as role interpretation varies across countries, for example, director of nursing or unit nurse manager does not mean the same thing in each country.

In the UK and the USA, it is now more usual for senior nurses to be referred to as nurse executives. The title executive indicates a corporate function. The nurse executive

role usually provides nursing advice without line-management responsibility for nursing. This role also includes a corporate function such as clinical service management or strategic co-ordination of corporate initiatives in quality assurance, risk management, re-engineering, or development of primary care (Malby, 1997). There is increasing reference in the literature to the role of the nurse executive. Smith et al (1994) suggest that nurses wishing to take on the role of nurse executive must have; flexible and action-orientated personal qualities, executive level business management skills, expertise on clinical affairs and completed graduate level degree work (Smith et al. 1997).

A very wide range of titles are used for middle management positions – the common element being the word nurse. The role normally involves management of different functions, for example management of: nurses, nursing, general services or a combination of functions. Many hospitals appear to split the management of nurses and nursing by employing a business manager and a clinical specialist. The business manager (head nurse, unit nurse manager) is primarily concerned with the management of nurses and the service, while the specialist clinical nurse consultant (CNC) or clinical nurse specialist (CNS) is involved in the management and development of nursing. The title Ward Sister is used in Ireland and in some hospitals in the UK, however, the title is no longer used in North America, Australia or New Zealand.

The review suggests that the role concept for nurse management varies between line-management positions, professional advisory positions, and for a combination of these and nurse manager positions with other non-nursing management responsibilities.

Role Expectations

Role expectations are the obligations that identify the attitudes, behaviours, and cognitions required and anticipated for a role occupant (Biddle, 1986). Sources that define a nurses role are institutional requirements, patient/client expectations, peer pressure, and the nurses conception of what the role implies. According to Douglas some of the most important roles involve the following skills and functions:

- human management skills;
- general nursing skills;
- fiscal management skills;
- medical staff relations;
- flexibility/negotiation/compromise; and
- total organisational view (Douglas, 1996, p74).

Four sets of expectations have been identified in relation to the nurse's role: official – institutional expectations; professional – peer expectation; communal – public expectation; and personal – self-expectation (Benne and Bennis, 1959). These four sets can be applied to the nurse management role. The expectations are dependant upon the various counter positions which make up the managers role set. For example, behaviour is influenced by: the patient, other nurses, medical staff, ancillary personnel, visitors and the organisational administration structure. Each of these individuals or groups of people hold differing role expectations of the nurse-manager and consequently nurse-managers are frequently faced with attempting to meet different demands (Gerrish, 1990). Lack of clarity concerning role expectations and uncertainty about one's work performance and behaviour can result

in role ambiguity or strain (Gerrish, 1990). External demands placed on nurse managers along with internal aspirations can frequently lead to the failure to fulfil role expectations, both personal expectations and those of others. The pattern of internal and external role expectations can be seen at work in hospitals. Nurse managers are often ascribed the roles of educator, manager and clinician. However, the sheer volume of responsibility encompassed within these three roles, plus lack of knowledge and skills, very often prevents the role occupant from effectively fulfilling the role prescription. The institutional (official) expectations of the nurse manager's role may be summarised in the five basic functions for nurse managers:

- Establishes objectives and goals for each area, communicates them to the persons who are responsible for attaining them.
- Organises and analyses the activities, decisions, and relations needed and divides them into manageable tasks.
- Motivates and communicates, stresses the importance of being a good team player provides positive reinforcement.
- Analyses, appraises, and interprets performance and communicates the meaning of measurement tools and their results to staff and superiors.
- Develops people, including self (Wise, 1995).

Litwin et al. (1997) reported on a redesign project which was conducted at a New Jersey medical centre to transform the nurse-manager role to a unit manager's role. The chief nurse executive came to the nurse-manager redesign process with a clear vision of expectations and hopes for the new nurse-managers role. She suggested that the new unit manager must: envision the future; see and build new paradigms; manage between paradigms; produce excellence; lead by influence, not power; and develop synergized self-managed teams (Litwin et al. 1997). Irish nurse-managers could possibly adopt this set of expectations, as a starting point, when considering future new management roles.

Professional/peer expectations are expressed in codes of conduct for nurses and midwifes. Specific codes of conduct for nurse-managers do not appear to be nationally or internationally available. An indication of the public/societal expectations of nurses can be perceived from patient charters. The official expectations of nurse-managers are made explicit through written job descriptions.

Nurse Management – Job Descriptions

When reviewing the literature, large variations were found in job descriptions for nurse management positions across countries. Job descriptions in Ireland tend to be general in focus whereas in the UK and Australia they are more specific, identifying the exact nature of the role, the relationships within the organisation, the line-management reporting structure (where appropriate) the primary objective, the key responsibilities and the expected results. There is a trend to incorporate a personal specification profile with the job description – setting out the: qualifications and experience; skills and abilities; and additional desirable qualities of the ideal candidates for the job. These often act as the guiding criteria for recruitment. Because of the variety of job descriptions, roles, functions, levels of nursing management and descriptive style, it is not possible to draw useful comparisons between job descriptions across countries. However, in 1990 the ICN summarised the range of functions expected of all nurse managers. These functions are

divided into those relating to the professional component and those relating to the corporate component of the management role and are presented in Table 2.4.

TABLE 2.4. Range of Functions Expected of all Nurse Managers

PROFESSIONAL COMPONENT

- Providing leadership and direction for nursing and the nursing service, formulating nursing policy and linking nursing with the broad goals of the organisation.
- Being the professional head of nursing, able to articulate nursing's philosophy, goals and standards of practice, be a spokesperson on nursing issues, and represent nursing and the organisation before other organisations and the community.
- Facilitating and contributing to nursing research, and generally promoting the advancement of professional knowledge and ensuring its integration into practice.
- Ensuring there is an effective workforce to meet the health service needs.
- Interpreting legal and professional matters related to nursing practice.
- Monitoring, evaluation and promoting nursing standards.
- Managing nursing service delivery.
- Establishing and maintaining networks, both nursing and inter-disciplinary.
- Providing advice on nursing and nursing issues.

CORPORATE COMPONENT

- Providing nursing advice, contributing a nursing perspective to and participating in strategic health planning, health policy development and resource management.
- Helping foster a sound environment for quality patient care.
- Helping ensure that health concerns are clearly articulated within management teams and general management structures.
- Participating in or taking a leadership role in task groups or projects that relate to the goals of the organisation as a whole.

Source: **International Council of Nurses (1990)** ***Preparation of Nurse Managers and Nurses in General Health Management: guidelines for national Nurses" associations and others.*** **Geneva: ICN, p.29.**

Role Set

Role set has been described as a constellation of relationships with the role partners of a particular position, that is, of all the actor's (nurse-managers) role partners (Biddle, 1986). For successful management, interdisciplinary relationships must be developed and maintained. The role set of the nurse-manager can be described as the interdependency group and is comprised of four sets of people; institutional, peer, societal and personal (see Figure 2.2). The role set is generally comprised of the same group who hold expectations of the nurse-manager. Although role set is part of the *role theory* framework, the literature available to the author did not specifically expand on the nurse-managers role set and so this subject is not examined in any greater depth. Further research needs to be conducted in this area to identify the extent of the nurse-managers role set; that is the people with whom a role occupant (nurse-manager) interacts and depends on for effective role performance. However, one could speculate they include at least, doctors, professions allied to medicine, chief executive officers, financial controllers, general managers, personnel managers, secretarial staff, catering and domestic staff etc.

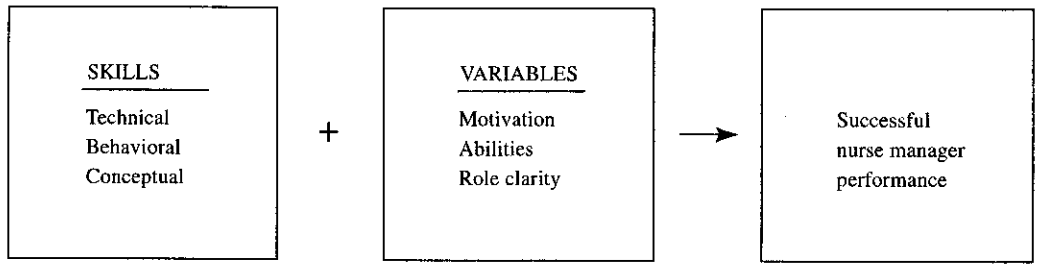
Role Behaviours

Role behaviours are considered to be actions (inputs, throughputs and outputs) relevant to a specific position (Biddle, 1986). Specific competencies (skills) are necessary to successfully perform management actions. Competencies are defined as, "non-discriminatory, critical characteristics that reflect or predict outstanding job performance. Competencies typically include knowledge, skills, behaviour, personal traits and other attributes" (Dubnicki and Sloan, 1991, p.41).

Superior performers apply these success factors more frequently, with more consistency, and in more situations than others in the work force. Competency profiles for nurse managers are described extensively in the nursing literature, however, there is little consistency in their presentation and so it is not possible to construct useful comparative tables.

Competencies are forged through generic and continuing education and administrative, managerial, and clinical experiences in a variety of delivery settings. The skills reported as being particularly important to health-care policy are: communication, consumer advocacy, power risk-taking, coalition-building, quality of care evaluation, and consumer-focused decision-making skills. Three types of skills, technical/behavioural/ conceptual are identified as necessary for successful nurse management. Once these skills are available, successful nurse-manager performance then depends on the variables of motivation, abilities and role clarity (Valadez and Otto, 1995, p.28) see Figure 2.3.

FIGURE 2.3 Skills and Qualities of the Successful Nurse Manager.



Source: **Valadez, A. and Otto, D. (1995) The role of the nurse manager. In: Wise, Y. *Leading and Managing in Nursing*. St.Louis: Mosby, p. 28.**

Stevens (1991) described the important qualities which she suggests are imperative for accomplished management; ambition, judgement, stamina, organisation, planning ability, communication, job knowledge, courage and integrity (Steven, 1991). She suggests that executive confidence is based on experience and self-knowledge and that all great leaders can persuade others to work together as a team. The desirable traits of nurse-managers are described as; being expert articulators, admitting failures, capitalising on strengths, knowing the work – what they want out of it – and integrating these (Wise, 1995). A critical factor in being an excellent nurse-manager is knowing how to manage clients and families and allocate resources and technology in an ever-changing environment.

Mateo et al (1997) suggest that managers have vital roles in balancing clinical practice and business-related outcomes. They postulate that the role comprises of management of

two main categories; staff management and fiscal management. Staff management includes recruiting and retaining a diverse staff. Fiscal management entails application of budgeting principles, use of productivity measurements and methods for forecasting activity levels (Mateo et al. 1997). They contend that the following behaviours are key components in successful nurse management:

- political savvy;
- effective communication;
- artful negotiation;
- adaptable collaborator;
- participative approach;
- change agent;
- visibility; and
- expertise in recruiting, retaining and working with a diverse staff in a team concept framework (Mateo et al. 1997, p.11).

In summary, throughout the literature the desired qualities/traits/skills reported for nurse-managers are: knowledge, integrity, ambition, judgement, courage, stamina, communication skills, planning and administrative abilities (Wise, 1995). The next section reviews the specific competencies reported for nurse executives and first-line nurse managers. Although officially nurse executives are not employed in Ireland, some nurses are performing similar functions and many more aspire to such a role.

Role Competencies – Nurse Executives

The international developments and investment in executive nurse positions is predicated on expectations of what the role occupant can achieve. Expectations are presence, leadership capacity and communication expertise. Byres (1997) says that changing health care structures requires executive nurses to have high-level skills in systems thinking, communication and relationship management and creativity in work group organisation and community coalitions.

TABLE 2.5. Nurse Executive Competencies

Competency	Outline
Communication:	written and verbal communication skills are critical.
Consumer Advocate:	active involvement at the highest administrative level deciding what policies are critical to patient care.
Power:	understand the uses and abuses of power, the types of power and how and when to use power appropriately.
Risk-Taking:	learning when the risk is essential to quality patient care and when with retrospective evaluation and feedback, a different solution might have produced a more desirable outcome.
Coalition Building:	build and develop coalitions. This requires an appreciation and understanding of many viewpoints, internal and external.
Quality of care:	understand the importance of quality of; life, care, service, and quality measurement.
Consumer Focus:	be grounded in the public good.

Source adapted from: **Byres, A. (1997) *The Executive Nurse: Leadership for New Health Care Transitions.* Albany: Delmar Publishers, p.29.**