Byres (1997), in her recent text on the executive nurse, suggests that as a corporate member of staff the nurse should: participate in the search and selection of key nursing staff; interpret nursing to other corporate staff such as human resources and legal staff; serve as a resource for clinical nursing inputs in the corporate decision making and policy-formation processes; work with corporate staff to shape vision, mission and goals and with quality management staff to develop guidelines as standards of nursing care and of patient care services. Byres describes the nurse executive as offering a unique combination of values, knowledge, skills and attitudes to the content and process of health care delivery. She identifies the competencies which nurse executives require for full participation in health-care policy formulation which are set out in Table 2.5.

Byres suggests that the executive nurse of the future will be an integrator of leadership and followership, displaying the following qualities: "novice zeal and expert grace; courage and playfulness; commitment and celebration; energy and ease; creativity and conservation; dignity and humour; truth telling and envisioning – transformational leadership"(Adalen et al. 1997, p. 111). She identified the critical skills which nurse managers destined for future leadership roles must develop, (see Table 2.6).

Vogelpohl (1996) suggests that the director of nursing role will need to evolve if the management of nursing in the organisation is to be successful. She suggests that blending the service end of nursing with the business end will ensure that the director of nursing is the driving force for quality through management of resources.

TABLE 2.6. Critical Skills for Future Nurse Leaders

Critical Skill	Responsibilities
Leadership skills:	opening a vision to strategies for developing nursing group process and skills.
Technical skills:	information management, financial analysis/synthesis, critical thinking, presentation skills and systems thinking.
Research skills:	critical, questioning, evidence based management.
Communication skills:	ability to use influence effectively, manage group process, and resolve conflict.
Analytical skills:	rapidly evaluate and synthesise multiple pieces of information. Decision making/problem solving skills used in clinical judgements.
Financial skills:	economical and financial analysis/awareness accountability for cost-effective quality care.
Co-ordination skills:	integrator, delegator, flexibility, willingness to collaborate with peers across functions, review of performance standards.
Problem-solving skills:	evaluation, analysis and decision making.
Delegation – coaching skills:	ensure inclusion/participation of each team member, measuring staff autonomy, assumption of professional accountability.

Source adapted from: **Byres, A. (1997)** ***The Executive Nurse: Leadership for New Health Care Transitions.*** Albany: Delmar Publishers, p.31.

Role Competencies – First-line Nurse Managers

The role of the first-line manager has been described as a balance between the use of self, use of staff and use of delivery systems (Stevens, 1974). As a result of several influences over time, the role has altered. Internationally, the one factor frequently mentioned as having a significant impact on the role and competencies is decentralisation, both at organisational level and throughout the nursing division. In a decentralised structure, the head nurse becomes more a manager than clinician. Primary nursing has

also had a significant impact on the role of first-line nurse managers (see section 2.3 for a description of primary nursing). Primary nursing relies on a participative style of management so that those at the bed-side have the authority to make decisions related to care and responsibility which previously belonged to the head nurse. One of the main differences is the responsibility of the head nurse in the unit for twenty-four hour care, not just the day shift (Carroll and Adams, 1994). The transition in nursing from the role of a clinician to a manager can result in role confusion and conflict. The reason for this is that the first-line manager must be credible with management and workers alike. While different skills are required to manage, technical expertise and clinical involvement are still necessary to ensure a continuing understanding of the work of nursing and to train future carers (Duffield, 1991).

In the UK, the role of the ward sister is changing and is increasingly veering towards a middle management role. Roberts describes the qualities required of a ward sister/manager if they are to maintain their traditional role as clinical expert while also fulfilling a new role as ward manager (Roberts, 1993). The competencies identified are: maturity of personality; assertiveness; a decisive confident air of leadership; ability to accept responsibility and constructive criticism; a professional attitude; dedication to the job and a genuine interest in the chosen field of nursing. She suggests the basic qualities needed by a ward sister are loyalty, honesty, approachability, tolerance and patience.

The extent of decentralisation (to unit/ward level) described in the literature has not yet been experienced in the Irish health service. Given the enthusiastic nature of the discussions taking place on decentralisation and empowerment at unit level, it is very likely that significant changes will be made in the Irish ward sisters role in the years ahead. It is vitally important that nurses prepare, in advance, for such changes by upskilling and expanding their repertoire of competencies, particularly in information technology and business management.

Role Conflict, Ambiguity, Incongruity, Stress /Strain

Difficulties in relation to the nurse-manager's role performance have been described in the following terms; conflict, ambiguity, incongruity and strain (as set out in Table 2.7). Role conflict results when two or more incompatible expectations for the behaviour of a person appear concurrently (Biddle, 1986). For both superiors and subordinates, significant role ambiguity makes attitudes, habits, and priorities less reliable and predictable (Heidenwolf Weaver et al. 1991). Incongruity arises when self identity and subjective values are grossly incompatible with expectations for the role. Ambiguity and incongruity in relation to role responsibilities may be the source of inefficiencies evident in the operation of some Irish departments of nursing (see chapter 3).

Redfern (1980) observed role conflict amongst ward sisters in relation to the many roles they have to play and also role ambiguity in relation to doubts concerning their responsibilities and colleagues expectations (Redfern, 1980). In a review of the nursing literature, Tumulty (1992) found that, overall, the literature supports the view that autonomy, role stress, and feedback are important factors to consider in efforts to create more satisfying and productive nursing roles.

Role stress for one individual also results in ambiguous and discordant conditions for occupants of interdependent positions. A source of role stress is the ambiguity that naturally occurs as new roles are established. Health-care facilities are changing as a result of technological advances and specialisation. New roles and the expertise needed to meet

the demands require an ongoing process of clarification and evaluation in order to provide the necessary service. This is an important consideration when contemplating significant change in nurse-management positions. According to Hardy and Conway (1988) role strain may be managed in several ways: redefining the role, redefining what is considered "adequate" role performance, re-establishing priorities within a role and among roles, role bargaining with role partners and reduced interaction with role partners (p. 159).

TABLE 2.7. Role Stress/Strain

Role conflict:	arises with incompatible role expectations.
Role incongruity:	arises when self identity and subjective values are grossly incompatible with role expectations.
Role ambiguity:	arises where role obligations are vague, irritating, difficult, conflicting, or impossible to meet, a characteristic of the social system, not of a person in the system.
Role overload:	arises where too much is expected in the time available.
Role stress:	arises where the social structure creates very difficult, conflicting, or impossible demands for occupants of positions within the structure.
Role strain:	arises in response to the external conditions of role stress and is a subjective state of emotional arousal (subjective feelings of frustration, tension or anxiety).

Source adapted from: **Porter-O'Grady, T. (1992)** ***Implementing Shared governance.*** **St.Louis: Mosby-Year Book) and (Biddle, B. (1986) Recent developments in role theory.** ***Annual Review of Sociology*** **p.66.**

Summary of Role Theory

The role concept literature highlights the debate in relation to the division of the management of nurses and the management of nursing. Whatever the outcome of the discussions, the literature suggests that it is vitally important that nurses retain control over the nursing function in any health-care organisation. The advice also emerging from the literature is that nurses should not persist in retaining an exclusive narrow management function but should influence health planning, policy development and resource management in the broader health service.

The diversity of the individuals or groups of people (patient, family, media, colleagues, nurses, doctors, managers, students etc.) holding expectations of nurse-managers' functions, gives an insight into the potential role conflict that might be experienced by nurses at all levels of management. It is important that nurse-managers recognise the potential for conflict between their own internal role expectations and the external expectations of others. There is a real need for realistic, explicit and detailed job descriptions for all nurse-managers. The job descriptions must be matched with defined competency profiles.

The literature constantly draws attention to the fact that competencies cannot simply be acquired in class-rooms or lecture theatres. They are developed over time through; observation, demonstration, instruction, guidance, trial and reflection. To build a balanced set of competencies nurse-managers need administrative, managerial and clinical experience. The identified characteristics, traits, qualities and skills should form a useful resource when reviewing or devising new job descriptions for nurse-managers in Ireland. There is a strong emphasis in the literature on the need for first-line managers to develop new competencies to prepare them for the new business orientation in the role.

Role conflict, ambiguity, incongruity, stress and strain have been identified at differing levels for nurse-managers. It is important to learn from these experiences and consider

potential role difficulties and prevention strategies when reviewing any role a nurse might have in the future management of the health service.

This section of the review explored the nurse-managers role using role theory as a framework, the next section of the Chapter examines, in a more general way, the most recent research related to nurse management roles.

2.2 Nurse Management Roles – Research

An extensive number of commentary articles have been published in the nursing press describing the changes in nurse-managers roles, however, only a small number of research studies have been reported. For the purpose of this review the studies have been divided into those which address senior nurse management roles and those that address first-line management roles. Where possible studies from each country under review have been included (UK, USA, Canada, Australia and New Zealand). It was not possible to locate any Irish research study which specifically investigates the role of the nurse-manager.

Senior Nurse Management Roles

The South West Thames regional health authority (UK) conducted a study in 1991 to identify a specific set of role competencies required of trust nursing directors in order to successfully fulfil their roles (Hennessy et al. 1993). The importance of taking a strategic view of senior management development, and planning such development to meet the future business challenges, was encapsulated in the competency framework adopted within the study. A broad cross-section of senior nursing and other National Health Service (NHS) managers, from both within and outside the region as well as key stakeholders were interviewed to solicit their personal views and insights on the direction in which nursing and health-care might evolve. The study identified developing trends in the nurse management role/functions which were grouped into near, medium and long term trends, which are shown on Table 2.8.

TABLE 2.8. Developing Trends in Nurse Management Roles

Time period	Movement
Near term trends in nursing:	From supervision to enablement. From functionalism to partnership. From vocation to qualification.
Medium term trends in nursing:	From structural to health-care focus. From managed to managing. From effective nursing process to effective/efficient process and outcome for patient care.
Longer term trends in nursing:	From existing architecture to tailored facility. From medical leadership to nurse leadership.

Source adapted from: **Hennessy, D. Rowland, H. and Buckton, K. (1993) The corporate role of the nursing director. *Journal of Nursing Management* 1, p. 162.**

An examination of the identified trends and comparisons with the developments in nursing management in Ireland suggest that the trends in Irish nursing might be placed somewhere between the near and medium term trends.

It was reported by the authors that participation in multi-functional learning sets which include directors of finance, doctors with management responsibilities and general managers was of particular importance to the development of the corporate role for the nursing director. The study identified the ability to plan and progress their own self-development and to determine pace of development as key competencies that all aspiring nursing directors should possess. The findings of the study suggest a three stage approach to the evolution of the trust nursing-director role from one of nursing management to a full corporate role as a member of the trust executive. This could be used as a model for developing executive nursing roles in Ireland. The three stages are leading the transformation in nursing, charting the way ahead and assuming full executive status (see Table 2.9). The role of the director of nursing and the competencies required for the necessary changes are set out on the table.

TABLE 2.9. Evolution of Corporate Director of Nursing Role

Stage of role evolution	Role of the Nursing Director	Competencies
Leading the transformation in nursing	Lead and manage change. Maintain high standards of care. Advise the executive on nursing issues. Contribute to trust evolution. Initiate development of senior nurse managers.	Employing personal networks. Building constructive relationships. Articulating patient care. Motivating people. Championing the human consequences of change. Delegating decision making. Planning and managing change. Delegating decision making. Planning self-development. Using basic concepts of business management.
Charting the way ahead	Providing strategic leadership for patient care. Assuming planning responsibility. Promoting training and development. Monitoring patient care. Initiating research.	Business planning. Linking people capability with strategy. Initiating projects. Monitoring progress. Aligning organisation and processes with strategy. Providing strategic leadership. Interpreting environmental and competitive trends. Settings goals and milestones. Allocating resources. Developing successors.
Assuming full executive status	Nurse Executive – equal place with executive directors. Corporate business management. Executive planner. Corporate leader for nursing.	Managing capital projects. Directing a health gain focused organisation. Contributing to trust evolution. Managing external relationships. Using high level of business management expertise.

Source adapted from: **Hennessy, D. Rowland, H. And Buckton, K. (1993) The corporate role of the nursing director. *Journal of Nursing Management* 1, p. 164.**

This research was conducted to develop a future focused competency framework for trust nursing directors. Twenty-two competencies were identified as necessary to steer the transformation of the nurse managers role to that of corporate trust nursing director. This competency set could be used as a guide when considering the development of corporate roles for nurse managers in Ireland.

In 1994, Jaco et al. conducted a descriptive research study to determine the responsibilities, activities and characteristics of nurse executives in the American public sector. A modified version of a role perception questionnaire was used for the survey.

The questionnaire was mailed to 168 (response rate not reported) chief nurses working in Veterans Affairs (VA) health organisations across the USA. During the statistical analysis the primary components of role functions, activities and responsibilities were divided into four categories; administrative, clinical, research and education and subcategorises of each of the four groups (see Table 2.10). It is interesting to note that dissatisfaction with the role was not reported.

TABLE 2.10. Key Responsibilities of the Chief Nurse Executive Role

Administrative	Clinical	Education	Research
Management Strategies/planning. Decision-making. Goal-setting. Staffing. Fiscal responsibilities.	**Direct** Consultant. Nursing rounds. **Indirect** Delegate responsibility to staff. Standard setting for nurse credentialing. Establish new programmes to improve care.	**Personal** Membership in professional organisation. Participation in activities in the community. Reading journals and books.	**Development** Stimulate development of projects. Set research goals. **Facilitation** Establish a research committee. Facilitate staff interest.
Leadership Spokesperson. Facilitator. Corporate thinker. People developer. Policy development. Interpersonal relationships. Communicator.		**Staff** Performance appraisal and proficiencies. Needs assessment. **Community** Faculty appointment. Speaker professional and community events.	**Utilisation** Development/use nurse information systems. Data-based decision making.

Source adapted from: **Jaco, P. Price. S. and Davidson, A. (1994) The Nurse Executive in the Public Sector. *Journal of Nursing Administration* 24, p. 60.**

The total time spent in each role component was reported by the chief nurses; administration (74%), clinical (11%), education (11%) and research (4%). Almost three quarters of the chief nurses time was spend on administration with the remaining three components of the role receiving attention in a mere quarter of the nurses time. As this study relates to chief nurses working in the public sector of the American health system it may have more applicability to the Irish health system than other American studies which relate to the private sector. The division of the key responsibilities of the chief nurse in the organisation, into four components may form a useful framework for further developments in the Irish senior nurse manager's role.

Another American study relates to competency-based selection for excellence in nursing management (Dubnicki and Sloan, 1991). The authors reported that promotion of nurses to nurse management positions in California (USA) is usually based on traditional criteria, such as formal education, professional experience and technical expertise. Dubnicki et al. suggest that, as the exploratory Hay group pilot study demonstrated, these criteria have little correlation to a candidate's probability of success as a manager (Dubnicki and Sloan, 1991). The study found that qualities such as self-confidence, high achievement orientation, analytical thinking, and persuasive skills are far more important determinants of success among nurse managers. Four nurse managers from each of six nationally prominent teaching hospitals in the USA were interviewed (24 in total). The nurse managers were asked to describe their role in significant events (what they did, said,

thought and felt) in the previous two years of their career. Each of the four sets of nurse managers were identified by their nursing directors as solid or outstanding performers. The researchers analysed the interview data to determine the competencies most typically displayed by the managers and the characteristics that tended to distinguish the outstanding performers from others. The directors of nursing were also asked to rate 100 managerial behaviours typically displayed by outstanding/solid nurse managers. The interviews yielded a competency model comprising nine core competencies which were categorised into five groups, as outlined on Table 2.11.

TABLE 2.11. Competency Groups Related to Nurse Manager Success

Group	Core Competencies (9)	Function
Achievement:	Initiative. Achievement orientation.	Getting the job done.
Management:	Directing others. Group management.	Working through others.
Interpersonal Relationships:	Use of influence strategies. Interpersonal sensitivity. Direct persuasion.	Working with others.
Problem Solving:	Analytical thinking.	Thinking through issues.
Personal Performance:	Self-competency.	Managing oneself.

Source adapted from: **Dubnicki, C. and Sloan, S. (1991) Excellence in nursing management: competency-based selection and development. *Journal of Nursing Administration* 21, p. 41.**

The authors suggest that the competencies identified be used to devise a profile (competencies) for future role occupants. However they caution that the selection criteria emerging from this study was based on a small sample of hospitals with a small number of nurse-managers and suggest that the model requires further testing. The nine identified competencies could possibly be used as a framework for further research into the specific competencies required for management in the Irish health-care setting.

In 1995, the NHS management executive reported on a study conducted to identify the characteristics of excellent doctors in management (Turrill et al. 1995). In-depth interviews were conducted with twenty-two consultants in twelve hospitals (5 teaching and 7 non-teaching) from seven regions throughout England. General managers/chief executives in consultation with senior clinicians were asked to nominate participants (doctors) who were seen as outstanding or fully satisfactory managers. All the interviewees had been involved in managing their hospital and/or a speciality. The interviews were taped, lasted approximately two and a half hours and focused on incidents which the doctors considered critical to successful performance in their management role. The coding framework clustered the observed competencies under five main headings; achieving, managing oneself, thinking, working with others and influencing. The behavioural data was analysed to produce a number of distinguishing competencies and also the most frequently displayed competencies (see Table 2.12). There appears to be similarities in competencies when compared with the core competencies identified for successful nurse management (Hennessy et al. 1993). However, caution should be exercised when drawing comparisons as the study methodologies were not entirely similar.

TABLE 2.12. Distinguishing/Frequently Displayed Competencies of Doctors in Management

Clusters	Distinguishing competencies	Frequently displayed competencies
Achieving:	Getting things done. Seeking to improve the service.	Demonstrating enterprise and initiative.
Thinking:	Thinking conceptually. Thinking strategically.	Thinking analytically.
Managing oneself:	Learning. Facing conflict.	
Working with others:	Being aware of others.	
Influencing:		Influencing strategically. Persuading rationally.

Source adapted from: **Turrill, T. Wilson, D. And Young, K. (1995)** ***The Characteristics of excellent Doctors in Management.*** **London: NHS Management Executive, Resource Management Unit.**

The researchers indicate that distinguishing competencies differ from technical and managerial competencies in that they represent primary behaviours which are characteristic of the individual (Turrill et al. 1995). They suggest that technical and managerial competencies are eminently trainable, but the more primary behaviours (the distinguishing competencies) may be improved only within the limits of the individuals innate potential. The report recommends selecting clinical managers from those clinicians who exhibit the primary behaviours as a sensible precursor to the implementation of any doctors in management programme. The use of critical incident interviewing is suggested as a means of identifying clinicians with the distinguishing competencies.

The findings of both studies (Hennessy et al. 1993; and Turrill et al. 1995) apply to the UK health service which is based on an internal market philosophy with a purchaser/provider divide and as such may not have direct applicability to the Irish health service. Similar studies would need to be conducted to identify the specific competencies required for successful nurse management in Ireland.

First-line Nurse Managers' Roles

In 1981, Redfern published the findings of the first extensive study of ward sisters' perceptions of the ward sister's role. The primary aim of the study was to gain some understanding of the opinions, perceptions and attitudes that sisters have towards nursing, the organisation they work in, the people they work with, the conditions under which they work; and whether these relate to performance, absence and termination of employment. Questionnaires, interviews and personal records were used to collect the information required. The sample was drawn from six health districts in the UK's West Midlands. The main sample consisted of all sisters employed in the general nursing division of two hospitals drawn from the districts.

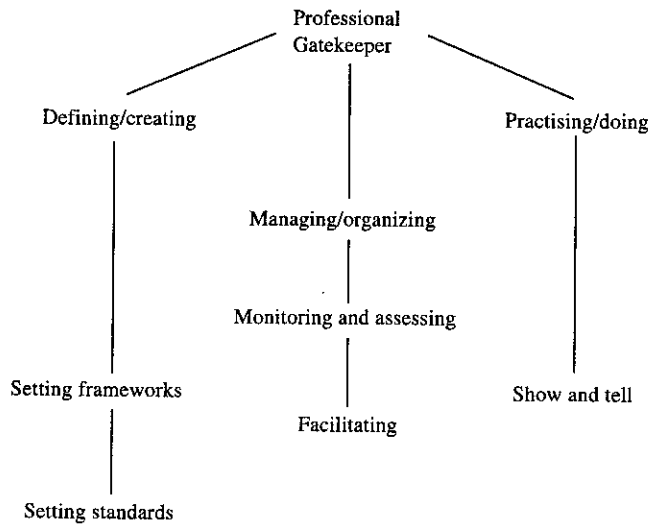
Three quarters of the sample of 134 sisters (88% response), experienced moderate to high levels of job related tension and role conflict. The results indicated that about 40% of the sisters were intending to leave their jobs or were uncertain about staying. The results showed that while the intrinsic satisfaction of the sisters was high, organisational problems and contextual factors led to major dissatisfaction for the sisters. Role ambiguity concerning areas of responsibility/authority and relations with more senior nurse managers

(nursing officers), administrative workload, clerical duties, telephone calls, organising and co-ordinating staff, numerous doctors' rounds, too few nurses and rapid patient turnover were considered to be responsible for the insufficient time available for direct nursing care and teaching. The lack of sufficient opportunity for talking to patients, getting to know them and discussing their problems with them, was emphasised in the study.

However, the study also found that for nurses who have reached the seniority of sister, levels of absence and turnover were totally unrelated to whether they choose to stay in or leave employment. This depended on the "perceived opportunity for alternative employment and the attractiveness of those positions relative to the ones held" (Redfern, 1981, p.47). Redfern suggested that changing the area of management, ward or speciality; changing management style; attending management courses; taking on a teaching commitment; or learning about research and carrying out a project related to work, would give the sisters the challenge which they sought. Although published seventeen years ago the findings and recommendations of this study still have application today.

In a later study, Lewis (1990) interviewed ten ward sisters in two large hospitals in the south of England using a semi-structured interview technique. Using grounded theory a substantive theory was developed that ward sisters act to gatekeep. Informed by the study findings, the author suggests that the overwhelming evidence is that, for good or bad, the personal philosophy of the sister sets the tone of the ward and the care within it. During the analysis, perceptions and strategies used by the ward sisters were identified. These are: setting frameworks; setting standards; monitoring and assessing competence; facilitating and supporting; showing and telling. In the analysis, the sister appeared to be the person who determined what could be done and not done by those in the nursing group. The strategies were organised into three major categories of work; defining or creating work, managing or organising work and practising or doing work, which are illustrated on Figure 2.4.

FIGURE 2.4 Ward Sister - Professional Gatekeeper.



Source: **Lewis T. (1990) The Hospital Ward Sister: Professional Gatekeeper. *Journal of Advanced Nursing* 15, p. 810.**

The study showed that one of the reasons the ward sister is able to exert such power is because of the professional gatekeeper role. Lewis proposed that sisters are seen as expert whether they are or not. He suggests that they may control the nursing function in a knowledgeable way or act to maintain the status quo (Lewis, 1990). Based on the findings of the study Lewis, recommends that:

- Ward sisters exert such influence that they have the potential to effectively negate any changes in the professional function and therefore should be involved in all discussion in relation to change.
- In order to control the nursing function effectively, ward sisters should be expert in the three processes of the nursing function; defining, managing and practising. Ward sisters must therefore have further education in theory relating to nursing frameworks, management and practice.
- As the maintenance of high professional standards is essential to the public interest, the clinical function of the sisters role must not be sublimated to the managerial function (Lewis, 1990, p.817).

The competencies expected for first-line nursing managers were established by Duffield (1989) for an Australian context. A list of 168 competencies was compiled from the literature and submitted to a panel of sixteen expert nursing administrators and academics who were asked to identify and rank in order the twenty most important competencies. The competencies most frequently selected are listed below in rank order:

- Ensuring quality care is provided.
- Setting unit goals.
- Planning safe, cost-effective patient care.
- Creating and maintaining a favourable working environment.
- Organisation of the unit.
- Allocating responsibility and authority appropriately.
- Maximising human resources.
- Developing & maintaining personal professional competence.
- Linking management with nursing care.
- Providing a forum for staff communication.
- Developing and maintaining staff morale.
- Participative decision-making.
- Controlling a unit budget.
- Knowledge of quality assurance activities.
- Acting as a resource person.
- Understanding the legal implications of nursing practice.
- Perceiving workload pressures on staff.
- Exacting accountability for work by staff and self.
- Providing opportunities for staff development.
- Conflict management (Duffield, 1989, p.999).

In a larger study, a survey of 412 (response 77%) first-line nurse managers employed in hospitals in New South Wales, Australia was undertaken to determine the competencies that they believed an individual should possess to fulfil the managerial role (Duffield et al. 1993). Using an established instrument, the researcher sought to determine respondents perception of the importance and relationship of the 156 competencies (used in Duffields first study) to the first-line nurse manager role (Duffield, 1989). Thirteen factors with a total of 69 competencies, identified from four major scales indicated that first-line nurse managers perceive their role to be extremely comprehensive in terms of managerial knowledge and skills. The respondents considered controlling, preparing and monitoring the budget of the unit to be the most significant competencies for functional management. Competencies related to staffing and financial issues were perceived to be essential to role performance. Ambiguity was found with competencies concerning patient care. This could have been because, in Australia, more managerial functions are expected of the first-line nurse-manager and, as a consequence, this may have affected capacity to undertake other functions such as provision of direct care (Duffield et al. 1993).

The factors involved in the first-line management role can be summarised into three main categories. The first category was described as a concern with economic management and involved budgets and resources (both human and physical) identified from the perspective of provision, accountability, monitoring and protection. The second major category concerned staffing and included issues such as developing staff potential, teaching staff and resolving areas of conflict between staff members. The third category is concerned with professional and personal development of the first-line manager. The study revealed that in addition to a major role in facilitating communication between the executive and unit staff, first-line nurse-managers expect to set the standards of care and act as change agents. The respondents identified the knowledge and skills required for role enactment, these have been summarised on Table 2.13.

TABLE 2.13. Knowledge and Skills Required for First-line Nurse Management

KNOWLEDGE DOMAIN	know about organisations behaviour, policy, care delivery systems, efficiency measures, quality assurance activities, staffing models, communication techniques, complaints procedures, research and grants techniques, budget and resource management and changes in nursing practice.
SKILLS DOMAIN	**planning activities** developing unit objectives, policies, ensuring staffing reflects workload, providing a safe, cost-effective standard of care.
	carrying out activities budget preparation, resource scheduling, protection, staff recruitment, orientation and development, scheduling staff to match workload, acting as unit spokesperson, change agent, researcher and provider of feedback.
	monitoring activities monitoring the performance of staff, the use of resources, the budget, the workload and staffing levels, general unit activities, stress levels in self and others and the professional development of staff and self.

Source adapted from: **Duffield, C. Donoghue, J. Pelletier, D. and Adams, A. (1993) First-line nurse managers in NSW: perceived role competencies. Part 2. *Contemporary Nurse*, p.111.**

The strength of this study is that practising first-line managers identified competencies for their own role. The emphasis on budgeting and financial issues may have resulted from decentralisation and restructuring within the health care system which took place in the

early 1990s in Australia. This study clearly demonstrates that first-line nurse-managers undertake a highly significant role in health-care management (Duffield et al. 1993). The reader is reminded that the study findings relate specifically to first-line management in Australia. The cultural environment and financial aspects of the Australian health system may not have direct applicability to an Irish situation.

In a Canadian study, Fullerton describes the role change from the traditional head nurse (ward sister) to that of nurse-manager. She suggests that the essence of the decentralisation philosophy places the first-line manager in a pivotal role in a nursing unit. Responsibilities include co-ordination, quality assurance activities, counselling employees, developing and maintaining nursing standards and appropriate staffing patterns, and acting as a role model. She advises that the nurse-manager can demonstrate a professional commitment to nursing by professional involvement in relevant nursing associations and by being skilled in written and verbal communication. The professional nurse-manager identifies problems and initiates problem solving techniques with physicians and other departments. Fullerton summarises the role functions of the nurse-manager as, administering labour relations, managing a budget, developing policies and accountability for all issues and concerns surrounding nursing practice at the unit level (Fullerton, 1993).

In a USA study investigating congruity between first-line management role expectations and actual competencies for enacting them, 113 nurse managers (61% response rate) in eleven New Jersey acute care facilities were asked to complete a skills questionnaire. The study found that when it comes to patient care, nurse managers do actively practise the skills they believe in performing. The significant findings of the study are:

- Managerial success may depend upon bonds as well as tasks- particularly in personal services.
- Nursing staff effectively identify with those managers who manifest strong clinical interests.
- Nursing staff admire those who display expert knowledge and skill and seek to emulate them.
- Most nurses still appear to be selected as managers more for their superior clinical performances than for any current managerial competencies (Heidenwolf Weaver et al. 1991, p.34).

This study demonstrated that nurses do feel the need to establish a credible reputation as a clinician. The authors suggested that this may be the reason why some respondents chose advanced clinical degree programmes over business or public health administration. The researcher concluded that discrepancies between the functions head nurses expect and their actual daily managerial practices show that in the long run, nurses need to agree the basic competencies which all nurse managers should possess (Heidenwolf Weaver et al. 1991).

In 1994 a review of twenty years of literature from both the USA and the UK regarding supportive supervision and the role of the nurse manager/ward sister was published. The authors found the nurse managers/ward sisters were key players within the entire health-care organisation. They can empower the nurses supervised to initiate changes to improve patient care. Nurse managers/ward sisters can also improve the working conditions and thus increase the job satisfaction and retention of those they supervise. The research from both countries found that all nurses from student nurse to top manager are seeking, in their supervisor, a person who will "enable them to give of their best while obtaining satisfaction from their work, rather than a controlling supervisor who attempts to mould them into a group of subservient drones" (Cameron Buccheri and Ogier, 1994). The

authors suggest that the behaviour of supportive supervisors includes: demonstrating value for each nurse as an individual; recognising their worth; allowing them to express opinions and assisting them in decision making and problem solving by communicating adequate information. The authors offer four basic suggestions for supporting nurse managers/ward sisters in their work:

- nursing supervisors must be given adequate resources to develop their expertise as health resource managers;
- frequent feedback should be given in relation to their own performance;
- senior nurses should not place too much emphasis on managerial functions of the ward sister at the expense of the clinical aspects of their role; and
- ward sisters must have support from their senior managers (Cameron Buccheri and Ogier, 1994, p.206).

Mintzberg (1994) conducted a study of managerial work observing approximately fifty different managers for one day each, to get a sense of the nature and flow and of their work and styles of management. The head nurse of a surgical floor, at a large Canadian hospital was observed as part of this work. Mintzberz presented the findings of this part of the study separately in the *Journal of Nursing Administration* (Mintzberg, 1994).

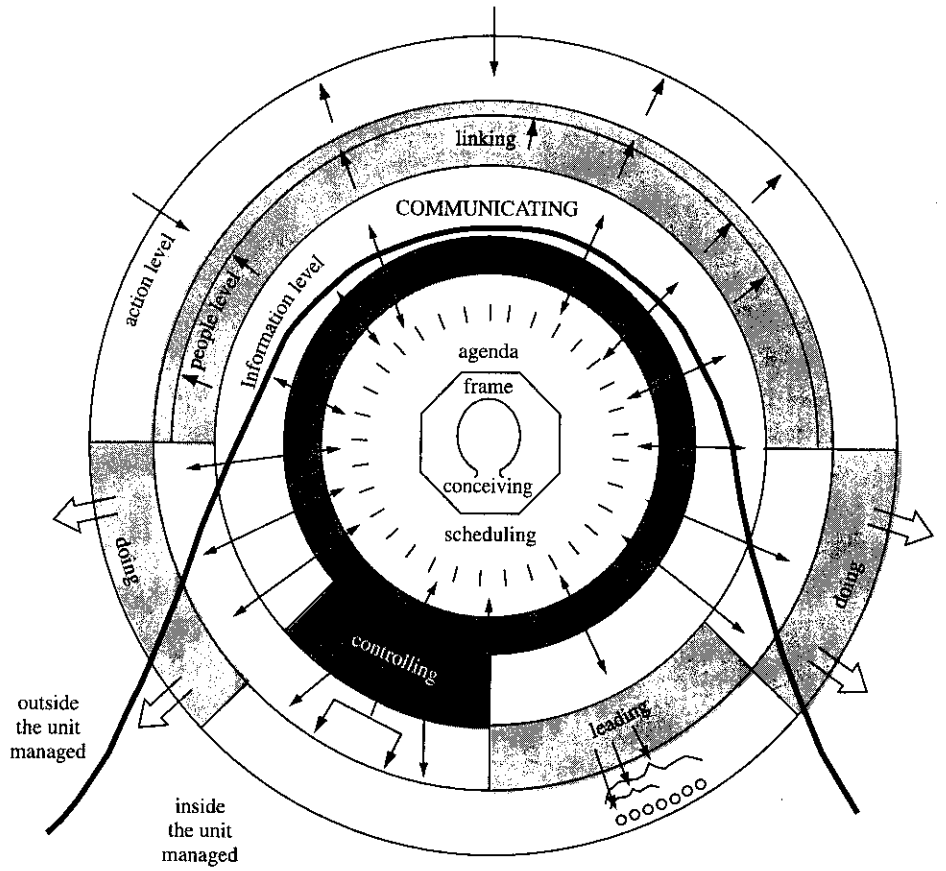
Mintzberg reported that the day revealed one of the smoothest and most natural practices of management observed. He found that the nurse worked mostly on her feet so that linking, leading, communicating, doing, controlling and other roles seemed to happen spontaneously and interactively (Mintzberg, 1994). He also commented "the remarkable thing about this experience in comparison with other managerial jobs is the way in which every thing flowed together in a natural rhythm" (p.31). He suggested that the effect of processing management "standing up outside the confines of an office", within earshot of many of the associated people is not to be underestimated as it makes for holistic and probably very effective practice.

Mintzberg proposes that the traditional style of nursing management which might be called the boss manager model in which all revolves around the big boss, does not work well for first-line nurse managers; it does not promote empowerment of workers in any situation. He contends that what might be called insightful or craft manager model seems most appropriate for truly effective empowerment. It involves informed and involved management with a good deal of respect for the professional competence of the staff.

Mintzberg, gives a detailed description of the craft model (see Figure 2.5). The model is made up of concentric circles. At the centre is the person who comes to the job, bringing a set of values, experiences, knowledge, and competencies. The person in the job creates a frame, which includes the purpose of the job, a particular perspective on what needs to be done, and specific strategic positions for doing the work. Surrounding the core are three concentric circles that represent three levels through which managerial work can take place, labelled information, people and action. Five core roles are described, these include communicating, controlling, leading, linking and doing.

Mintzberg elaborates on the five functions as follows: communicating – seeking and receiving information and sharing it with others, whether internally as disseminator or externally as spokesperson; controlling – using information to control the work of others, whether by the issuing of specific directives, the designing of organisational structure, or the development and application of formal systems and procedures; leading – encouraging

FIGURE 2.5 A Model of Managerial Work.



Source: **Mintzberg, H. (1994) Managing as Blended Care.** ***Journal of Nursing Administration*** **24, p.30.**

the enabling people within the unit to take effective action whether by focusing on the individual on the group or on the entire organisation; linking – relating to people outside the unit by the establishment of a network of contacts, which is used to represent the needs of the unit and to transmit its influence externally and also by the receipt of influence transmitted to the manager by these people (Mintzberg, 1994). In later work, Mintzberg (1997) developed a further framework composed of four quadrants: cure (physicians), care (nurses), control (managers), and community (trustees), to identify issues that are key to understanding and delivering improved services in hospitals. To develop the framework the activities of executive directors, senior system managers, clinicians and head nurses were observed. Of twelve issues Mintzberg found four to be common across groups; fragmentation, mission, deals and problem solving. The other issues were representation, selectivity, advocacy, perception, credentialism, visibility, commitment and bundling (Mintzberg, 1997).

Mintzberg argued that nurses may, in fact, move more easily into management and often make better and more natural managers than doctors because of their pre-disposition to the caring approach (Mintzberg, 1994). Some of the split-brain research suggests that women tend to be less differentiated in their pre-dispositions than men. They tend to activate both the verbal left hemisphere and the spatial right hemisphere simultaneously, whereas men tend to favour one or the other at given times (Moir and Jessel, 1991). This suggests that women might be more predisposed to the practice of management itself, at

least if a natural balance of analysis and intuition is considered desirable (Mintzberg, 1994). Nursing being a predominantly female profession would appear to have natural abilities which can enhance the management roles. Nurses have unique contributions that can be influential in the wider arena of health-care. They have experience in a range of areas related to service, teaching, management, knowledge, understanding of other health-care personnel and an understanding of the patient and consumer viewpoint. Some nurses have the skill and ability to maintain a role that incorporates both general and nursing management and can develop the potential of nursing care in its widest sense across the boundaries in an organisation (Batehup, 1992).

Litwin et al. (1997) reported on a case study involving the redesign of the nurse manager's role. Although the project was based on the patient centred redesign model (PCR), in fact it involved introducing a new model of care delivery, optimising staff and downsizing the nurse management group. These changes appear to have involved the aggregation of nurse management functions and involved redundancies. As this study relates to a particular hospital in the American health-care culture it does not have direct applicability to an Irish setting. However, the authors reported the lessons learned when attempting to change the pivotal role of nurse-manager (at unit level). They propose interventions which may help facilitate a somewhat easier adaptation of change in nurse management roles. They were:

- Realise that the concept and the functions of redesign will be vehemently challenged and be prepared to respond non-emotionally with fact-based information.
- Be aware that managers may influence physicians to voice concerns over the proposed changes.
- Keep key members of the medical staff updated and involved practically.
- Allow enough time for the planning process.
- Allow team members time away from daily activities. Often the team members and their managers are unprepared for the level of time and effort required.
- Realise that cultural change is not resolved at one point in time but rather over time.
- Do not underestimate the stress of the change process and do not be afraid to seek support from colleagues.
- Remain focused on outcomes.
- Spend extra one-on-one time during this process with the nurse management group as a whole, as well as with individuals.
- Keep senior leadership involved and informed – their commitment will be critical to the process (Litwin et al. 1997, p. 13).

This frank advice could be very useful for Irish nurse managers who may well consider it appropriate to make substantial changes in the current first-line nurse managers roles.

Summary of Research

Because of the diverse nature and variety of reporting mechanisms, it is not possible to make comparisons across the fourteen studies reported in this section of the report. It appears that the various researchers have made differing interpretations of what is understood by competencies. Some report role functions as competencies and others the skills and abilities required for role performance. Despite the inconsistencies, the studies provide very valuable information and to provide the reader an understanding of

international interpretations. All the studies reported a blending of the managerial and nursing functions as the essence of the nurse-manager's role. Through the many detailed reports, the functions of the nurse-manager appear to fall into four broad areas; economic management, staffing, facilitating communication and professional/personal development. The concept of evolving the senior nurses role from that of nurse-manager to corporate-manager is very useful (as described for the UK). While many Irish nurse-managers aspire to a corporate function, the reality shock involved in a "big bang" move from the role of the traditional ward sister/unit nursing officer to a corporate role would possibly present problems for many of the current Irish nurse-managers. The research highlights the importance of considering the qualities of self-confidence, high achievement orientation, analytical thinking and persuasive skills, when devising weighting/scoring mechanisms and selection criteria for future nurse-managers. The importance of applied learning in management development is emphasised across the studies.

The over-riding message from the research is that unit nurse managers/ward sisters are key individuals determining the success of management throughout an entire health-care organisation. Also, continuing purposeful management development is essential for the success of nurse management at all levels. Nurse managers should draw inspiration from Mintzberg's confidence in nurses' natural attributes, which he contends assist greatly in performing a management function.

2.3 Issues Related to Nurse Management Roles

A group of important issues related to nurse management roles are reported in the literature. Although not entirely related, the issues have been drawn together for the purpose of discussion. The most important issues are that of nursing leadership, strategic planning, models for nursing care delivery and the educational preparation of nurse-managers. Although not always overtly expressed or written, the nurse-manager has traditionally been very concerned with the quality of the service delivered to patients. The review of the role concept and functions indicates that internationally, senior nurse-managers roles are being focused on quality assurance. For this reason, a brief outline of total quality management in nursing is given later in this section. Promotional issues, such as the existence of a glass ceiling and the queen bee syndrome in nursing are also discussed at the end of the section.

Leadership

Leadership is the vital ingredient in the development of any profession. The central importance of leadership is evident in the manner in which the topic pervades the review of nurse management role behaviours (competencies) (Hein, 1998). Leadership; qualities, style and development are written of extensively in the nursing literature. This section of the work gives an overview of the most recent writings on leadership in nursing, using the following headings; leadership definitions, types of leadership, leadership characteristics and leadership development research.

Leadership Definitions

A distinction between the term leadership and management is drawn in the literature. The terms are not synonymous. Leadership is a broader concept than management (Hersey and Duldt, 1989). It is proposed that, leaders do the right thing, while managers

do things right (Bennis, 1989). In 1993, Rafferty on behalf of the King's Fund published a discussion document on leadership, *Leading Questions*. At the time she proposed the following working definition for leadership:

> Leadership is the ability to identify a goal, come up with a strategy for achieving that goal and inspire your team to join you in putting that strategy into action. Leaders set the tone and shape the culture in organisations. They demand high standards, they create a culture of pride, make people feel important and enable them to realise their potential (Rafferty, 1993, p.1)

When considering a definition for leadership, the Kings Fund (UK) draws on the earlier work of Maxwell, which stated:

> Leadership is partly about power and partly about charisma, but it is by no means solely about those two qualities. It has to do, for example, with breadth, relevance and coherence of vision; the ability to communicate that vision; picking good people to work with and helping them to grow; sticking to essentials; and the willingness to make mistakes (but not too many or too big)...in health care it has both professional and corporate dimensions which have to mesh (Maxwell, 1985).

Sieloff (1996) describes the one characteristic of a leader, which a manager may not necessarily have, as the visionary attitude to how care should be provided. She contends that managers tend to be very effective in the day-to-day running of an area. However, leaders, because they have a vision of the future for the area, are more effective in moving the area towards that future. In a leadership situation, there has to be a follower or followers. Manthey (1990) describes the role of managers as guiding, directing and motivating, while the role of leaders is to empower. She suggests that leaders are people who influence others by how they act and what they say (Manthey, 1990). Hancock (1993) suggests that the concept of leadership is not one that many nurses can easily adapt to, due perhaps to the traditionally female and submissive nature of nursing (Hancock, 1993).

Types of Leadership

Two main types of leadership are described in the nursing literature – transactional and transformational leadership. Transactional leadership is hierarchical, status conscious, directive, controlling and is typically best suited to a traditional military style organisation, while transformational leadership is empowering, participative and collaborative (Dunham and Klafehn, 1990).

Transformational leadership is said to promote autonomous nurses who are committed to excellence, create a nurturing environment, provide expert nursing care, strive to achieve positive outcomes, serve as preceptors and mentors, seek opportunities for continuous quality improvement and design a new independent nursing culture of caring professionals (Trofino, 1996).

Although there are two main types of leadership, many different leadership styles are described in the nursing literature. Some of the common styles are; the constitutional, the charismatic, the circumstantial, the contractual and the constructivist (Rafferty, 1993). *Situation leadership theory* (circumstantial) is based on the assumption that there is no one singularly successful leadership style, but that a variety of styles are used by an effective leader which is contingent upon the variables present in each situation (Hersey and Duldt, 1989). The theory proposes the use of a multicratic leadership style, drawing on the traditional, autocratic, democratic, participative, consultative, explorative and

laissez-faire styles (Sullivan, 1990). Kerfoot (1996) suggests that aggressive, totalitarian, tough leaders usually fail because of their inability to handle the emotional side of leadership. She reports that many industry executives are now realising that training programs that teach the "soft stuff" of the emotional side of leadership offer great dividends (Kerfoot, 1996). According to Kerfoot, values-based leadership strives to instil people with a sense of altruism and empathy, and the emotional intelligence to go beyond the technical side of work to the higher levels of meeting the emotional demands of the job. Johnson (1992) recognises that the ability to visualise the better solution clearly and to communicate it effectively to others, involved in and impacted by changes, may well be the most powerful tool any individual or group can hold. For the future, the authority of nurse-managers lies in their ability to work with and through people and be transformers of current reality to a new shared vision of a desired future (Johnson, 1992).

Characteristics of Nurse Leaders

Previous leaders or nurse managers may have focused on managing the nursing staff. Sieloff (1996) proposes that rather than fostering a "them" versus "us" practice environment, the focus should be inclusive. By defining nursing staff as clients of managers, the "them" perspective can be eliminated. She suggests that the clients of tomorrow's nurse managers will be the nursing staff, their own superiors and the organisation. All three need the care of the nurse-manager. She identified the characteristics of future nurse leaders, using the following headings: changing view of clients, managing the environment, being a visionary, sophisticated communication skills and using new resources (as depicted on Table 2.14). The use of consistent critical thinking in challenging the status quo is seen as an important leader characteristic.

TABLE 2.14. Characteristics of New Nurse Leaders

Leader Characteristics	Outline
Changing view of clients:	Clients of nurse managers – staff with whom the nurse leader works. – manager's superiors. – organisation.
Managing the environment:	Management of the relationships or the environment in which healing is provided – rather than nurses. Clarifying whether role expectations of nursing staff are reasonable within the given practice environment.
Being a visionary:	Sharing vision, goals and objectives with the staff with whom the leader works and their own superiors within the organisation.
Sophisticated communication skills:	Consistent critical thinking – not accepting the status quo. Articulation of linkages (quality and cost-effectiveness). Clear communications and validation of successful communication.
Using new resources:	Awareness of and reversal of "oppressed group behaviour". Enhancing the visibility of nursing within the organisation. The use of nursing theory as a framework for management. The use of power as a positive resource.

Source adapted from: **Sieloff, C. (1996) Nursing Leadership for a New Century.** ***Seminars for Nurse Managers*** **4, p. 228.**

Sieloff (1996) suggests that future nurse leaders should recognise that their function is not to manage people but to manage the environment. She contends that registered nurses, like other health care providers are professionals and therefore do not need to be

managed. This suggestion is made on the premise that nurses are sufficiently professionalised to be independent in practice. In light of this belief, the term manager should connotate management of relationships or the environment in which healing is provided. For many staff, this perspective may require a culture change. Future discussions on nursing management must consider if the current population of Irish nurses has been adequately prepared for such independent roles. Sieloff also makes the very important point that if a nurse-manager is unable to discuss a nurse's role in relation to cost, as well as quality, the manager will put nursing positions at risk when budgetary constraints are addressed. If nursing loses its visible contribution to the successful delivery of health care, it places itself at risk of extinction within the organisation. She emphasises that nurse managers need a nursing knowledge base from which to function to ensure that quality cost-effective care continues to be provided.

"Oppressed group behaviour" is a recognised characteristic, sometimes found in nursing (Lovell, 1981). Roberts (1983) described an "oppressed group" as one which is controlled by forces outside the group which have greater prestige, power, and status and that exploit the less powerful group. Historically nurses have been controlled by hospital authorities and physicians (Roberts, 1983). When oppression occurs, the group demonstrates conflict within itself rather than directing the conflict toward the dominant group. Sieloff, suggests that by increasing their awareness of involvement in "oppressed group behaviour" a nurse leader can accomplish three goals: change their own behaviour, serve as a role model to others and facilitate changes that improve the status of the nursing group.

In the USA, nurse executives have described nurse leadership for health-care into the next century using terms such as: visionary, ethical, empowering, reflective, health-outcome oriented, collaborative, community-oriented, team players (Adalen et al. 1997). Wheatley and Smith (1995) list thirteen attributes or characteristics associated with effective and empowering leadership, described by various writers as follows:

- An attitude of constant learning rather than assumed mastery.
- High self-esteem.
- Willingness to ask questions and listen to answers.
- A capacity for building relationships.
- Appreciation of other people.
- Ability to develop leadership in others.
- Capacity to handle criticism by listening and drawing out concerns.
- Innovation and initiative.
- Capacity to develop a vision of the future.
- Ability to communicate well at every level.
- Integrity and trustworthiness.
- Capacity to trust others.
- Coaching and counselling skills (Wheatley and Smith, 1995).

The one characteristic, suggested by all authors for nurse leaders, is the ability to identify and present a vision for the future of nursing. Other commonly reported characteristics include the ability to empower the nursing team, communicate skilfully and build relationships (internal and external).

Ogier (1992) used a grounded theory methodology to establish that "ward sisters who have a leadership style that is approachable, nurse learner orientated and sufficiently directive for the nature of the work have a pattern of verbal interaction with nurse learners that is perceived by the nurse learners to be propitious to them" (Ogier, 1982, p.69). Results of the study indicated that ward sisters have different leadership styles. Not only was there a difference between individual sisters but there was some evidence of a difference in leadership style associated with the type of ward managed. Ward sisters in charge of surgical wards appeared to have a more directive style of leadership than sisters in charge of medical wards.

Rafferty (1993) conducted an interview study with twenty-eight prominent nurses in the UK. Part of the study considered the philosophical question of whether leadership ability innate or can it be learned. A number of the interviewees felt strongly that they had in fact "learned leadership" and that knowledge had come through political apprenticeship which sharpened their skills in organising and campaigning as well as rhetorical skills. The interviewees also considered the issue of nurse executive functions by posing the question nursing needs executive authority, but does it need nurse executives? The interviewees considered that nurses need to become skilled in the politics of persuasion, networking, power-brooking and designing health services around nursing need. Participants considered that nurse executive positions are essential to realise this aim. Rafferty suggests that nurses need to take a greater leadership role in primary care, learn from other countries and engage with the socio-economic and global issues surrounding health-care. The interviews suggested that leadership must be addressed with multiple programmes threaded throughout the structure of the health service and enabling nurse leaders to be chosen and developed at all levels. In concluding the discussion, Rafferty suggested that nurse leaders need, not only imagination but the political, practical and intellectual skill to take nursing forward. She advised that nurses seize the initiative and promote a radical agenda to ensure that the key positions in nursing are filled by people with the calibre that the UK health service and the profession so urgently need.

In October 1997, the Royal College of Nursing (RCN) published the findings of a Ward Leadership Project. The RCN conducted a three year investigation into the role of the ward leader – the sister or charge nurse – and the senior nurse. As a result of this work the RCN proposes to publish a practical "tool kit" for all ward-level nurse leaders, which will be available in 1998. Four trusts were selected to participate in the study, two acute and two integrated trusts. One senior nurse and six ward leaders were identified from each trust to join the project (28 participants in total). Baseline data was collected using a multi-leadership questionnaire, organisation of care tools, clinical and personal profiles and in-depth interviews. Interventions in each of the trusts involved: personal development plans, workshops, action learning, observation of care, patient stories, mentorship and networking. Two of the major findings of the study were:

- Ward leaders can influence the care provided by individual nurses through their ability to transfer their techniques, skills and talents to other nurses.
- Although employers can influence the quality of patient care, it is the qualities of individual nurses which have a more direct effect on the way patients are looked after (Royal College of Nursing, 1997, p.4).

Five major themes emerged from the qualitative data which highlighted the areas where the participants needed to develop skills in order to become patient-centred clinical leaders. These were: learning to manage self; building, developing and managing effective relationships with team members; patient focus; networking (internal and external); and increased political awareness (Royal College of Nursing, 1997).

The results of the study demonstrate statistically significant changes in the participants leadership style and in assessment of sisters by other nurses in their team. Feedback from the ward leaders indicated that work based learning was the key to their success. The work based learning techniques were perceived as assessable and relevant, compared with traditional management and leadership programmes which focus on theory. The core skills, techniques and talents required of ward leaders or senior nurses were outlined by participants in the project as: self-management; the ability to develop, build and manage effective relationships, the need to focus on patients, networking and political awareness. As a result of the study, the RCN made ten recommendations for ward leadership development which are grouped under three headings, care, education and environment, the detail of which can be found on Table 2.15.

TABLE 2.15. RCN Ward Leadership Project Recommendations

To provide nursing care that meets patients' needs

- Patients must be at the centre of determining what is acceptable care.
- All health care practitioners must learn to actively listen to what patients are telling them.

To provide nurses with the education & support they need to effectively deliver patient-centred care

- Nurses need to be encouraged to participate in life-long learning opportunities.
- Staff nurses should undergo career development before they become ward leaders. It is vital that in becoming ward leaders, they maintain a patient-centred focus to their work.
- Once a ward leader is appointed they need support to enable them to maximise their potential. This can be done through mentorship, clinical supervision, action learning and recognition from within the organisation that they are supported and valued.
- Continuing professional development should focus on needs-led programmes. Problem-based and experiential learning opportunities need to be expanded.

To provide an environment that enables nurses to provide patient-centred care

- Trust Chief Executives and Directors of Nursing need to ensure that organisational structure and resources support the patient centred actions of successful ward leaders.
- Each trust should agree patient-focused indicators of good practice to use as measures of quality and performance. Possible indicators could be based on issues like: levels of noise at night; the use of names; listening to patients; attention to detail; and privacy and confidentiality.
- More research is needed to see whether the experiences of the participants in this project are similar for other members of the health-care team.
- The model described in this research should become a model for clinical leadership development.

Source adapted from: **Smith, P., Parsons, R., Murray, B., Dwore, B., Vorderer, L. And Okerlund, V. (1997) The New Nurse Executive an emerging role. Journal of Nursing Administration. 24, p. 57.**

A major study of nursing leaderships needs, undertaken when developing nursing leadership in Europe was conducted by the King's Fund (UK) in partnership with Johnson and Johnson. (Malby, 1997). The study involved a literature review and workshops for health care leaders from fifteen countries in Europe. The workshops/seminars were held in Germany, UK and Spain and attended by representatives from fifteen different

countries. The review of the nursing leadership literature was conducted by Keith Hurst (Senior Lecturer, Nuffield Institute, University of Leeds) and published as part of the main report. This work provides a very succinct review of leadership in nursing by theme (15 themes). Hurst summarises the myriad of desirable, undesirable and misconceived leadership characteristics described through the literature (see Appendix 2). The desirable characteristics are predominantly reported. The international study revealed the need for nursing leadership development and suggests that this should be part of a wider approach to leadership development for clinical professionals. Whilst the initial focus for development was nursing, the workshops highlighted the need for multi-disciplinary development as well as uni-disciplinary development. In each of the countries involved, there were fewer leadership development opportunities specifically for nurses than there were for doctors or managers. All the countries involved in the study identified the need for development of leaders from clinical backgrounds (particularly nurses) in certain areas: health reform, involvement of users, partnership working, being European, and valuing nursing contribution. The study lead to the development of the profile of the strategic nurse leader in Europe under the following headings: strategist, systems leader, courageous, confident, credible, learner and developer, see Table 2.16. This recent work forms a valuable resource and should assist in identifying future leaders for nursing in Ireland.

The workshops drew together very useful comparative information on leadership in nursing in each of the participating countries: Poland, Estonia, Netherlands, Norway, Slovenia, England, Denmark, Finland, Hungary, Germany, Sweden, Czech Republic, Spain, Belgium and Ireland. The discussions held during this study lead to three main ideas for leadership development across Europe: "European summer school for strategic leaders with clinical backgrounds; learning network for current strategic level nurse leaders; and internet web site and distance learning" (Malby, 1997, p.57).

TABLE 2.16. Profile of Strategic Level Nurse Leaders in Europe

Strategist:	Sees possibilities, has clear ideas, creative, works within the "big" picture, shapes and influences, opportunistic, able to develop and implement strategy to achieve health gain. Understands the use of power and politics, able to work with national and local priorities, politically aware.
Systems leader:	Develops generative relationships, works where there is energy in the system, sees connections and networks, works across boundaries, develops groups, creates meaning and identify, understands knock on effects of short term decisions, widely networked, develops information processes. Works with users, sensitive to local community needs.
Courageous:	Develops choices, takes risks, entrepreneurial but with feet on the ground, committed, positive, ethical.
Confident:	Achiever, works hard and uses time well, knows the business, can work with the credible media, clear presenter of ideas, and able to manage the business. Able to lead beyond hierarchy in complex organisations.
Learner:	Reflective, learns from work and personal situations as well as from reading and developed formal learning experiences (programmes), seeks supervision. Develops others, coaches, mentors others, recognises own role as a role model, sees potential in others. Able to act as process consultant. Self aware and able to recognise and maximise personal impact, comfortable with self and able to express themselves through their work.

Source adapted from: **Malby, R. (1997)** ***Developing Nursing Leadership in Europe – A study of Nursing Leadership Needs. London: Johnson and Johnson/King's Fund,*** **p.3.**

Nurses, no matter what gender, will have to face several challenges in developing their leadership capacity. When considering nursing in Ireland, Joyce (1997) describes the challenges facing potential Irish nurse leaders as:

- Overcoming isolation.
- Overcoming traditionalism and tribalism.
- Developing strategic thinking.
- Developing personal confidence.
- Balancing finance and quality care.
- Obtaining a breadth of vision.
- Moving out of the expert box.
- Grasping the challenge of primary care and population based services (Joyce, 1997, p.8).

The new Office for Health Management has made important advances in developing leadership development programmes for nurses in Ireland (see Chapter 3). In a recent publication from the Irish Office of Health Management (November, 1997), Doherty (1997) commented that perhaps the key to women in management lies in changing attitudes most particularly among women themselves. She advised that women need to begin to perceive themselves as health service leaders of the present and future. She commented that "in a service largely produced by women, the lack of vision of ourselves as leaders does a grave disservice both to ourselves and the people we work for" (p.8).

Strategic Planning and Innovations in Nurse Management

This review indicates that internationally health-care services are experiencing tremendous change. This challenges nurses to be creative and adopt a proactive form of management. As nurse managers continue to be part of an evolving, fast-paced, competitive environment, it is essential for them to manage strategically (Nash and Opperwall, 1988). If nurses are to make a significant contribution to the changes two important skills are required those of strategic planning and innovative management. This section discusses the issues in some detail.

The role frequently reported for the most senior nurse in any co-operation is that of strategic planner for nursing. It is vitally important that all senior nurses have a clear understanding of the concept. Strategic planning for non-profit organisations is based on the premise that leaders and managers of public and non-profit organisations must be effective strategists if their organisations are to fulfil their missions, meet their mandates, and satisfy their constituents in the years ahead (Bryson, 1995).

Strategic planning is a set of concepts, procedures and tools designed to assist leaders and managers. To set a strategy, one must simplify complexity and choose the main focus and elements (Lehmann, 1998). It is the peripheral vision that captures more of what is at stake, what could go wrong, and what are the strengths to be leveraged and also how to lay out multiple steps to get to the end game. Strategy is defined as a disciplined effort to produce fundamental decisions and actions that shape and guide what an organisation is, what it does and why. Nash et al. (1988) describe the purpose of strategic planning as the production of a clear, timed plan for the organisation to achieve its goals. They present a five step process for strategic planning: outline the practical vision, identify underlying contradictions, formulate strategic proposals, introduce tactical systems and finally implement a calendar setting out the schedule for tactical implementation (Nash and Opperwall, 1988). Strategic planning is not the same as strategic thinking and acting. Strategic planning is useful only if it improves strategic thought and action; it is not a substitute (Bryson, 1995).

The formation of strategies comes from a variety of sources: the vision of new leaders, group learning, innovation, what already works, chance and planning (Bryson, 1995). Strategic planning can help facilitate communication and participation, accommodate divergent interests and values, foster wise and reasonably analytic decision making and promote successful implementation. According to Bryson (1995), the benefits of strategic planning are: the promotion of strategic thought and action including heightened attention to organisational future direction; improved decision making; enhanced organisational responsiveness and improved performance; improved policy and decision making. Bryson, presents a ten step strategy change cycle:

- Initiate and agree upon a strategic planning process;
- identify organisational mandates;
- clarify organisational mission and values;
- assess the organisation's external and internal environments to identify strengths, weaknesses, opportunities and threats;
- identify the strategic issues facing the organisation;
- formulate strategies to manage these issues;
- review and adopt the strategic plan or plans;
- establish an effective organisational vision;
- develop an effective implementation process; and
- reassess strategies and the strategic planning process (Bryson, 1995, p. 23).

The ten steps should lead to actions, results and evaluation. The activities of the strategic planning process for the nurse manager must be co-ordinated with, and yet be separate from, the organisation's overall planning process. The plan for nursing care must be integrated to achieve synergy in the overall organisation's planing process, but the planning process and plan components must be separate to align responsibility, control, and self-determination of nurse-managers (Davidhizar, 1995, p.69).

Innovative management is described in a review article by Tross and Cavanagh (1996) as a developmental process which requires a climate that is conducive to change. The stages identified are; awareness, interest, trial, evaluation, and adoption. They believe that innovation and change should begin with top-management. The aim should be to foster the circumstances (training, organisation structure, culture and strategy) which can foster and sustain change (Tross and Cavanagh, 1996). The factors necessary are vision, commitment to excellence, participative safety and support. Before any innovation can have a high adoption rate among a group of individuals, it must be of proven quality and value, its effects must be easily demonstrable and information about it must be reasonable and accessible (Rogers, 1983). They advise that managers will have to establish an internal climate that supports creativity and innovation and one that goes beyond paying lip service to the idea of innovation. It is suggested that managers have a choice to innovate or stagnate. Staff empowered to innovate will not only be desirable, but absolutely essential for the survival of hospitals. Nurses in general and nurse-managers in particular need to feel that they are in control of what they perceive as professional issues if they are to be able to implement change with confidence. The authors concluded that with globally rising health care costs, no delivery system can afford not to invest in nursing management innovation and the evaluation of such interventions (McCloskey et al. 1994).

In relation to nursing management innovations, McCloskey et al (1994) found that few organisation and management changes have been evaluated systematically for their impact

on quality and cost. They contend that management innovations must be evaluated with rigor equal to that of patient care innovations. The authors suggest that managers increase their risk in decision making by introducing management innovations, without sound evaluation. They caution that this practice may ultimately increase health care costs by implementing organisational changes that are untested and costly.

This section of the review indicates that while strategic planning is discussed extensively in the management text books, there is little evidence (from research reports) of nurses actively engaging in strategic planning.

Models for Nursing Care Delivery

Within any nursing organisation, care is delivered according to some structured methodology. A very important function for the nurse manager is to select the appropriate model/system to guide the delivery of nursing care within the department or organisation. Today's nurse-manager has a number of nursing care delivery systems that demonstrate ways of organising nursing's work. A nursing delivery system is a set of concepts defining four basic organisational elements; clinical decision making, work allocation, communication and management (Kerfoot, 1996). These factors ultimately determine the quality of the product. The delivery system impacts on the work performed and the workers experience. Manthey highlights that managing a successful implementation or change in the patient care delivery model is one of the trickiest challenges confronting nurse administrators (Manthey, 1990). She suggests the reason the process is so complex is that in a complex hierarchical bureaucracy, the change must "embody a very sophisticated development process within itself" (Manthey, 1990, p.204). Though different, the systems share the unique perspective of nursing management that combines the concern for quality of care with the best use of available resources. A brief overview of some of the systems for nursing care delivery is given below (see Table 2.17). The dates given refer to the introduction of the various systems in North America. The overview emphasises the particular features of the systems which are pertinent to nurse management.

Total Care Nursing

Previously referred to as "case nursing." This is the oldest of the care systems. One nurse is assigned to one or more patients for the delivery of total care (Douglas, 1996). The patient may have a different nurse every shift and no guarantee of having the same nurses each day. The nurse manager has the ultimate responsibility for all patient care.

TABLE 2.17. Major Components of Nursing Care Delivery Systems

System title	Year started	Description of system
Total care nursing	1800's	each patient is assigned to a nurse for total care for a shift.
Functional nursing	1940's	hierarchical division of labour, task allocation.
Team nursing	1950's	registered nurses supervise auxiliary nursing staff.
Primary nursing	1960's	registered nurses give total patient care to a few patients.
Modular nursing	1960's	geographically based nursing involving a mixture of team and primary nursing.
Cross functional, multidisciplinary teams	1980's	co-operative interdisciplinary practice, management and co-ordination of the care patient receives in all settings throughout an episode of illness.

Source adapted from: **Marriner-Tomey, A. (1996) Guide to Nursing Management and Leadership. 5th. edn. St. Louis: Mosby, p.231 & Wise, Y. (1995) *Leading and Managing in Nursing*. St. Louis: Mosby, p. 430.**

Functional Nursing

Functional nursing is a system of care that is borrowed from industry and concentrates on duties or activities. This pattern of care involves an assembly-line approach in which the nurse-manager delegates major tasks to individual members of the work group. The advantages and disadvantages of the functional system are controversial among nurses and hospital administrators. Many hospitals administrators consider the functional system the most economical way to deliver nursing services. Douglas suggests that this may be true if primary consideration is given to production and secondary consideration is given to quality. Another advantage is that the nurse manager maintains greater control over work activities. However, the patients care can be fragmented because each patient has a variety of care givers for each specific task (Eckhart, 1996). In this centralised system the manager bears responsibility for all activities of those providing care and for the quality of care given. The nurse-manager is barraged with input from all sides and must also complete administrative functions. The dichotomy of roles can become overwhelming and lead to inadequate fulfilment of job expectations (Douglas, 1996).

Team Nursing

During the 1950's, a nursing care delivery system known as "team nursing" became popular (Eckhart, 1996). In team nursing a professional nurse leads a group of health personnel in providing for the health needs of an individual or group of people through collaborative and co-operative effort. Team nursing is based on a philosophy of certain beliefs and values:

- the worth of every individual;
- the need for a qualified person to be the overall co-ordinator and interpreter of plans for care;
- emphasis on co-equal status with minimal hierarchical lines of demarcation between leaders and followers; and
- sensitivity and responsiveness to the need for adaptability and change (Douglas, 1996).

When team nursing is used the nurse manager or designated person delegates leadership responsibility to a nurse leader for a specific group of patients. Team members relate to the team leader, who in turn relates directly to the nurse-manager. The nurse-manager's role changes from that of an organiser and manager of tasks to a co-ordinator, consultant and evaluator. Team nursing is one form of decentralisation, the intent of which is to bring decision-making to an operational level, which is accomplished by reducing the degree of vertical control at the top level and developing increased horizontal communications at lower levels of the nursing structure. A clear line of organisational structure is needed for the nursing team to provide a mechanism for horizontal and vertical communication. It is reported that team nursing increases the cost of providing care as more registered nurses are required than for functional nursing (Eckhart, 1996).

Primary Nursing

Primary nursing is both a philosophy for nursing care and a model of organising care to achieve high-quality outcomes. It is based on the philosophy that patients, instead of tasks, should be the focus of professional nurses. The cornerstone of primary nursing is decentralised decision making (Manthey, 1990). Its goals are to achieve patient-centred

individualised care that is co-ordinated, comprehensive in scope and continuous from admission to discharge (Douglas, 1996). Staffing for primary nursing usually requires that one registered nurse be assigned approximately from four to six patients (depending on patient acuity). Two or more of these patients are the nurse's primary patients. Primary nurses have accountability, authority and autonomy for the care of their primary patients and for attention to the patients families twenty-four hours a day throughout the patients hospitalisation. Primary nurses are accountable for the outcomes of nursing care, not just for the care itself.

The associate nurse cares for the patient by using the care plan developed by the primary nurse while the nurse is off duty. The associate nurse is expected to contact the primary nurse regarding changes in the care plan. Primary nursing has been described as a method aiming to create autonomy for individual clinical nurses (Eckett et al. 1996). The primary nurse, physician and nurse-manager control the quality of patient care by maintaining an effective communication system. There is a colleague relationship between nurse physician and nurse-manager rather than the traditional hierarchical structure. Primary nursing decreases the number of people in the chain of command and reduces the number of errors that can result from a relay of orders (Marriner-Tomey, 1996). The success of primary nursing depends on the quality of the nursing staff and administrative support. In many hospitals in Ireland a hierarchy is assumed among professionals. For the success of primary nursing the traditional nurse to nurse and doctor to nurse hierarchies would need to be set aside.

Biley (1990) examined the place of the ward sister once primary nursing has been introduced and found that it is essential that the ward sister relinquishes accountability for the entire ward and every patient so that individual primary nurses are allowed to become truly and individually accountable for the care delivered to their case load or group of patients (Biley, 1990). McMahon (1990) conducted a study to demonstrate whether the adoption of lateral management structure (primary nursing) creates genuine change in the power relations on hospital wards (McMahon, 1990). Three different management structures were observed; traditional hierarchical, team nursing and primary nursing. Nurses interactions were recorded as they worked and nurses own perception of their collegial relations were measured using a likert scale questionnaire. On the wards which had a hierarchical ward management structure, power seemed to rest in a position, regardless of who held it at any particular time. On the primary nursing wards, power seemed to be vested in individuals. The power and communication patterns observed suggested that team nursing is no less hierarchical than the traditional management system. Statistical analysis of the results suggested that nurses on the primary nursing wards found their collegial and inter-professional communication to be significantly more collaborative than that of nurses on the hierarchical wards (McMahon, 1990).

Modular Nursing

Modular nursing is a modification of team and primary nursing. It is a geographic assignment of patients that encourages continuity of care by organising a group of staff to work with a group of patients in the same locality. The fixed geographic area typically represents ten to twelve patients per module. This system is sometimes used when there are not enough registered nurses to practise primary nursing. In modular nursing, each registered nurse delivers direct care to a group of patients and is assisted by paraprofessionals (Marriner-Tomey, 1996)

Cross Functional, Multidisciplinary Teams

A recently evolved model is that of patient centred care. Cross functional teams consist of groups of professionals and assistive personnel from nursing and other departments whose reporting responsibilities are to a particular patient care unit rather than the traditional department e.g. physiotherapy, dietetics, speech therapy (Kerfoot, 1995). Care is designed around the needs of the patient and not the needs of the department or professionals. In the cross functional multidisciplinary team model, nurse-managers operate at a sophisticated level integrating all services. To ensure cost-effective and high-quality care, the nurse-manager is required to integrate with other units and professionals, which means frequent communication, networking, planning creative patient care, and seeing in and beyond the care unit to achieve goals (Douglas, 1996).

In self-managed cross functional teams, the nurse often accepts accountability to manage people who come from traditionally centralised departments such as house keeping or dietary departments. Vestal (1995) suggested that interdisciplinary, cross-functional teams will be the health-care model of the future.

Developments in Models for Nursing Care Delivery

In a seminal work on patient care delivery models Mayer, Madden and Lawerenz (1990) present a comprehensive review of the patient care delivery models in use in the USA at the time. Although eight years old this text gives a very extensive review of the diverse models used to organise nursing work. The models describe research based developments in many leading American hospitals and health care institutions (acute-care /long-term-care/community-care/rehabilitation). Unfortunately, the researcher was unable to locate a second or updated version of this text or any other such publication. Therefore it is not possible to access the success, over time, of the models described in the text. Table 2.18 lists twelve of the main models described by title, institution where the used and the main features of the model. A review of the various models indicates that primary nursing and managed care are the common elements across most of the models, however, each model has been adapted to suit the particular environment of the institution. Staff empowerment, accountability and cost control appear to be the rational behind model selection and use in the organisations.

The level of competency, educational background of available nursing staff and the acuity of the patient population influences the nursing care delivery system selected by nurse-managers. In situations where there are few registered nurses, few second level nurses (such as state enrolled nurse (SEN) (UK) and licensed practical nurse (LPN)(USA)), many support staff are employed. Mainner-Tormey contends that this is an expensive and relatively dangerous mix, because untrained nurses' aides do not have the educational background to recognise what needs to be reported.

Team nursing is appropriate when there are some registered nurses, many second level nurses and few nurses aides employed. The registered nurses plan and direct the care, administer medications and carry out the more complicated treatments. Although this system provides good physical care the greater proportion of the working team are not adequately educated to understand the pathophysiological basis of symptoms, to plan nursing services or detect changes at an early stage. This type of skill-mix within a team may not be able to adequately provide for patient education and respond to psychosocial needs (Marriner-Tomey, 1996).

TABLE 2.18. North American Models for Nursing Care Delivery

Patient Care Delivery Model	Outline of Model
The Professionally Advanced Care Team Model ProACT (PPM) Robert Wood Johnson University Hospital.	Two distinct RN roles – Primary Nurse and Clinical Managers. Created to deal with nursing shortages.
Cost containment Model Cedars-Sinai Medical Centre.	Features include – primary nursing patient satisfaction, quality of care, job satisfaction, reduction of costs & improved productivity.
Professional Practice Model (PPM) Johns Hopkins Hospital, Boston.	Primary Nursing introducing standards of care/practice, staffing standards, nursing role definition, quality assurance monitoring, peer review and self-scheduling.
Alternative Delivery System Primary Case Management, Hermann Hospital.	A case management model based on principles of primary nursing linked to a clear career ladder.
Differentiated Practice Model South Dakota Project for Nursing & Nursing Education.	Case Management with differentiation of practice between nursing case manager and nursing associated case manager.
Team Nursing for the Nineties Friendly Hills Regional, Medical Centre.	Role re-definition using the true meaning of team. Team led by Registered Nurse with Licensed Practical Nurse (LPN) and two nursing aides.
Nursing Professionaliation & Self-Governance Iowa, Veterans Home.	Professional autonomy, self-regulation, 24 hour accountability of staff nurses for patient care in a long-term care setting.
Co-operative Care Models Vanderbilt University Medical Centre Co-operative Care Centre (VUMC) New York.	Reversal of the patient and professional roles. Low acuity patients delivering self-care with a family member as care partner.
The Professional Nursing Network St. Marys Hospital and Health Centre, Arizona.	Case Management applied in Group Practice.
National Medical Enterprises (NME) Caregiver System.	Multiskilled caregiving with expanded roles. Units divided into caregiver centres.
Organising a nursing system through Theory Based Practice St. Elizabeth's, New Jersey.	Orem's self-care theoretical foundation as a basis for nursing care delivery. Identifying patient self-care defects as a means of planning nursing needs.
Patient Care Technician (PCT) Model New England, Deaconess Hospital.	Nurse extended model to deal with shortages in the nursing profession.

Source adapted from: **Mayer, G. Madden, M. And Lawrenz, E. (1990)** ***Patient Care Delivery Models.*** **Maryland: An Aspen Publication.**

Primary nursing is selected where a high proportion of the staff are registered nurses as they have the educational background and ability to accept complete accountability for the group of patients assigned to their care. Primary Nursing can be used as a tool by nurse-managers to access the competency and skill of registered nurses. Using this method for arranging patient care delivery, nurses who underperform are very readily identifiable.

Manthey disagrees with the selection of delivery systems outlined above. She contends that, team nursing can be used with an "all RN staff" just as well as primary nursing can be used with a skill-mixed staff. Since there is not more work to be done because of the delivery system itself, there is no need to change staffing in order to change the delivery systems. When giving this advice she appears to have neglected to consider the skill-mix and resultant competencies within the team delivering care. However she does suggest that staffing levels and mixes should always reflect the acuity and volume of patient care needs rather than a shift in delivery system (Manthey, 1991).

Profile of the Workforce.

With the recent effort to cut costs in highly competitive environments, hospitals have cut staff, aiming at a minimal staff-to-patient ratio. Restructuring exercises have taken place on the basis of downsizing the hospital nursing workforce (Aiken et al. 1996). These developments appears to be happening internationally particularly in the UK, USA and Canada. Benner suggests that there are distinct skill levels among nurses, which translate directly into how patients are cared for. She cautions against the view that "a nurse is nurse" she suggests that this unenlightened view can translate into the stance that "anyone can do it." She contends that anyone who has studied the organisational literature knows that true productivity and profitability over the long term are based first and foremost on strong quality and reliability. Benner (1996) summarises the implications of her research for nurse managers as follows:

- The skill levels of clinicians need to be determined, recognised, rewarded and utilised accordingly.
- Attention must be given to the distribution of skills of nurses for proper staffing of shifts and modes of care delivery.
- The creation of acute care hospitals requires the identification of expert practitioners across all units and specialities. Anything, whether staffing mix or patient-nurse ratio, that reduces the contact of nurse with the patient flattens the practice of even the most expert nurse.
- High use of non-nursing personnel as part of a patient care system is more difficult to manage and creates greater risk to patient safety.
- Managers can promote the development of expertise in individual nurses by attending to the stages of skill acquisition (Benner et al. 1996).

Nurse Extenders

The use of nurse extenders is a management innovation aimed at redesigning the care delivery system to achieve the most efficient and cost-effective skill mix of nursing personnel without compromising quality. Unlicensed personnel are added to the nursing staff with a subsequent increase in the patient-to-registered nurse ratio i.e. fewer nurses. Having reviewed the relevant literature, McCloskey et al. (1994) suggest that evaluation of this innovation does not build on prior research and is not of adequate rigor to assert that using nurse extenders is justified for cost, satisfaction, or quality. Grinspun (1996) commenting on Canadian nursing, suggests that the move to replace registered nurses is no longer sporadic. She reports that it has become a regular strategy for cost containment with the potential of taking on epidemic dimensions if nurses do not speak out. Benner suggests that hiring narrowly trained non-nursing personnel to do assigned tasks has real limitations for the development of clinical expertise and for the safe care of highly unstable patients (Benner et al. 1996). An alternative innovation is the move some hospitals have made to return to an all registered nursing staff, which has been given the term "All RN staff."

Professional Practice Model

The Professional Practice Model (PPM) is a system (structure, process and values) that supports registered nurse control over the delivery of nursing care and the environment in which care is delivered. In a review of the literature Hoffart et al. (1996) identified that the PPM has five subsystems: values, professional relationships, a patient care delivery

model, a management approach and compensation/rewards. The five elements of the PPM can be realised in a variety of ways depending on the particular needs of the institution, the practice setting, the type of patients cared for, and the characteristics of the work group. There is no one Professional Practice Model. The authors reviewed the use of PPM at five different hospitals and identified primary nursing and case management as the care delivery systems most often used. The authors identified that decentralising decision making, expanding the scope of unit nurse manager responsibilities and instituting structural changes to support professional practice were common activities in the management sub-system. Compensation and reward systems generally recognising professional achievement and contribution toward organisational goals were also found (Hoffart and Woods, 1996).

All Registered Nurse (RN) Service

An all RN service is a system of nursing where patient care is delivered entirely by a registered nurse. In this system, unit or nursing assistants are assigned to the nurse for non-nursing and /or environmental tasks (Kramer, 1990). Freeman (1996) describes the implementation of such a system at the Mercy Medical Centre in Baltimore. In a restructuring move, the hospital discontinued its nursing assistant and technician positions and boosted it registered nursing staff by 40% to assume the extra duties. The rationale behind the change was two-fold; to improve the quality of patient care and to save money. The hospital projected that it could save $500,000 per year in the new system as nurses have higher skill levels and work capacity than assistant staff. This system is being increasingly used in the USA and Canada, particularly at Magnet hospitals (Kramer, 1990). Magnet hospitals are medium to large size urban or rural community hospitals or medical centres that have a reputation for high retention of nurses and excellence of nursing practice (Kramer and Schmalenberg, 1988). In 1982 the American Nurses' Association (ANA) sponsored the original Magnet hospital study which resulted in the designation of forty-one hospitals across the United States as Magnet hospitals (McClure et al. 1983). Experimentation, value formulation, excellence of care, recognition of the competence, power, and autonomy of the individual, particularly nurses are the main themes operative in the Magnet hospitals. During follow up studies (1986, 1989, 1990) it was established that as a group the hospitals continue to display evidence of cultures of excellence and leadership in working out creative and successful solutions to todays problems in nursing. In general, Magnet hospitals have not encountered a nursing shortage despite the prevalence of severe nursing shortage in other hospitals. The units in these hospitals are often autonomous and self-governed. The nurse manager's role is typically broad in scope.

In 1994 Aiken et al, investigated if hospitals known to be good places to practise nursing (Magnet hospitals) have lower medicare mortality than hospitals that are otherwise similar with respect to a variety of non-nursing organisational characteristics. The findings demonstrated that the Magnet hospitals had a 4.6% lower mortality rate. The Magnet hospitals studied had a significantly higher ratio of RN's to total nursing personnel and slightly higher nurse to patient ratios. On the basis of their analysis of matched hospitals (Magnet and non-Magnet) the researchers concluded that the matched comparison hospitals are not identical in nursing organisation to the Magnet hospitals. The researchers concluded that the finding reinforced their belief that the mortality effect derives from the greater status, autonomy and control afforded nurses in the Magnet hospitals, and

their resulting impact on nurses behaviours on behalf of patients. The researchers propose that the finding is not simply an issue of the number of nurses, or the mix of credentials, it is also related to the empowerment of nurses (Aiken et al. 1994)

Research regarding exclusively RN staff models indicates an increase in staff, patient, and physician satisfaction. With an increase in professional orientation, personal liking of colleagues and co-operation with others (Grinspun, 1996; Hartz et al. 1989; Krakauer et al. 1992; and Shamian and Chalmer, 1996). All-registered nurse staffing has been found to be economical, with respect to decreased turnover, sick leave, unpaid absences, float hours and overtime. International literature suggests that frequent shortages of nurses have made "all RN staff" systems difficult to introduce (Marriner-Tomey, 1996).

There is currently no nationally agreed standard for calculating the numbers and mix of nurses required to delivery patient care in specific settings. Although staffing establishment is considered to be beyond the scope of this current review any consideration of management of nursing in the Irish health services will need to take this important issue into account.

Education for Nurse Managers.

Emerging from the literature is a strong belief that management education for nurse-managers is either inadequate or non-existent. According to Flynn (1987) managerial competence is not a cultural attribute, nor is it a gift received with entrance into a promotion within nursing administration. He suggests that nursing managerial competence is the result of managerial skill developed through careful training and practice.

The lack of direct application of knowledge gained in a first-line management course by participants when they return to their workplace has been highlighted (Bevan, 1982). The causes suggested include: a lack of application on the part of those teaching, a weakness in the superior in expecting the first-line manger to have a greater knowledge base on their return and a lack of involvement on the part of more senior administrators in such programmes. Bevan (1982) suggested that the situation could be resolved if all levels of nursing-managers undertake, ongoing, continuing education courses in management. It is advised that if nurses are to administer nursing services effectively then adequate resources must be provided for their education and educational standards must be upgraded to ensure that managers are equipped with the essential knowledge and skills.

In 1991, an Australian nurse reviewed the international literature in relation to education and preparation for first-line managers (Duffield). She found that the methods suggested to improve the educational preparation of nurse-managers vary considerably, and include:

- Journal club.
- Individual tuition.
- Group problem-solving.
- Classroom as well as experiential learning experiences.
- A series of workshops.
- In-house courses using peers as well as more senior nursing administrators to teach.
- Staff development sessions.

- Engaging a human resource consultant to work with managers individually.
- Adopting a competency-based programme.
- Charge nurse leadership projects in which participants present the process and results of a change they introduced or a resource they developed on the unit.
- The use of leadership self-assessment tools from which individual programmes can be developed (Duffield, 1991, p.61).

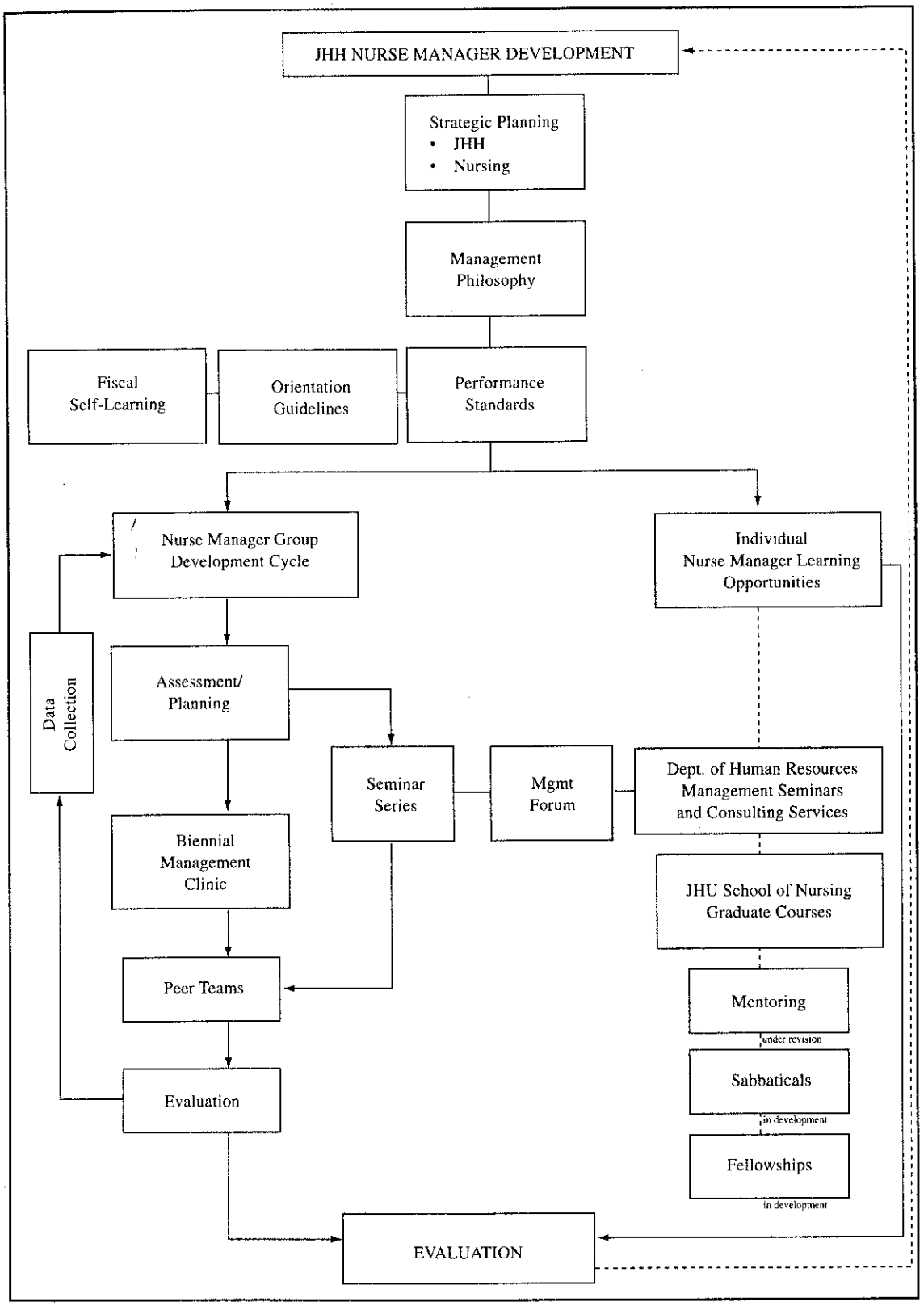
Duffield concluded that successful management does not result from management functions learned in school or educational workshops. Successful management also involves effective use of both the manager's affective and cognitive domains. Davidhizar (1995) suggests that mentoring and apprenticeship with a successful nurse leader is for many novice managers a highly valuable way to learn management skills, as it allows the techniques of a successful nurse manager to be visualised and modelled (Davidhizar, 1995). This type of programme is referred to as shadowing.

A UK survey was conducted to obtain the views of senior managers about regional priorities for addressing the management training and development needs of senior nurse-managers. A multi-disciplinary management-development environment was found to be highly valued (Balogh and Bond, 1993). Nurse-managers reported that contact with other professionals raised their confidence about the potential nursing has in making a specific contribution to the management process. The experience of learning in a multidisciplinary environment was perceived to break down many traditional suspicions and barriers. The author suggests that the level of enthusiasm for contact with other professionals is indicative of an emerging pattern of increased professional collaboration.

A task force was set up in the Johns Hopkins Hospital (a 1000-bed, decentralised academic, health centre in the USA) to develop an education program for the sixty-eight unit nurse-managers (previously called head nurse) of the hospital. An education needs assessment, completed by the nurse managers indicated that the top priority development needs for nurse-managers were; motivating others, managing change, creating a unit culture, managing performance, developing leadership, creating a vision, mentoring/coaching staff, and creating development plans with staff members (Sullivan et al. 1994). The task force realised that a single workshop or a series of lectures on management theory would do little to influence long-term learning and achieve a sustained change in behaviour.

The group designed a nurse-manager development programme which was evaluated over a four year period. The final model pictured three groups of learning experiences for nurse-managers (see Figure 2.6). The first group included orientation guidelines, fiscal self-learning packet and optional structured learning activities for new nurse-managers that related directly to performance standards. The second group of learning experiences focused on the nurse-manager group development cycle – a dynamic structured progression of education events to facilitate learning, nurse-manager collaboration and networking across all departments. The third group of learning experiences represented five sets of individualised learning opportunities for nurse-managers at all levels of experience (human resource management seminars/consulting services, university, school of nursing graduate programme, mentoring, sabbaticals/fellowships and the institution-wide management forum).

FIGURE 2.6 John Hopkins Hospital Nurse Manager Development Program Model.



Source: **Sullivan, P., Baumgardner, C., Henninger, D. And Jones, L. (1994) Management Development: Preparing Nurse Managers for the Future , part 1 program model.** ***Journal of Nursing Administration*** **24, 36.**

Sullivan et al. (1994) reported that while successfully supporting the development of independent speciality-focused initiatives/centres of excellence, decentralisation, made it difficult operationally for nurse managers to share support/expertise across different departments. The opportunities which the Johns Hopkin's development programme offered for horizontal networking were found to be very valuable by the nurse-managers.

Duffield (1991) found that there is little similarity between the frequency with which competencies are mentioned in the literature and those deemed (by an expert panel) important for the role of first-line nurse managers. To ensure competency, nurse-managers must clearly identify methods of maintaining and upgrading their skills. Duffield, concluded that the literature cannot be recommended as the sole method of maintaining competence. However, she does recognise that literature is invaluable in keeping abreast of current techniques, practice or proposals for new developments (e.g. new rostering or management information systems). It is also useful as a forum for securing new approaches to management or changes in health care climate, which may require more or different skills of managers.

In a Canadian study, Fullerton (1993) found that 46% of directors of nursing and 60% of all nurse administrators had not acquired any additional academic preparation beyond their basic nursing education. In a review of the literature, Fullerton could not find a consensus regarding educational requirements for first-line managers. She suggests that given the complexity of the role, not all nurse-managers have received sufficient managerial education and training. In relation to level of educational preparation she commented that it is difficult to conclude that a master's degree is necessary for the position, when several alternative educational programmes have been successful in developing the necessary skills of negotiation, decision making, conflict management, scheduling and financial analysis. Rather she suggests that personal experience programmes that incorporate both theory and preceptorship are most desirable for first-line nurse managers.

The ICN, when making recommendations in relation to the preparation of all levels of nurse managers, uses the term preparation in a broad sense to refer to three key areas: "political – how to develop the roles and positions, and get people in to them; educational – how to educate people for their management roles and functions; and support – how to support and develop people in their management positions" (International Council of Nurses, 1990, p.47). The ICN suggests that the effective preparation of nurse-managers should be based on planned linkages between the three areas and strategies which are based on and emerge from the nature/goals and type of organisational design and the organisation's desired roles/key functions of nurse managers. Malby (1997) proposes the following approaches to learning for future nurse-managers: development centre (the use of external experts to help individual nurses to assess their learning needs against a profile for nurse leader), modules (experiential and theoretical learning), action learning sets, learning diaries, secondments and placements, organisational development, mentors (non-nurse), discussion with current leaders, leadership networks, nurse mentor programmes and board level mentors.

The common theme throughout the literature is the need for specific multi-faceted career-long development programmes for nurse-managers. The value of a multi-disciplinary approach to management development is highlighted. The rapidly changing nature of the health services emphasises the constant need to update, review and be creative in developing methods for programme delivery.

Management Quality

An important aspect of the nurse-manager's role is to ensure that patients receive a quality product. The need for nurse-managers to be directly involved in quality initiatives is reported throughout the literature. Quality management (QM) is a management philosophy where quality is built into the product or service from the initial planning stage through to the implementation phase (Wise, 1995). The philosophy was initially used in business and industry but is now widely used in the health services. The main principles of quality management are:

- Managers need to be committed to quality management.
- All employees must be involved in quality management.
- The goal of quality management is to provide a system in which workers can function effectively.
- The focus of quality management is on improving the system not on assigning blame.
- Every organisation has internal and external customers.
- Customers define quality.
- Decision must be based on facts (Wise, 1995, p. 565).

Total quality management (TQM) is the title given to an organisational philosophy that ascribes to and supports continuous customer/client satisfaction. The philosophy is similar to quality management but emphasises involvement from the total organisation to prevent errors from occurring. The focus is on teamwork, obtaining customer satisfaction and planning to prevent errors. There is an increasing emphasis on the absolute need for nurse managers to be involved in quality improvement initiatives. The subject is extensively covered in the nursing literature. Due to the breadth of the current review, the subject is not considered in detail except to present the findings of a useful project undertaken in the UK.

The Standards for nursing management document, produced by nurses in the South West Thames Regional Health Authority, provides nurse managers with a quality framework which creates a system to assure the quality of nurse management (Bradbury, 1992). It states explicitly how nursing management contributes to organisational goals. This can help strengthen nursing within a general management structure. There is a distinction drawn between clinical standards and management standards. The nurse-managers role is to support nurse clinicians in giving better care through quality. Nine organisational standards for nursing management have been developed. Each interrelates with others and all have an impact in supporting direct patient care. The suggested standards, set out below, reflect the comprehensive nature of nursing management:

- Standard 1 Values and objectives
- Standard 2 Organisational management
- Standard 3 Human resources
- Standard 4 Patient care
- Standard 5 Research and evaluation
- Standard 6 Ethics
- Standard 7 Climate for care
- Standard 8 Education and staff development
- Standard 9 Policy (Bradbury, 1992, p.17).

The standards provide a quality framework by the evaluation of management practice against specific criteria for management practice. By evaluating the quality of their own work, managers enable the group of nurses they manage to deliver a high standard of patient care. The standards have four key uses, they provide:

- guidance for evaluation of existing management standards for nursing;
- a framework for the development of new approaches to management;
- a framework to support clinical quality initiatives; and
- assistance in the contracting process (Bradbury, 1992, p.18).

Nursing Management Diagnosis

The concept of specific nursing management diagnosis was developed by Morrison (1997) by integrating nursing diagnosis and organisational diagnosis as a basis for nurse-manager decision-making. A two phase study was conducted to assist in the development of a nursing management diagnosis set. Phase one consisted of generating problems and judgement related to managing nursing units by conducting focus group interviews with thirty-five nurse-managers from four south-eastern states of the USA. The second phase consisted of a three-round delphi survey of nurse-managers using questionnaires developed from the nursing management problems and judgements identified in phase one. Of the 72 nursing management diagnoses identified 66 were validated at a 70% level of agreement by nurse-managers (see Appendix 3)

Morrison contends that the knowledge developed by this research provides a structure for problem-solving and evaluation in nursing management practice. The list of diagnoses provides an objective mechanism for summarising concisely the symptoms and situations that warrant nursing management intervention. By having a list of nursing management diagnoses from which to choose, nurse managers can reduce the time spent in diagnosing the nursing and organisational situations and quickly proceed to planning interventions.

Glass Ceiling and Queen Bee Syndrome

The glass ceiling has been defined as that invisible barrier beyond which women cannot advance in the corporate world (Scheele, 1994). Andrica (1997) suggests that women continue to experience the hidden barriers to advancement beyond middle management (Andrica, 1997). The glass ceiling is invisible but women experience it as a very real barrier when they vie for promotion for top jobs (Davidson and Cooper, 1992). This problem has even greater impact on nurse management because the model of gender-based segregation is even more evident in large health-care organisations where senior doctors and senior executives are almost exclusively male and the occupations such as nursing are almost exclusively female. "The strength of the glass ceiling is the power structure of a male-dominated culture" (Crawford, 1993, p.335).

The literature suggests that the glass ceiling above which women may advance is being lowered. This is a consequence of general management replacing the traditional unit-professional management in which women were comparatively well represented as nurse and therapy managers (Parkyn, 1991). However in the UK, the struggle for recognition continues for nurse-managers with the continued NHS reorganisations of clinical directorates and trust status. Clinical directors are seldom nurses and Wall (1994) suggests "the nurse may often be number three in the pecking order after the business manager"

(p.17). Wright is concerned that the director's job is seen as a natural role of doctors (Wright, 1991). Andrica (1997), a management consultant recognises that nurse executives have a very clear understanding of both the clinical and administrative side of health care. She advises that they should capitalise on this asset in order to achieve more powerful roles in future health-care organisations.

Kelly (1997) comments that in the Irish health service the glass ceiling is now ready to crack open. However, she cautions that "we must be careful that the promotion of the concept of women in senior management is on the basis of their ability to get a job done" (p.6). She advises that women must be helped at an early stage to recognise their talents and encouraged to apply for training and promotion, but not to the detriment of men who have an equal role in the delivery of service (Kelly, 1997; O'Connor, 1997). Barriers to promotion in nursing in Ireland are discussed in greater detail later in chapter three of this report. A gender issue related to that of the glass ceiling is the queen bee syndrome.

The queen bee syndrome is used to describe women who make it in a man's world (Staines et al. 1974). The women manifest antifeminist behaviours towards female colleagues. They are individualistic decision-makers and tend to hoard information and isolate themselves from friendly and mentoring relationships with female colleagues, thereby warding off potential competition (Knight, 1992). The queen bee looks down at subordinates and does not extend help to assist them to grow in work roles. She typically identifies with those outside of nursing.

According to Knight (1992) queen bees allow themselves to be co-opted and work closely with the male-dominated groups. Co-option is a strategy adopted whereby one group persuades a person to join their system by praise and rewards. The individual reciprocates by seeking power through attempts to be more like the dominant group. Knight suggests that queen bee behaviours are barriers to organisational effectiveness and the development of future nurse leaders. Nurses who continue to manifest queen bee behaviour compromise their leadership ability. These nurses are placed in a marginal position in terms of the power they have to secure better working conditions for nurses, to build collegial relationships with others and to develop effective nursing leaders for the future. Knight stresses the importance for nurse-managers of recognising queen bee behaviours in staff members and the need to work to reduce such behaviours (Knight, 1992).

The international literature indicates that the prevalence of queen bees in nursing is on the decline. A study conducted in 1990 in New York among a convenience sample of 260 registered nurses found that 16 (6.15%) demonstrated queen bee traits. Of these, nine held staff nurse positions, five head nurses and two assistant directors of nursing. As no studies of the queen bee syndrome exist for nursing in Ireland it is not possible to draw comparisons. The syndrome could be one of the contributing factors to the small number of female senior managers employed in the health service in Ireland. A research study would need to be conducted to establish if this is in-fact true. In the New York, study a significant inverse correlation was found between the queen bee phenomenon and educational level, that is, as queen bee-ness increased, educational level decreased, with most of the queen bees being diploma prepared (Knight, 1990). This suggests that leadership development should contribute to the prevention or reversal of the queen bee syndrome.

In this section of the review a group of important management issues have been discussed: leadership in nursing; strategic planning and innovation; models for care

delivery preparation for management; quality management; management diagnosis; promotion opportunities for nurse managers and gender issues.

Summary

In this chapter role theory was used as a four point framework to explore the role of the nurse-manager, as presented in the literature. The role theory model (see Figure 2.2) lead the review to focus on job-title, job-description and competencies as indicators of the nurse-managers role concept, role expectations and role behaviours. The main findings of the most recent research studies investigating the role of nurse-managers were presented. The important issues of leadership, strategic planning, models for nursing care delivery, profile of the workforce, education for nurse managers, quality management, the glass ceiling and the queen bee syndrome and their relationship to the management role were also examined.

The international review of nursing management titles suggests the role concept for nurse managers varies between line-management positions, professional advisory positions, a combination of these and nurse manager positions with other non-nursing management responsibilities. It might now be appropriate for Irish nurses to review some of the current nurse management titles (matron, ward sister) which could be considered indicative of more traditional ascribed roles.

From the review it is apparent that there is a need for both nurse-managers and nurses in general health management. It is important that nurses do not dedicate themselves to a narrow management function but become actively involved in the management of the broader health service. Failure to adopt such a change could result in a significant reduction in the influence nurses have in the management of the health service. Nursing must make its contribution to the successful delivery of health care very visible and explicit. There is a need for strong nurse leaders to represent nursing at policy making tables within health organisations. The profile of the strategic level nurse leader is described as: a strategist; systems leader; courageous; confident; credible; learner and developer. Many suggestions were submitted to the Commission on Nursing for the introduction of nursing advisory posts at Health Board level. The role, functions, responsibilities and competencies described for nurse executives practising in the UK and USA could be used as a guide to develop a new nurse executive role for Irish nurses.

It is necessary for all nurse managers to develop a business mind-set and continue to preserve clinical insight. It is suggested that the most powerful way for nurse managers to maintain their professional status is through clinical involvement. There is a real danger that involvement in clinical practice might be neglected as nurses take on more business related management functions and nurses are advised to develop strategies to maintain clinical involvement. The debates about the management of nurses and the management of nursing could potentially splinter the nurse-managers role reducing the potential strength of the role. However it is recognised that in the very complex health care systems that now exist it might be difficult for one head nurse to achieve all aspects of the management of the total nursing service. There is a need for a balance between clinical practice and business related outcomes. A useful way might be to consider the nurse managers role from four aspects; clinical, administrative, education and research. Specific detailed job descriptions could be used as a guide to ensure a balance is achieved between the business and clinical elements of the nurse-managers job. When devising new or

redesigning management functions for nurses, cognisance should be taken of the potential conflict between internal and external role expectations.

From the review it is clear that a wide range of competencies is necessary to successfully perform management functions. Some of the identified competencies might be considered to be natural attributes, which need to be cultivated, but others are specific management skills which must be acquired through ongoing management development. As the health service develops, new skills become necessary and for this reason, management development should be continuous and structured in some way. The value of applied learning through mentoring, shadowing projects, learning sets and networking are highlighted in the literature. Nurse-managers have reported the advantages of being involved in inter-disciplinary and multi-faceted development programmes.

The nursing teams expectations of a nurse-manager are that the manager will enable them to give of their best while obtaining satisfaction from their work rather than a controlling supervisor who attempts to mould them into a subservient group. The reader is reminded of reported inadequacies of the "boss manager model" where the ward sister acts as a gate keeper. The international literature suggests that registered nurses like other health care providers are professionals and therefore should not need to be managed. The focus of the nurse-managers job should be on the management of relationships and the environment in which care is delivered. In Ireland, careful consideration needs to be given to the educational preparation required for such independent roles. The next chapter of this review examines in detail the role of the nurse in managing the health services in Ireland.

CHAPTER 3

THE ROLE OF THE NURSE IN MANAGING THE HEALTH SERVICES IN IRELAND

Introduction

The historical literature demonstrates that nurses have played a pivotal role in the design and development of the Irish health services (Scanlan, 1991). To reach an understanding of the present day role of the nurse in management, it is necessary to trace the development of the management role of nurses from the earliest time. For this reason this chapter explores the evolution of the nurse managers' role and developments in the health service which have influenced this role. The current role of the nurse manager is also described and issues facing nurse managers addressed. A manual and computer search of the Irish nursing literature revealed a paucity of publications on the role and function of nurse managers in the Irish Health Services. The information available to the researcher is reviewed in this chapter. A small number of recently written, but unpublished, research studies of a diverse nature were located and are reviewed and presented in the final section of the chapter.

3.1 Historical Context for Nurse Management

The earliest use of the term nurse in Ireland can be found in the Brehon laws where reference is made to "nursing fees" and the term "nursing back to health" (O'Kelly and Ronan, 1994). These laws also laid down how and where an injured person be nursed. When Christianity came to Ireland centres of health care were established. The nursing care was provided by monks or nuns, who acted as both carer and manager with no distinction between roles. There was no need for a complex management structure. St. Patrick, who came to Ireland in 432, opened the first hospital when he asked St. Brigid and her companions to nurse and minister to the ailing (St.Vincent's Hospital, 1975). After the reformation the monasteries were suppressed and no provision was made for the health care of the poor or the sick pauper until the beginning of the 18th century. During the 18th and the first half of the 19th century, the majority of nurses were classified as domestics and nursing was considered a function for "menials" (Scanlan, 1991, p. 55). The growth of Irish hospitals in this century was dependent on socially minded philanthropic individuals who founded hospitals for the free treatment of the sick poor. These hospitals formed the origin of what are now described as voluntary hospitals.

A number of epidemics in the 19th century prompted the government to provide for the sick poor. In 1838 the Irish Poor Law System established work houses. These evolved into some of the present day hospitals, becoming, after the famine, the work house accommodation for the sick poor, and later developing into the county hospital scheme and Local Authority hospitals.[3] At this time nurses could be broadly divided into four categories, inmates nursing the sick poor in poor houses, nurses working in voluntary hospitals who were of a slightly higher social level, sisters in charge of wards, and matrons who were of a superior class to the others and who had some degree of administrative and management function (Department of Health, 1980). It is evident that the position and status of nurse managers, sisters and matrons was clearly established and recognised at an early stage in the development of the health service.

In 1947 most nurses were female and unmarried, work hours were long and pay poor. Girls preparing for marriage were recruited to mainly religious training schools. The apprenticeship system of training was used and because of the marriage bar, nurses often only worked for a few years (McCarthy, 1997). This led to the emergence of a hierarchical structure with a mainly female workforce, a few registered experienced nurses and many young apprentice student nurses managed by a small number of ward sisters and matrons. An exception to this was the psychiatric nursing service where men were traditionally recruited and employed until retirement. In addition religious services played a dominant role. McCarthy highlights the important contribution of the religious orders to nursing practice. However, she suggests that the vocational, self-sacrificing, hierarchical emphasis which permeated the profession has not been to the advantage of a predominantly female work force.

Formal training programmes were set up for nurses in the 1890's. Hospital authorities, seeing the value of their service, accepted probationers for training. After the introduction of nurse training, the old style nurse disappeared to be replaced by a more sober, disciplined workforce (McCarthy, 1997b). This development brought with it a hierarchical structure with matrons occupying the highest role. These were often referred to as lady superintendents whose function was administrative and domestic. The workforce comprised of sisters, nurses, assistant nurses, student nurses called (probationers) and very few domestic staff.

Matrons were responsible for the trainee nurses. The matron knew the character and ability of each probationer. She directed, disciplined, and had no hesitation in dismissing or advising nurse candidates to leave nursing (McCarthy, 1997). She governed nursing behaviour through the strict enforcement of rules and regulations, implemented through the requirement to live in nurses' homes. These homes existed until the late 1980's and only in 1994 were students given the independence to find their own accommodation. The matron in earlier years fulfilled the role of both matron and tutor, however, over time the teaching role was delegated to suitable ward sisters and thus originated the role of nurse tutor (Department of Health, 1980, p.19). The apprentice form of nurse education was legalised in the 1919 Nurses Act and was further authenticated by the nursing legislation of 1950. The system was hospital based and produced nurses who were highly skilled at hospital work but were unquestioning and submissive (Tracey, 1987). This impeded the development of potential nurse leaders: managers as nurses were taught to be re-active rather than pro-active. Some changes were made in the curriculum (1979 and 1992) as a result of EEC Directives but it was not until 1994 that major reforms were introduced. The current move to third level education has altered the focus of the programme from a

[3] Tierney, B., Developments of Nursing in Ireland, unpublished papers.

training to an education process (McCarthy, 1997). The next section of the review examines the origin of the matron's role.

Origin of the Matron's Role

As far back as the 16th century the title matron was in use. Matron was usually a married woman or a widow and functioned as a housekeeper. The function of the matron in Dr. Steeven's Hospitals in the early 19th century is described as follows:

> To take care of all the functions belonging to the house. To keep all stores and deliver them to the nurses as occasion requires. To see that the several nurses keep their ward clean – to lay up carefully the old linen and blankets and to deliver then to the surgeon as often as he shall call for them.[4]

Thus her role had very little to do with the delivery of nursing. The value placed on the services of a nurse manager may be assessed by the fact that the yearly salary of a matron in 1786 was £15, and nurses received £12 (St.Vincent's Hospital, 1975, p.52). In the late 19th century the focus of the matron's role moved from mainly domestic responsibility to include the charge of female servants and nurses. Management was hierarchical, where all decisions were referred to and controlled at the top.

As nursing evolved, mainly through the work done by the religious orders who attended the sick and saw that the physicians' orders were carried out, the title Sister came into use and continues to be used. Effectively two levels of management existed: matrons managing the entire hospital and ward sisters co-ordinating the operational activities of individual wards. By the mid 20th century an image of the matron had emerged which represented her as a well-educated, capable manager and educator with responsibilities that affected every aspect of patient care and every phase of hospital life. "She wielded immense power in a world consisting primarily of women" (Seccombe, 1987, p.218). The complex and varied management responsibilities of the modern nurse-manager are far removed from the housekeeping responsibilities of the matron in the 19th century.

The Irish Matrons Association was founded in 1904 (Scanlan, 1991). The association was renamed "Association of Irish Nurse Managers" in 1997. In 1919 the Irish Nurses Union (INU) later called the Irish Nurses Organisation (INO) was formed and moves to improve working conditions and the education of the profession were initiated (Irish Nurses Organisation, 1969). The Matrons Section of the INO was formed in 1954. The section emphasised the importance of improvements in post-basic education, especially in administration. Other aims of the section were to: see the profession recognised in a consultative capacity in hospital planning; more representation of matrons on An Bord Altranais; the establishment of a nursing division in the Department of Health. In 1961, the Ward and Departmental Sisters' section of the INO was formed and focused attention on human relations and their importance in administration. The section lobbied for courses in administration for all administrative nursing staff. The importance of nursing involvement in policy making for the health service at this early stage (1954) had been identified. Almost forty-five years later these issues are still central.

Developments in Hospital Structures

From 1900-1970 hospitals in general were managed by various statutory authorities including Voluntary Boards, Boards of Guardians, Boards of Health and from 1942 to

[4] Tierney, B., Developments of Nursing in Ireland, unpublished papers.

1970 by the County Councils. The system prevailed until the establishment of the eight regional Health Boards pursuant to the Health Act 1970. This in general led to a tripartite management system in the acute hospitals with a doctor administrator (resident medical officer), matron and the hospital administrator holding individual responsibilities. Within the acute hospitals services, the directors of nursing/matrons who work in the larger hospitals are responsible for nurses, nursing and possibly some related functions, in the smaller county hospitals the role can be wider and encompass many functions.

The structure of the modern health system is based on the 1970 Health Act which established eight health boards and set out how the health service is managed, structured operated and financed. Today the acute services are administered by distinct hospital systems, the voluntary public hospitals, hospitals set up as corporate bodies[5] and the health board hospitals. Some of the voluntary public hospitals are partly owned by religious orders, run by boards of governors and administered by boards. All but a minor part of the current hospital expenditure is met by public funds with the exception of private hospitals – some of which are also nurse training schools. These hospitals provide for teaching and training of doctors and nurses. Services for the mentally handicapped are mainly provided by voluntary organisations.

The health board hospitals provide acute services as well as long stay and psychiatric care. These hospitals are administered by the eight Health Boards and financed by state funds. Most of the regional health board hospitals provide nurse training facilities, and postgraduate medical education (Tierney, 1988).

3.2 Influences on Nurse Management (major reports).

The role of the nurse manager as well as the health care environment in which they operate has been directly effected by a number of recent reports, as presented on Table 3.1 and the policies introduced as a consequence of these. Of particular relevance are: Working Party on General Nursing Report; Health the Wider Dimension; Report of the Commission on Health Funding; Dublin Hospital Initiative Group Reports; Medical Manpower in Acute Hospitals; Shaping a Healthier Future; The Future of Nurse Education and Training in Ireland; The Management Development Strategy and Continuing Professional Education for Nurses in Ireland: a Framework. This section of the review provides an overview of the relevance of the reports for nurse management.

Working Party on General Nursing

A Working Party on General Nursing was established by the Minister of Health in 1975. The work of the group spanned four years and resulted in the publication in 1980 of the first major report on general nursing in Ireland. The Working Party considered both the management and the organisation of nursing services. It recognised that the nursing structure at the time presented problems for managerial grades from staff nurse to matron. The working party suggested that the problems were associated with unsuitable or obsolescent patterns of organisation, the absence of a standardised organisational structure and a consequential lack of defined roles and functions (Department of Health, 1980).

[5] Beaumont Hospital, St. James's Hospital and St. Lukes Hospital, all presently funded directly from the Department of Health. This will change with the proposed new Eastern Regional Health Authority.

In relation to the matrons role the Working Party found that the post holder was a senior nurse administrator but often, due to historical reasons, the commitment far exceeded normal administrative practice in terms of time and duties. Matrons were overburdened with day-to-day problems and were unable to delegate because of lack of support staff. The report described the role of the matron at the time but did not make recommendations in relation to the development of the role. The report, however, did make recommendations in relation to the establishment of the role of the director of nursing. The future role of the director of nursing was outlined as that of manager of the hospitals nursing service, comprising functions relating to; "planning, organising, controlling and co-ordinating the service and developing policies/standards for nursing and nursing education" (p.42). The report highlights the key role which the director of nursing should have in the overall management of the hospital. The Working Party identified the need to develop the role of the director of nursing as the most senior nurse. Despite these recommendation the issue continues to be voiced as a concern by many nurses.

To inform their report the Working Party on General Nursing commissioned a survey of Irish nurses attitude to career development and working conditions. This was conducted by the Institute of Public Administration (IPA) (McGowan, 1979). The data was collected by questionnaires, which were group administered to 1,119 nurses working at 44 hospitals and 165 public health nurses working in the community. The sample was stratified by staff roles: staff nurses; ward sisters; nurse administrators; teaching staff; public health nurses and matrons. A number of the findings are still pertinent to nurse management.

TABLE 3.1. Irish Health Service Reports which Effect Nurse Management

Author/Publisher	Year	Title
Department of Health	1980	Working Party on General Nursing.
Department of Health	1984	The Psychiatric Services: planning for the future.
Department of Health	1985	The Nurses Act.
Department of Health	1986	Health – The Wider Dimensions.
Department of Health	1988	The Years Ahead: A Policy for the Elderly.
Department of Health	1989	Report of the Commission on Health Funding.
Department of Health	1991	The Dublin Hospital Initiative Group Reports.
Department of Health	1993	Medical Manpower in Acute Hospitals.
An Bord Altranais	1994	The Future of Nurse Education and Training in Ireland.
Department of Health	1994	Shaping a Healthier Future: a strategy for effective health care in the 1990's.
Irish Matrons Association	1994	Irish Nurse Management – The Way Forward.
Department of Health	1996	Health (Amendment) (No. 3) Act, 1996.
Department of Health	1996	A Management Development Strategy for Health and Personal Social Services in Ireland.
An Bord Altranais	1997	Continuing Professional Education for Nurses in Ireland: a framework.
Department of Health & Children	1997	Statement of Strategy.
Department of Health & Children	1998	Working for Health and well-being – Strategy Statement 1998-2001.

The respondents suggested that matrons were limited in power. Most nurses were dissatisfied with the promotion opportunities available in nursing. A suggestion offered by the respondents was that more posts be created at ward sister level. However, there was a general belief that many nurses were not interested in promotion because there was insufficient extra remuneration for the added responsibility. It is interesting to note that most respondents felt that length of service within a hospital should be taken into account in deciding promotions. When considering the post of assistant matron the results show that assistant matrons were gravely dissatisfied with their role. In the attitude survey, 61% of assistant matrons indicated that they considered they had no real area of responsibility (McGowan, 1979). Despite these findings, little has been done to date to differentiate the role and responsibilities of the assistant matron.

The Working Party report suggests that as an ideal, the role of the ward sister should include expertise in nursing, clinical teaching and management. The attitude survey found that this was unachievable due to the heavy nursing practice commitments, for the ward sister, allowing insufficient time for a management role. The Working Party advised that because of the heavy demands made on ward sisters time, it was unrealistic to expect that one person could continue to shoulder the sole responsibility without assistance. To date this support is not widely available. Neither the existence of the post or the function of junior ward sister was referred to in the report. The author was unable to locate detailed information on the establishment of the junior ward sister's position. However it appears that the post was first introduced in the voluntary hospitals and the majority of post holders are still employed by large voluntary hospitals.[6] The post was initially introduced at St. Vincent's Hospital, Elm Park, in the 1970's. The Department of Health sought advice from management consultants from the UK when the new St. Vincent's hospital was opening. It was envisaged that the junior ward sister would assist the ward sisters, take charge in their absence and supervise the work and teaching of student nurses.

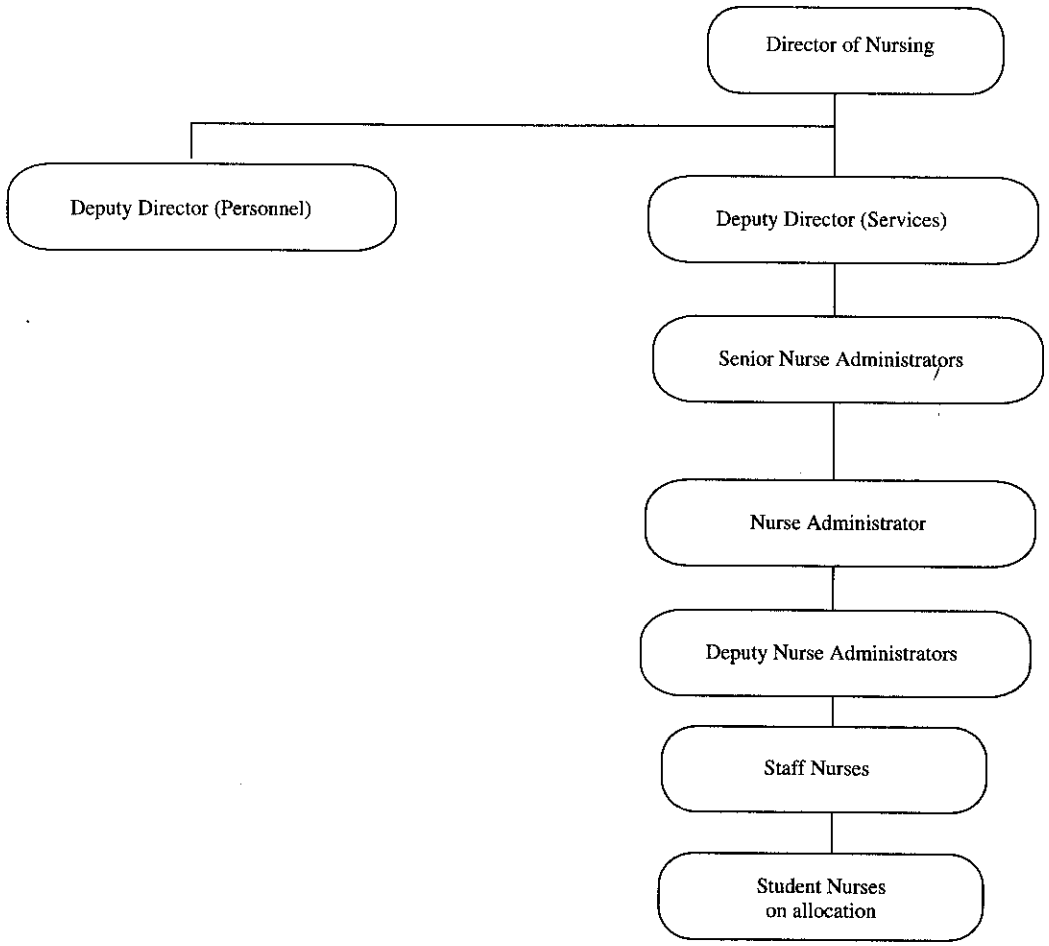
The Working Party set out a potential model for basic, middle and higher nursing management structures (see Figure 3.1). The structure was recommended in the context of a tripartite hospital management system, so that the administration of hospitals be shared by general, medical and nursing staff. The report did not make specific recommendations in relation to nursing management in obstetric or specialist hospitals. However, it suggested that the proposed structure should apply to any hospital regardless of size, type or bed complement. To facilitate this structure, the Working Party suggested that a number of new posts be introduced: that of, deputy director of nursing (personnel), deputy director of nursing (service), senior nurse administrators and nurse administrators. While recommending the establishment of new roles the specific role functions were not identified. In the proposed structure the position of ward sister appears to be replaced by that of nurse administrator. It appears that the recommended structures were not introduced in full and if they had, a long, layered chain of command would have resulted.

However by the late 1980's there were often as many as five to six layers of management in hospital nursing from; junior ward sister, ward sister, unit nursing officer, administrative sister, assistant matron/assistant director of nursing, deputy director of nursing to that of director of nursing/matron. In this highly centralised system, decisions for front-line action were often made at the point furthermost away from the issue. Such a complicated structure can lead to time delays, an overburdened top management and a decision maker who has lost touch with front-line practice.

[6] Verbal information supplied by the Personnel Department of the Irish Department of Health and Children, 16th October 1997.

The report suggested that senior nursing personnel should be relieved of direct responsibility relating to such matters as housekeeping services and staff residences except in the case of smaller hospitals. Some progress was made in larger hospitals who now employ separate functional officers to manage catering, laundry, supplies and staff residences. The Working Party made several recommendations on public health nursing management, which are set out in section 3.3 of this chapter.

FIGURE 3.1 Higher Management Structure *Working Party on General Nursing*



Source adapted from: **Department of Health (1980) *Working Party on General Nursing Report.* Dublin: Stationary Office.**

Major Policy Documents 1980's

In 1986, the Department of Health published a consultative document (the first in twenty years) on health policy: *Health the Wider Dimensions*. In the years preceding this publication, health policy had tended to emphasise curing, which resulted in a rapid development of the acute general hospital system and a significant reliance on high technology medicine. The objective of the health care system at the time was described as providing an efficient reparative service for damaged health rather than one which promotes positive health. The focus of nursing in the early 1980's was on hospital care and all nurse training took place in hospitals, preparing nurses to work primarily in hospital settings. This document suggested a redirection of the health services to bring

about a more appropriate balance between prevention, cure and care. Around this time, the Department of Health also published two documents *The Psychiatric Services: planning for the future* (1984) and *The Years Ahead: a policy for the elderly* (1988). On the basis of these reports, major efforts were made to develop both psychiatric and care for the elderly services in the community, close to where people live and work. This heralded a significant change in the health care environment in which nurses operate. Ultimately this change led to the phasing out of large institutions for psychiatric care as well as some inappropriate long term care of the elderly in acute general hospitals.

In *Health the Wider Dimensions,* the Department of Health recognises that given budgets, and complexity of the service provided, the average hospital is comparable to a sizeable commercial organisation. However, unlike commercial organisations the Department admitted that essential management structures and expertise in hospitals, have been largely neglected, including the management of nursing.

Commission on Health Funding

The report of the Commission on Health Funding, chaired by Hederman O'Brien, in 1989 commented that the Commission feels the poor quality of management in the health services is a problem that needs to be addressed urgently (Department of Health, 1989). The Commission recommended that priority should be given to the development of management training programmes. A crucial element of the proposed approach to the management of services is that all service providers, whether hospitals, homes, agencies or individuals, should have explicitly stated roles, objectives and service requirements. The *Commission on Health Funding* recommended that staff from all disciplines or professions should be entitled and encouraged to compete for management posts in any proposed structure. Hederman O'Brien states that "doctors, nurses, paramedics and others with administrative or managerial experience within and outside the health services can all bring different insights and experience to bear on the job of running services effectively and efficiently and the resultant cross-fertilisation can only benefit the overall management of the services" (p.172).

Without this recognition there is a danger that few nurses will hold general management roles and a large proportion of managers will be drawn from non-medical backgrounds resulting in nurses losing influence on management. The key source of the problem identified by the Commission was management rather than funding of the health services. The major deficits identified in the health care organisational structure were:

- it confuses political and executive functions, and therefore undermines both;
- it fails to achieve a proper balance between national and local decision making;
- the decision-making process does not provide a sufficient role for information and evaluation;
- accountability within the structure is inadequate; and
- there is insufficient integration of related services (Department of Health, 1989).

The Commission suggested dividing the funding and policy making functions of the Department by establishing Area Health Authorities with responsibility for both funding and policy making for the particular area. This change is in progress.

During 1987-1989 Ireland experienced an economic recession. Significant cut backs in services were implemented and value for money sought based on the recommendations of *The Commission on Health Funding* and the *Dublin Hospital Initiative* reports. The result was that many smaller hospitals were closed or amalgamated and nurse managers were left with little option but to let go long term temporary nurses with no facility to recognise their commitment and service. An embargo was placed on recruitment throughout the health service. This environment was particularly stressful for nurse managers as they were not permitted to fill nursing vacancies. This resulted in many nurses leaving Ireland for the Middle East, UK and USA. The three reports mentioned above describe the health environment in which nurses sought to fulfil a management role and highlight the major deficiencies which later reports aimed to rectify.

Medical Manpower in Acute Hospitals.

In 1993, a collaborative study group, chaired by Tierney, comprising nominees of the Department of Health, Comharile na n-Ospideal and the Postgraduate Medical and Dental Board examined medical manpower in acute hospitals. A discussion document was produced commonly called "The Tierney Report" *Medical Manpower in Acute Hospitals* (1993). The major recommendation of the group was the need for a definite change in hospital medical manpower policy to achieve a consultant-provided, as distinct from a consultant-led service for all patients (Tierney, 1993). To effect this aim, the group set a target to employ only one junior doctor per consultant in the health service by the year 2003. The proposed dramatic reduction in the number of junior doctors has major implications for nurses, particularly for nurses managing the delivery of the service. It is not inconceivable that nurses in the future may be asked to take on some of the work previously performed by doctors, as has happened in other countries, particularly in the USA. Nurse-managers must anticipate and plan for the changes in the work systems of the health service and take cognisance of the implications of these changes.

In March 1996, the discussions progressed when the Institute of Public Administration convened a consultative conference to discuss this report and to develop ideas on how to move forward to achieve patient-centred care in Irish hospitals (Joyce, 1996). One hundred and twenty medical consultants, hospital managers and policy makers participated in the deliberations. This report shows very limited evidence of nurse participation. Of the 120 participants two represented nursing, the Chief Executive Officer of An Bord Altranais and a board member. A significant outcome of the conference was "the consensus on the need for change, although full agreement was not reached on what precisely these changes should be" (P.4). A question rises about this consensus, given the lack of nurse representation.

In May 1998, the Minister for Health and Children announced the establishment of a forum on medical manpower to develop a programme of action to deliver changes necessary in the area. The Minister stated that new initiatives are required relating to training, career structure and service delivered by doctors. He instructed the forum to consider particularly, ways to create better careers for young doctors, to reduce the need for so many to emigrate after qualification, to improve post graduate medical training and to effect improvements in the delivery of medical care to patients.[7] Nursing does not appear to be represented in the membership of the Forum.

[7] Press release from the Department of Health and Children announcing a major initiative on medical manpower, 7th May 1998.

In all hospitals offering nurse training, the director of nursing /matron is accountable for both nursing services and nurse education. A collaborate review of nurse education and training facilitated by An Bord Altranais commenced in 1990 and reported in 1994: *The Future of Nurse Education and Training in Ireland.* A number of weaknesses which militate against a beneficial experience for student nurses were identified. These include lack a of preparedness for certain duties, a lack of clinical teaching, an emphasis on work rather than learning, and an involvement in non-nursing duties (An Bord Altranais, 1994). In relation to delivery of service, An Bord Altranais recommended that future students be given full student status and their dual status of employee and student be discontinued.

The traditional apprenticeship model of pre-registration nursing education and training has been replaced since 1994 by a new registration/diploma programme, radically altering both the system of education and the composition of the work force in major hospitals. The schools of nursing remain as distinct entities within the health service. The Department explicitly set out the role of the director of nursing/matron in the new programme, "the director of nursing / matron (head of the nursing service) retains overall responsibility for the School of Nursing which continues to be managed by a Principal Nurse Tutor who reports to the head of the nursing service."[8]

It is considered important that nurses responsible for the delivery of nursing care continue to have an input and close association with the education of future nurses. Nurse leaders believe that education could easily be divorced from practice if directors of nursing were no longer regarded as leaders of the clinical discipline in matters of education (Irish Matrons Association, submission to the Commission on Nursing, May 1997). The Department of Health concur with this when they state that "the director of nursing/matron and the principal nurse tutor should guide the development of the programme" (Department of Health, 1997, p.3).

In the new programme the director of nursing is responsible for the employment of three new grades of nurse "clinical-placement-co-ordinators," "nursing-support-staff-supervisor" (both at sister level) and "nursing-practice-development-co-ordinator" (at assistant-matron/assistant-director-of-nursing level). The role of the practice-development-co-ordinator is to develop nursing practice, implement a quality assurance programme, supervise the clinical-placement-co-ordinators and ensure that the clinical areas of the hospital to which students are assigned provide optimum teaching and learning environments. The clinical-placement-co-ordinators support the students and co-ordinate and assist the nurse tutors, ward sisters and staff nurses in relation to the students" clinical placements (Department of Health, 1997)

In the new model, where students are supernumerary in clinical areas, the principal nurse tutor plans clinical placements. However, the director of nursing takes direct responsibility for all matters relating to the clinical placements, including supervision of the students and the assessment by registered nurses of the students" clinical proficiency. The Department clearly states that the, "director of nursing/matron should carefully monitor and keep accurate records of the attendance of student nurses in the assigned clinical areas during their placements. It is the responsibility and duty of the head of the nursing service to ensure that the student nurses gain the maximum exposure to clinical practice and gain proficiency in clinical nursing skills" (Department of Health, 1997, p.12). It is

[8] Department of Health and Children (1997) Personnel Management Development Unit – Organisational Guidelines for Staff Relating to the General Nursing Registration/Diploma Programme.

clearly stipulated that the final decision on all matters relating to clinical placements lies with the head of the nursing service. While the changes remove the reliance by nurse managers on student nurses to provide a service contribution they pose many challenges to nurse managers (An Bord Altranais, 1994). This change dramatically alters the profile of the nursing team, from 50% students and 50% staff to a work force that will be composed of registered nurses and attendants/healthcare assistants (titles vary from hospital to hospital). The style of management needed to lead a team containing mixed staff competencies is different to that comprised of 50% learners and 50% registered nurses. This leads to potential skill mix problems never experienced before by Irish nurse managers.

There is a genuine fear amongst nurses related to the development of a two tier system of traditionally trained apprentice nurses and diploma nurses. Managers must be aware of the concerns of existing staff who may feel threatened by the new diploma nurses and fear for their own promotional opportunities. In spite of the changes, there is a continuing central role for the director of nursing/matron in the professional preparation of future nurses. Some nurse tutors argue whether or not it is appropriate, or possible for the head of the nursing services to maintain such a direct role in the programme (submissions to the Commission on Nursing from various nurse tutors).

Shaping a Healthier Future

In 1994 the Department of Health developed a Health Strategy: *Shaping a Healthier Future* on which to base the future direction of the health services. Both *Health – The Wider Dimensions* (1986) and the report of the *Commission on Health Funding* (1989) influenced the development of this strategy. The strategy calls for an improvement in and reshaping of the way in which services are planned and delivered, providing for more decision-making and accountability at regional level, together with the application of better methods of performance measurement. The strategy indicates a shift in the management of services to provide a more patient-centred, accountable and equitable service. The concepts of health and social gain underscore the strategy. The strategy recognised that "the service will stand or fall on the contribution of the staff who provide it" (Department of Health, 1994, p.40). Nursing is a major force within the health-care delivery team. The Health Strategy outlined proposals for resolving major flaws in the health care system: a number of which relate to nurse management:

- The current recruitment procedures and management development and training programmes will be urgently reviewed to produce a strategy for developing the required management capacity over the next decade.
- The Department recognises that in addition to strengthening general management, specific initiatives are necessary in relation to the involvement of the medical, nursing and other professions in management (Department of Health, 1994, p.41).

The Health Strategy makes clear the responsibility of consultant doctors in relation to health service management and particularly in relation to clinical directorates. While the role of the nurse is mentioned, there is not the same level of detail expressed in relation to the contribution nurses may make to management (Department of Health, 1994).

The Health Strategy confirmed the change first signalled in *Health the Wider Dimension.* Unlike neighbouring countries, the focus is on co-operation rather than competition as a means of mobilising the health care system. While the Minister for Health will continue to have ultimate accountability to the Oireachtas for all health services, the strategy stated

that the Department will no longer be involved in the detailed management of services. These changes are gradually being implemented, although to date significant progress has only been made in one health board. The Eastern Health Board is to be replaced by a new Eastern Regional Health Authority which will be responsible for funding all health and personal social services, both statutory and voluntary in Counties Dublin, Kildare and Wicklow (the new changes have been outlined for all staff members in a letter from, the Chief Executive Officer, Eastern Health Board). Issues such as service levels, staffing and funding will no longer be negotiated directly with the Department of Health by chief executives and directors of nursing in non health board hospitals. Instead they will negotiate with the Regional Health Authority.

Health Amendment Act 1996

The legal framework to support the redirection of the Department of Health is set out in *The Health (Amendment) (No3) Act, 1996.* The Act requires all health boards to adhere to an agreed service plan for each financial year, and transfers to the health boards the responsibility for funding of voluntary agencies. The creation of Area Health Authorities will remove the Department from day-to-day involvement with individual voluntary agencies other than in relation to matters of national policy. The challenge for nurse managers is to ensure that they have a voice in this new structure.

Management Development Strategy for the Health and Personal Social Services.

The Department of Health has acknowledged that the essential management structure and expertise in hospitals have, by and large, been neglected. An important reason for these deficiencies has undoubtedly been the lack of any emphasis on management training (Department of Health, 1986). To address this deficiency *The Management Development Strategy for the Health and Personal Social Services* was launched in December 1996. The aim of the strategy is to strengthen management capacity throughout the health services, leading to better managed services and ultimately, improvements in health care and in the health of the population. It contains over fifty recommendations in such areas as: recruitment; selection and initial training; performance measurement; developing managerial effectiveness; continuing development; career development and health services management education. The strategy raises issues which directly affect the development of nurse managers, and contends that there is a need for:

- a clear job description which reflects new roles and duties;
- each new manager to have a development plan;
- systematic support to help individuals to assume and identify with a managerial role;
- recognition that the aspirations and commitment of many health service staff are not being harnessed by the organisation for which they work;
- acknowledgement that little progress has been made in providing equal opportunities for women in health services;
- planning management development programmes, the starting point being the identification of development needs;
- managers to have a considerable input into planning and taking forward their own development;
- a greater variety of development methods to be explored including mentoring, development centres, competence-based learning, flexible use of learning materials, etc. and
- the establishment of a fast track register of potential high flyers (Department of Health, 1989).

When reviewing the wide range of programmes offering management education to members of the health services, the steering group for the management strategy, found that most provisions were classroom-based and provided instruction in management principles and techniques. Comparatively little evidence was found of attempts either by education providers or health service managers to turn this knowledge into effective management. The strategy presents a new model of management development which integrates personal and organisational objectives (Dixon and Baker, 1997). The model demonstrates how management development can occupy the middle ground where organisational and individual development overlap. The emphasis placed on management development in preference to isolated theoretical management courses in the strategy is welcomed.

In 1997, a new Office for Health Management was established by the Minister for Health and Children the purpose of which was to facilitate management development within the health services in Ireland and to execute the objectives of the management strategy. The Office for Health Management has demonstrated a specific commitment to management development and leadership for nurses. Already this year, the Office has arranged Master Classes for senior nurse managers, naming the series *Effective Nurse Leadership: making a difference.* The office has also launched a leadership development programme for young nurses (Office for Health Management, 1997).

In April 1998, the Office for Health Management and the Irish Nurses Organisation came together at the invitation of the Department of Health and Children to co-fund four new programmes for leadership development in nursing. It is anticipated that these new innovative programmes will greatly enhance the capacity of nurse managers to develop the leadership skills and competencies needed to enable them to successfully meet the challenges emerging in an ever changing health care environment. The programmes are as follows: *Managing and Leading Nursing Programme*, provided by the King's Fund, London – designed for nurse managers from medium sized hospitals; *Action Learning Programme*, provided by the University of Limerick – designed for nurse managers from smaller hospitals; *Changing from within Programme*, provided by the Centre for Development of Nursing Policy and Practice at University of Leeds – a pilot staff management development programme for all nursing staff at Longford/Westmeath General Hospital, Mullingar; and *Public Health Nursing Leadership Programme*, provided by the Royal College of Nursing, UK – designed to develop the leadership skills of a cohort of Superintendent and Senior Public Health Nurses in two neighbouring Health Boards (Doherty, 1998).

Continuing Professional Education for Nurses in Ireland: a Framework

In 1995, An Bord Altranais established a continuing education committee to examine and make recommendations in relation to the continuing education needs of the profession. The work resulted in the publication in 1997 of a framework document for *Continuing Professional Education for Nurses in Ireland* (An Bord Altranais, 1997). In the preparation of the report, An Bord Altranais invited the Institute of Public Administration (IPA) to, "provide a researched report on the continuing education needs of nurses in the health services based on the views of managers (nursing, medical and administrative) and nurses from the various divisions of the register" (p. 43).

Information was collected from multiple data sources – interviews, workshops and documentation. One hundred and fifty-nine of the 360 nurses selected (44%) for the

sample participated in twelve workshops. Semi-structured interviews (40) were conducted with a range of managers in the health services. The key issues identified were:

- changes in nursing practice over the next three to five years;
- most important areas in which nurses require further education;
- priorities within these areas;
- accreditation of continuing education;
- role of the employer in continuing education;
- funding and support;
- access to continuing education; and
- mandatory or voluntary continuing education (An Bord Altranais, 1997, p.49).

It is interesting to note that the management role of nurses was not often explicitly raised as a high-priority issue. It tended to be much more strongly stressed in the interviews with nurse-managers. It was suggested that nurse-managers must not lose sight of nursing in the general management sphere and that the experience and knowledge of nurse managers must be used to ensure a quality service while retaining the role of manager of all nursing staff. Nurses at the group workshops argued that it is important for nurses to know the routes along which they could specialise. The need for a clear pathway and adequate career structure in nursing was emphasised (An Bórd Altranais, 1997). The continuing professional education committee considered the findings of the IPA's research when making their recommendations.

The report presents thirteen recommendations for future developments, two of which specifically relate to management:

- employers need to ensure that appropriate systems, such as career advice, staff appraisal and clinical supervision, are in place to offer advice and support to the newly registered nurse.
- appropriate management courses be provided to meet the needs of nurses functioning at all levels of administration and those nurses who wish to remain in clinical areas (An Bord Altranais, 1997, p.28).

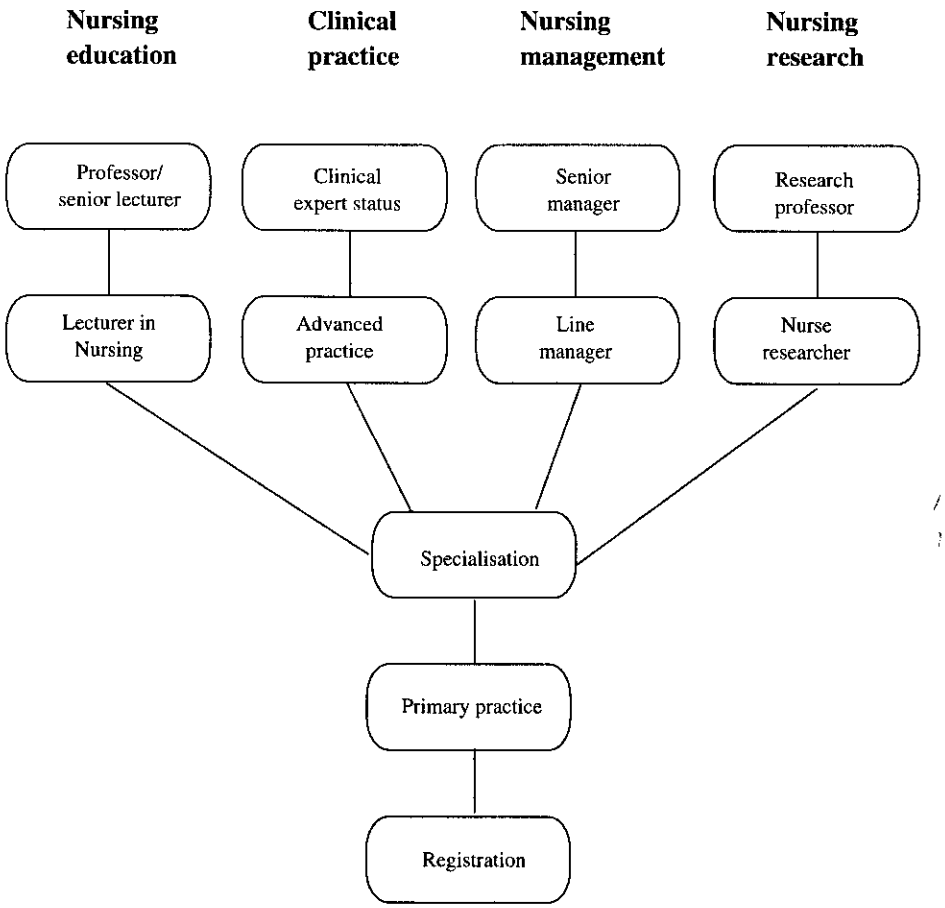
Nurse-managers have an essential role in the appropriate and sensitive introduction of suggested new systems for staff appraisal and clinical supervision. Prior to the introduction of any new system, it is essential that nurse-managers receive appropriate training which should from part of the management courses which the report recommends.

The report presents possible multi-stage professional pathways for nursing career development in four areas; clinical nursing, management, education and research (see Figure 3.2). A career structure of nurses in management is presented from specialisation, to first-line manager to senior manager. Specific details of the roles envisaged are not given and require further exploration. Historically, the main routes for promotion in nursing in Ireland have involved a move to education or management. The framework suggested also recognises the need for a career path in clinical nursing and research.

The unstructured proliferation of clinical nurse specialists in recent years, in response to the demand for nurses to equip themselves with new skills and knowledge to cope with changes in service needs, has caused confusion in relation to specialist practice. This has significantly increased the complexity of the nurse management role. The framework presented could possibly be used to bring clarity to the debate in relation to specialist

and advanced practice. How the career ladders in clinical nursing and research might be introduced and maintained in nursing presents a challenge for nurse managers.

FIGURE 3.2 Possible Professional Pathways - an overview, *An Bord Altranais.*



***Source:* An Bord Altranais (1997) *Continuing Professional Education: a framework.* Dublin: An Bord Altranais, p. 26.**

Statement of Strategy

The *Statement of Strategy* for the Department of Health, launched in 1997 is part of the continuing process first mapped out in *Shaping a Healthier Future*. The statement sets out in a precise manner the mission, role and objectives of the Department of Health and Children. The key goals for the Department are clearly listed. Four of the elements listed under personnel management and development goals are specifically related to nursing management. These are to:

- support the work of the Nursing Commission and lead the ensuing implementation programme;
- develop manpower planning criteria appropriate for nursing;
- persue the implementation of the management development strategy in conjunction with the Office for Health Management.....to allow for a greater degree of management decision making by professionals in the health services;
- review the legislation in respect of nursing and medical practitioners (Department of Health, 1997).

The explicit statement in relation to the implementation of the recommendations of the Commission on Nursing is particularly pertinent to nurse managers. Nurse managers have long debated and lobbied for criteria and national standards in relation to staffing numbers and skill mix. The strategy makes a welcome commitment to developing manpower planning criteria in nursing. A return to the review of the nurses Act 1985, suggested in the document, would greatly assist nurse managers in the organisation and delivery of the nursing service. When considering the issue of internal reorganisation the Department makes a commitment to strengthen certain aspects of professional support including nursing and paramedical areas.

Working for Health and Well-being – Strategy Statement 1998-2001

Working for Health and Well-being – Strategy Statement 1998-2001, is an elaboration of the 1997, Statement of Strategy, and builds on the process started in 1994 with the Health Strategy. The statement is intended to be more specific in relation to outcomes, than the earlier 1997 statement. The document sets out key tasks facing the Department particularly in the areas of: services for children; food safety; services for persons with a mental handicap; services for older people; cardiovascular disease, cancer and accidents; abortion; structural and administrative reform in the health services; and safety of blood products. The influence of the external environment and the Department's role in responding to the health needs of the nation are addressed in detail. While not explicitly discussed, nursing and the management of the nursing services will have a major contribution to make in achieving the goals set out in the strategy statement. A detailed outline of objectives set for each division of the Department are presented. The Personnel Management and Development Unit of the Department has further developed the 1997 objectives and set specific targets in relation to nursing. These are: to support the work of the Commission on Nursing and lead the ensuing implementation programme; develop manpower planning criteria appropriate for nursing; and ensure the ongoing development of nursing education and training (Department of Health, 1998).

3.3 The Current Role of Nurse Managers in Ireland

This literature search revealed that very little information is available on the current role of Irish nurse managers. The reasons for the paucity of information are unclear, it could be that: due to excessive service commitments, nurse-managers do not have time to write; nurse managers may not have had the opportunity to reflect on the nature of their work in order to communicate it to others; the subject may not be given adequate attention by health-care researchers and so is not perceived as sufficiently important to attract research funds; it may be that nurse managers do not have a sufficient understanding of research methodologies, to allow them to study the role; or it could also be due to the fact that Irish nurses are unaware of the opportunities to publish their work. A significant factor is also the lack of a major Irish research based management journal.

In 1993, a hallmark document was published by the Irish Matrons Association (new title Association of Irish Nurse Managers) setting out their vision for the future of nursing management. In acknowledging the tremendous changes in the health services and nursing, the Irish Matrons Association make explicit the contribution of nurses to management in the publication of their strategy document. The strategy proposes changes in relation to the function of senior nurse-managers. The way ahead which they envisaged

embodies five main stands relating to; the management of nursing, management of nursing practice, personnel management, information systems, and financial management (see Appendix 4).

When considering the potential changes in health care management the Irish Matrons Association make an explicit statement on the role of the nurse in future management structures:

> We believe that nursing as a professional discipline is best managed by managers with a background in nursing and consider that, irrespective of any changes which may take place in the management of the health services, accountability for all aspects of the management and professional practice of nursing in each hospital must be held by the Senior Nurse Manager (Irish Matrons Association, 1993, p.4).

The strategies explain the responsibilities held by senior nurse managers and the reactions that are required by: the Department of Health; the Irish Matrons' Association; hospital managers and senior nurse-managers to ensure that the role of the senior nurse manager evolves in tandem with that of other senior health service managers. While the document was discussed with the Department of Health, it appears that little has changed with the exception of the appointment of a Chief Nurse at Department level.

To assist the Commission on Nursing in their work, the Department of Health and Children prepared a document "Nursing in Ireland Background Information." This document gives an overview of the Department of Health and Children and its involvement with nursing in Ireland. Included in the document is a census of the nursing staff employed in agencies directly funded by the Department for 1995 (updated figures for 1996 have been supplied to the Commission by the Department). The census presents a simple listing of the numbers of nurses employed by title and gender. From the census, the author identified twenty-one line management positions in nursing. For the purposes of this review the census figures have been regrouped by the author. The groupings generated are senior nurse manager, middle nurse manager and first-line nurse manager. The selection of the groupings is for illustrative purposes only. This exercise was conducted in an effort to differentiate where the various nurse management roles may lie, it is not intended to be comprehensive and does not cover all possibilities (see Table 2.3).

The review suggests that the management of nursing functions at three levels in Ireland; first, second and highest level management. First level management involves; the operational management of nurses and nursing at unit/ward level, ensuring the efficient delivery of day-to-day patient care. Second level management (middle management) involves administrative management of nurses and nursing across services in a geographical or divisional area. The highest level of management involves total responsibility for all matters relating to nursing and allied services in an organisation.

The Department reports a total of 27,250 nurses working directly in the publicly funded health service. Of this number 4,706 (17.27%) are employed in management positions. Traditionally the structure for nursing has been described as pyramidal but when the figures are examined in detail a cenotaph gives a more realistic presentation of the current situation. Nursing management in Ireland has a broad base which rises sharply to a peak. Considering this structure it is not surprising to find that of the total population of nurses only 0.86% of nurses are employed at the most senior level, 2.03% in middle management, 14.21% in first-line management and 0.15% in educational management. Of the total

group identified as nurse managers, 82.32% are first-line mangers, 11.8% middle managers, 5% senior managers and 0.85% are employed in educational management.

When divided by gender 675 (19.83%) of the total nurses employed in management are male. When compared with the total number of male nurses registered with An Bord Altranais in 1997, 3,686/53,641 (6.78%) the figures present a disproportionally large representation of male nurses in management. It is interesting to separate the figures for males and females in each management category: 42 (17.9%) of the senior managers are male; 110 (19.84%) are employed in middle management, 508 (13.11%) are involved in first-line management and 14 (35.0%) are in educational management (see Table 3.2).

TABLE 3.2. Numbers of Nurses Employed in Various Management Roles

Title	Female	Male	Subtotal	% Total
Senior Management				
Director of Nursing/Matron	161.00	13.00	174.00	
Chief Nursing Officer (Psych)	4.00	29.40	33.40	
Superintendent Public Health Nurse	29.00	—	29.00	236.40 (0.86%)
Middle Management				
Deputy Matron	11.50	—	11.50	
Assistant Chief Nursing Officer (Psych)	37.95	81.23	119.18	
Assistant Director of Nursing/Assistant Matron	141.26	12.00	153.26	
Unit Nursing Officer	79.27	9.00	88.27	
Night Superintendent	81.50	7.00	88.50	
Theatre Superintendent	14.00	—	14.00	
Supervisor-Welfare Home	13.67	—	13.67	
Senior Public Health Nurse	66.00	1.00	67.00	555.38 (2.03%)
First line Management				
Ward Sister	1,171.00	24.00	1,195.00	
Nursing Officer (Psych)	252.33	232.00	484.33	
Public Health Nurse	1,305.10	—	1,305.10	
Theatre Sister	128.60	72.00	200.60	
Night Sister	88.50	2.00	90.50	
Junior Ward Sister	225.00	4.00	229.00	
Deputy Nursing Officer	186.50	174.00	360.50	
Assistant Supervisor – Welfare Home	9.00	—	9.00	3,874.03 (14.21%)
Educational Management				
Principle Tutor	24.00	10.00	34.00	
Principle Tutor II (Psych)	2.00	4.00	6.00	40.00 (0.15%)
TOTALS	2,726.08	674.63	3,400.70	(12.47%)

N – for all nurses = 27,249.86 (N – for nurse managers = 4,705.81)

Groupings constructed by the author for illustrative purposes only.

Source: **Health Service Census, December 1996 – figures supplied by the Department of Health to the Commission on Nursing (7th October 1997). The figure excludes nursing staff working in: agencies, private hospitals, nursing homes, private sector or employed by general practitioners.**

Senior Nurse Managers

Currently there are three grades designated as senior nurse managers. They are known as: matron/director of nursing (DON); chief nursing officer (psychiatry) (CNO); and superintendent public health nurse (SPHN). Under the recent pay deal, the current

grading and salary scales are set out in what is commonly called the "Blue Book". There are five bands allocated to the grade of director of nursing/matron. These range from matron of a small district hospital/welfare home to the matron of a large training hospital with responsibility for over 200 nursing staff. The banding is based on type of hospital, activity level, whether the hospital is a centre for pre-registration nurse training or not, the number of nursing staff and the presence of an accident and emergency department. For the first time in Ireland discussions are taking place in relation to performance related pay for senior nurse managers. In the case of the band one directors of nursing/matrons, an agreement is being sought by the Department of Health and Children for the introduction of performance pay (up to a maximum of £2,500) conditional on agreement to a new job description and the discontinuation of premium payments/allowances. The "Blue Book" presents the numbers employed in each band and the top of the salary scale of each – which have six increment points as follows:

Band 1 – 11 posts	20,000 patients per annum, over 200 nurses, and pre-registration nurse education.
Band 2 – 19 posts	10,000 patients per annum, over 100 nursing staff.
Band 3 – 31 posts	over 1,000 in-patients per annum.
Band 4 – 42 posts	budget in excess of £ 1,000,000.
Band 5 – 39 posts	

Band 1 – £35,000	DON			
Band 2 – £33,000		CNO		
Band 3 – £29,500			SPHN	
Band 4 – £28,776				Matron(non-acute)
Band 5 – £25,668				

A very small number 11(7.74%) of the post holders are employed in band one. The superintendent public health nurse (not included in the numbers above) is graded as a band three director of nurse/matron. The chief nursing officer has a separate pay scale the top of which falls between the director of nursing/matrons on bands one and two.

Director of Nursing/Matron (acute hospital)

In the Irish health care system the post of the most senior nurse manager is given the title "Directors of Nursing," "Matron" or "Chief Nursing Officer." The post holders are generally recruited through the Local Government Appointments Commission (LAC) for health board hospitals, or directly through the Voluntary Hospital system.[9] As previously stated little has been written on the role and function of the director of nursing/matron in Ireland. The current and future role of directors of nursing has recently been described by McCarthy (1997b). The role is seen as: transactional, focused on the here and now, reacting and solving problems very often at the lowest level. The future role envisaged sets out responsibilities related to strategic planning, leadership, policy formulation and quality management.

A recently published job description for the role of the director of nursing gives an insight into the current role. The director of nursing was stated as being accountable for the delivery of an efficient, effective, caring, patient focused nursing service and the management development and direction of the school of nursing (Department of Health

[9] Voluntary hospitals includes the 3 hospitals termed "corporate bodies."

and Children, 1997 – job description for matron/director of nursing). The key responsibilities for the position are described in relation to:

- providing strategic leadership;
- developing, review & maintain a total nursing service organisational structure;
- setting objectives and develop policies;
- direction and co-ordination of schools of nursing/midwifery;
- developing a staff training and development strategy;
- participating in the overall financial planning of the hospital;
- undertaking budget holder responsibility as designated by the General Manager;
- developing, monitoring and reviewing appraisal procedures;
- fostering a high level of morale;
- formulating relevant personnel policies;
- advising and inform the General Manager;
- maintaining a safe environment;
- maintaining good public relations; and
- keeping up to date with nursing literature.

Matrons/Director of Nursing (non-acute hospitals)

Non-acute hospitals in this group may include: county, community, district or welfare hospitals. Many involve long-term care for the older person. In these hospitals the matron (band 4/5) has a much broader remit than that of the matron in the large acute hospitals. There is often only a single nurse manager who in fact is also the general manager for the unit, involving direct management of day-to-day operations. The responsibilities include: planning all staffing levels and functions; directing nursing work, even at the lowest level; controlling the allotted budget; development and upkeep of the work-place and accounting for stock (McCarthy, 1997). Although less specialised than the director of nursing in acute hospitals the role of the matron in non-acute hospitals often involves twenty four hour responsibility for the service, often without the backup and support of a deputy, assistant or secretarial staff.

Nurse Middle Management

Some hospitals have established clear divisions based on the provision of patient services and on medical casemix and/or intensity of work. Within these, nurse managers are called:

- Assistant Director of Nursing
- Assistant Matron
- Assistant Chief Nursing Officer
- Unit/Divisional Nurse Manager
- Directorate Nurse Manager
- Unit Nursing Officer
- Superintendents
- Administration Sisters

McCarthy (1997) comments that methods of recruitment, job descriptions and role functions vary considerably among this group. Some of the managers have developed a work role in just one area: for example, bed management or staff scheduling. These middle management roles are generally more administrative than managerial, often resulting in confusion for staff related to who has the ultimate responsibility for decision making in areas such as; working arrangements, skill mix, educational requirements or career plans. In many structures, all requests ultimately appear to be referred up to the director of nursing with middle managers acting merely as gatekeepers. However, of note are some recent innovations in hospital management structures, for example the introduction of clinical directorates or service management models. These structures introduced new clearer roles for nurses in middle management e.g. divisional nurse management roles. In these systems, it is suggested that the nurse manager has direct managerial responsibility, authority and accountability for all nurses in a designated area. However, the success of such devolution of responsibility appears to be related to the ability of the middle manager to manage and make autonomous decisions and the ability of the most senior nurse manager to "let go" functions previously personally undertaken. Browne (1997) described the role of unit nursing officer/service manager, in new units of management in acute hospital care and O'Shea (1995) outlines the role of the nurse-manager when describing the introduction of clinical directorates at a large hospital (discussed in greater detail in section 3.5 of this chapter). Despite the introduction of new roles, there is a lack of publications on; responsibilities held, perceptions of the role, implementation and success. There is however a body of knowledge to substantiate the belief that much has changed over last five or so years for middle managers. A very recent development for middle managers is the establishment of a new organisation called the Irish Nurse Managers Network (INMW). This group intends to represent the interests of nurses who are senior to ward sister but are junior to directors of nursing. The network aims to provide mutual support on a wide range of issues (The Irish Times, October 23rd, 1997).

First-Line Managers

Nurses were traditionally promoted to first-line management positions (ward sister/nursing officer (psychiatry) because of clinical expertise or seniority which could not be recognised in any other way. In more recent times appointments have been made on the basis of managerial competencies and appropriate experience. There are large variances in the levels of responsibility autonomy and decision making given to first-line managers across hospitals in Ireland. This varies from the highly centralised system where the function of the ward sister is purely operational with little decision making authority to (in a very few sites) decentralised systems where the sister has direct responsibility for; service plans, resource management, recruitment and pay/non-pay budget. A recent economic review of the Irish Health services found that:

> the management of the hospital system seems to be unduly centralised and bureaucratic. Budgets for individual hospitals take into account the actual outputs of hospitals only to a limited extent and are generally based on historical spending. Moreover, in a hospital it is rare for budget responsibility to be devolved to operating units (OECD, 1997, p.141).

This analysis suggests that future emphasis will be placed on budget responsibility at unit or ward level. As McCarthy (1997) highlights, a good clinician is not always a good manager. She contends that the role change from provider-of-care to manager is a difficult

transition for many nurses, who can be caught between the expectations of patients, care-givers and managers. Further, it is stated that bi-directional accountability is required to ensure safe and effective care of patients, assignment of work and implementation of policies. It may be that ward sisters recruited in the past may not always be willing to take on the challenge offered. These relate to: the estimation of work to be done; staffing and skill mix; recruitment; nursing practice development; quality assurance; budgeting and service planning for wards and units (McCarthy, 1997).

In a recent study examining the management and professional aspects of the ward sister's role, the present system for ward management is likened to that of an hour glass, with the ward sister in the middle and all information flowing in and out of the ward through her (Maher, 1996). It is acknowledged that this places the ward sister in a powerful position. How the sister decides to use the power/authority/responsibility governs the ethos of the ward.

When preparing for a larger study, analysing the continuing education and training needs of ward sisters, Howley (1997) formed ward sister focus groups. During the discussions, the groups were asked to identify the responsibilities of the ward sister. This resulted in a comprehensive list of functions for the post compiled by practising ward sisters. The reported responsibilities included: (the groupings are constructed by the current author – not the original researcher)

Management responsibilities:
human resources; patient care; physical resources; duty rosters; delegation of work; setting standards; policies; planning/evaluating care and budgeting /cost effectiveness.

Education responsibilities:
patient education; in-service; teaching and assessment.

Staff development responsibilities:
counselling; caring for staff; motivation of staff, health and safety.

Communication responsibilities:
liaison; staff meetings; orientation of doctors; managing change; dealing with conflict and dealing with patient complaints (Howley, 1997, p. 97).

In it's submission to the Commission on Nursing, the Department of Health and Children reported that the ward sister and nursing officer grades represent the first-line management in nursing and related services. The Department suggests the role has traditionally been multi-faceted involving both administrative/managerial tasks and clinical leadership input. The issue of motivational forces attracting nurses to ward sister/nursing officer posts, the relative importance into the future, of leadership and managerial skills and clinical expertise, the distinction between management and delivery of nursing care and the role of the ward sister/manager in the context of the enhancement of specialist skills in the staff nurse grade are areas which the department wishes to see researched. The few studies (unpublished dissertations), of first-line nurse managers that could be personally sourced, are included in the review. It is interesting to note the paucity of Irish research of first-line nurses managers despite the fact that a wide range of material has been published in the UK on this subject (see Chapter 4).

New Management Structures (pilot projects)

Since 1994, the Department of Health has initiated several pilot studies exploring alternatives for the optimal management of large general hospitals. One of the objectives of these projects is to secure a closer association between the clinicians involved in the delivery of care and the overall budget and resources available for that service. The Department of Health supplied a listing to the Commission on Nursing of the various sites where pilot projects are in operation. As the projects are still at pilot stage and have not been fully evaluated, (with the exception of Beaumont hospital, where the pilot is complete), very little written information is available. All projects are at various stages of development, some in the early planning phase. The Commission on Nursing wrote to the director of nursing/matron at each hospital to obtain her/his views in relation to the changing management structures within the hospital. The author has used the responses from each hospital to construct a comparative table of the nursing structure in the pilot projects (see Appendix 5). The information is limited and based on personal responses at individual sites and as such it is not possible to draw conclusions from the information.

Although each project appears quite different, the responses suggest the nursing involvement in the proposed structures has taken two general directions; that of clinical directorates, or services management models. It is interesting to note that the Department of Health and Children described all but one of the new projects as following the clinical/ directorate model. The principle of decentralisation underpins both systems, the focus for the role of the director of nursing has been redefined and moved from operational-management towards strategic management. The major change appears to be in the role of the nurse across services in middle management, a position which has been very underdeveloped in the past. The middle management position is seen as central to the success of the pilot projects examining potential management structures (see Appendix 5). Although many of the new projects are based on devolvement of budgets to the first-line-managers, there was no evidence of significant developments in the ward sister's role.

The implementation of the clinical directorate model of management in the pilot sites involved the appointment of a clinical director with ultimate responsibility for the management of the services provided in the clinical area involved. In all cases, the director of the clinical directorate is a medical practitioner with complete autonomy and responsibility for the budget. A business manager and nurse manager generally work with the director. The nurse manager has responsibility for all issues relating to nursing including the allocated nursing budget.

In the hospitals that choose a system of general management, services are divided into speciality areas, the medical personnel work closely with nurse-managers within the speciality team. Unit nursing officers/service managers (UNO/SM) are appointed to manage, facilitate and co-ordinate the speciality services. Browne (1997) describes the objective for introducing a general management structure as "allowing services to be managed at speciality level, by the key players and clinicians, in terms of budgets, autonomy and discretion" (p.17). He describes the role of unit nursing officers/service manager (UNO/SM) as a key one. While reporting directly to the director of nursing , the UNO/SMs provide services equally to three principal interests – director of nursing, speciality consultants and general management. Browne contends that the emphasis on services to be provided as distinct from formal reporting relationships is crucial. The nurse involved in middle management in this system has responsibility for a broader range of services encompassing more areas than nursing. He/she is required to manage nurses,

nursing and the service provided. The pilot projects appear to be at different levels of development where some general services nurse managers have complete budget responsibility, while others have not yet taken on the full role.

A comprehensive evaluation of the various new initiatives in general hospital management structures must be conducted to establish outcomes in relation to quality of patient care and effects on nursing services.

Management of Nursing in Psychiatry

A detailed examination of the role of the nurse in managing the psychiatric health services in Ireland is beyond the scope of the current review. However, management structures in psychiatric hospitals appear to be somewhat similar to that of general hospital's and much of the general discussion in this work relates equally to management of nursing in general or psychiatric hospitals. In this section, a brief overview of developments in psychiatric nurse management roles is presented.

History of Psychiatric Nurse Management

Robins (1960) traces the development of the psychiatric services in Ireland from the Brehon laws to the 1960's. He gives a very detailed account of the calibre of staff employed to care for the mentally ill in the 1800s. Initially male attendants were called "keepers" and the female attendants, despite their lack of training were known as nurses. The keepers were responsible for the personal care of the male patients and the nurses looked after the female patients. By the end of the century all staff were known as attendants and their function was mainly custodial. During this time it became accepted practice to keep male and female patients apart. Separate institutions for the care of male and female patients were developed.

The first psychiatric nurse was registered in Ireland in 1921 (Department of Health, 1992). In the early 20th century a head male nurse managed the psychiatric service in the male hospital. He was assisted by a deputy head nurse and a night superintendent (head night nurse). Charge nurses and deputy charge nurses managed the services on male units. In the female hospitals the nursing service was managed by a matron, deputy matron, and night superintendent (head night nurse). Ward sisters and deputy ward sisters managed the female wards.[10] In 1968 the first steps were taken to develop a unitary nursing administration with one nurse in overall charge of male and female services. In the late 1970's a new nursing structure was introduced for the psychiatric services, with the establishment of the posts of; chief nursing officer (CNO) and assistant chief nursing officer (ACNO). In 1976 a joint management / union working group was established to conduct an examination of the grades of CNO and ACNO. This group produced an agreed document describing the roles, duties and responsibilities for the grades. Over time the posts of head male nurse and matron were replaced by CNO's and deputy positions by ACNO's. Ward sisters and charge nurses both now use the title nursing officer.

In 1982, discussions commenced between the Department of Health, individual Health Boards and the Local Government Staffs Negotiating Board (LGSNB) about promotion in the psychiatric services. The discussions became known as the Psychiatric Nurses Forum. Up to this time a system of promotion on the basis of seniority operated. A directive from the EEC required Ireland to amend the Employment Equality Act, 1977. The effect of the amendment was that it was no longer possible to classify posts as being male or female, or to prevent any members of staff seeking promotion in particular posts

[10] Verbal report of the services supplied by Mr. Dick Bennett, Chief Nursing Officer, Eastern Health Board.

because of their sex or marital status. The implementation of the directive required a change in the practices for dealing with promotion in the psychiatric nursing services, a matter, which the forum considered in detail. Following intensive discussion this finally resulted in an agreement in 1986 on the following issues: open recruitment; selection procedures; qualification and experience requirements for promotion; composition of interview boards; marking systems; acting up procedures; pre-interview preparation for candidates; notification of interview results; and a limited compensation scheme (for those, in an acting up capacity, who (on the date of the agreement) would have had an expectation of being promoted, but were unsuccessful at competition for a post) (Nurses Forum, 1986).

Reports Relating to Psychiatric Nursing

In the 1970's the psychiatric hospital was the focal point for the psychiatric services. In Ireland large numbers of patients resided permanently in hospitals. These hospitals were designed to isolate the mentally ill from society. In 1983 there were 11,906 patients in health board psychiatric hospitals and units (Trant, 1984). A very significant change in the hospital-based service was first suggested in the report *Psychiatric Services- Planning for the Future*, published in 1984. The report was prepared by a specially appointed study group. It contained a detailed analysis of the psychiatric service at the time and provided guidelines for the development of services. The focus of the report was on shifting resources from institutional to community services. The service envisaged was to be comprehensive, community oriented, sectorised and integrated. It was suggested that services should be delivered to a target population within a geographic boundary, by a multi-disciplinary team.

Chapter 14, of the report made eleven specific recommendations in relation to the organisation and management of the services (Trant, 1984). Rather than separate hospital and community psychiatric nurses, the report recommended that psychiatric nurses work in any component of a comprehensive psychiatric service. It was suggested that nurses have the opportunity to work in a hospital or community setting or rotate between both. The report recommended that a multidisciplinary Catchment Area Management Committee be set up in each health board. Chief nursing officers and sector nursing representative were included in the multidisciplinary management team. It was envisaged that the committee would be responsible for both community and in-patient psychiatric services. The report recommended that the day-to-day management of the psychiatric hospitals should be the responsibility of a small management team in each hospital composed of chief psychiatrist, senior administrator and chief nursing officer. The implementation of many of the suggested changes has radically altered the psychiatric services in Ireland. As a result of the re-orientation in policy, the psychiatric nursing role was extended to many new locations. This has dramatically altered the management role of senior psychiatric nurses. The current job description for the chief nursing officer describes the position as follows:

> The chief nursing officer is responsible for the delivery of an efficient psychiatric nursing service right throughout the catchment area: in hospitals, in hostels, in day centres and in the community. He/she would be mainly concerned with policy matters, with the co-ordination of activities, with ensuring that all staff in the structure are facilitated and trained to carry out their proper functions, and with seeing that these functions are efficiently conducted. The chief nursing officer should also take a strong positive interest in staff development in all its aspects.[11]

[11] Job Description for Chief Nursing Officer supplied by the Department of Health and Children, 23rd October 1997.

Priorities for development of the psychiatric services are explicitly set out in the Department of Health's documents *Shaping a Healthier Future, The Green Paper on Mental Health* and the *White Paper on Mental Health* (Department of Health, 1994), (Department of Health, 1992) and (Department of Health, 1995) respectively. It is anticipated that the new Mental Health Act will give greater protection to the civil rights of the small number of people with mental illness who have to be detained for treatment. The Department of Health have made a commitment to improve services to meet the special needs of particular target groups, such as the elderly mentally ill, persons with a mental handicap in psychiatric hospitals and children and adolescents with psychiatric problems.

Psychiatric nurse managers have been at the forefront of the developments of the services which include; sectorisation, introduction of day hospitals and day centres, de-institutionalisation of services in the parent hospitals, integration of services in other hospitals, and the acceleration of the provision of group homes and hostels in the community. Recognising the impact of the changes on the managers' role, the Association of Administrative Psychiatric Nurses (1995) proposed a new job description for senior nurse managers of the psychiatric services. As part of the discussions on the introduction of performance related pay for chief nursing officers, the Department of Health and Children is currently agreeing a new job description for CNO's.[12]

Management of Nursing in the Community

The management of nursing is not an exclusively hospital based matter. The public health nurse has long been seen as a key professional in community care services and in the Irish health services as a whole. A detailed examination of the role of the nurse in the management of community health services is beyond the scope of the current work. However this section of the review presents an introductory overview to the nurses role in the management of community health services.

The role of the nurse in managing the health services in this area can be seen as that of: integrator, including assessment of need, co-ordinator of services, collaboration with other health professionals, hospitals and voluntary organisations (Department of Health, 1997). This section of the review traces the development of the role and examines the role of current public health nurse in the management of the health services.

Public Health Nursing

The present system of public health nursing has its origins in the dispensary system, the Health Act 1953 and a White Paper of 1966 which outlined the direction for future developments in public health nursing (Department of Health, 1980). The present day role of the public health nurse results from an amalgamation of three distinct specialist areas of community nursing: domiciliary midwifery, public health nursing and care of sick people at home (McCarthy, 1997). Although in 1956, the Minister for Health encouraged health authorities to make available home nursing and midwifery services, a ministerial circular was not issued until 1966. This circular outlined the aims and objectives of the service and indicated the various client groups with whom the public health nurse should work. It also recommended the appointment of superintendent public health nurses and the establishment of a position for a nursing advisor (community nursing services) in

[12] Information supplied by the Personnel Department, Department of Health and Children, 23rd October 1997.

the Department of Health. The post of nursing advisor, community nursing services was established in the Department of Health in 1981 (O'Sullivan, 1994). The structure for community health services is currently under review and includes the introduction of the post of general manager for community care services.

Organisation and Management of Public Health Nursing Services

Public health nurses work in an overall service which is managed by a medically qualified director of community care (this system is changing with the current introduction of general managers). The public health nurse also traditionally works closely with general practitioners. The Department reported that there are 1,401 public health nurses employed in the health services. When categorised by grade the numbers show the employment of: 29 superintendent public health nurses, 67 senior public health nurses and 1,305 public health nurses.[13] The superintendent is the senior manager and has responsibility for effective and efficient delivery of the service, planning and quality control. The job also involves responsibility for evaluating how the service meets the nursing needs of the community. Senior public health nurses report to the superintendent both administratively and professionally. Their responsibilities are the day-to-day administration of the service, the smooth flow of communication, the provision of professional support and supervision of staff (Department of Health, 1997).

Reports Relating to Public Health Nursing

The provision of health care in the community has been examined in the work of several review committees. The reports produced, have influenced the development of the service and the role of the public health nurse. Table 3.3 lists pertinent reports.

In 1980 the Working Party on general nursing (see section 3.2 of this chapter) reported that there were two grades in the public health nursing structure – superintendent public health nurse and public health nurse. The Working Party recommended that the title superintendent public health nurse should be changed to chief community nursing officer and public health nurse should be retitled community nursing officer. To date these changes have not been made. The report also recommended that there should be an intermediate supervisory grade for community nursing, titled a senior community nursing officer. It was envisaged that the nurse in this post would be responsible for; the implementation of policy by the routine organisation and management of the nursing services within the part of the community area allocated; and for the co-ordination and practical training programme for all students. In 1982, the intermediate grade of senior public health nurse was introduced (Department of Health, 1980). While the Working party recommended a senior nurse for every eight to ten nurses the ratio, in 1996 was approximately 1:20.

A report was commissioned by a national committee of public health nurses who came together in 1993, to address matters of concern to the profession. The study was conducted on behalf of the committee by O'Sullivan (Institute of Public Administration (IPA)) and published in 1994. Thirty-seven structured interviews were conducted. Management was strongly represented in the sample (superintendent and senior public health nurses (17), those in management positions (6), hospital based nurses and other professionals (16)).

[13] Health Service Census, December 1996 – figures supplied by the Department of Health to the Commission on Nursing (7th October 1997). The figure excludes nursing staff working in: agencies, private hospitals, nursing homes, private sector or employed by general practitioners.

The perceived strengths, weaknesses, opportunities and threats facing the service were identified using SWOT analysis. The report highlighted the crucial role of the public health nurse in the management of the Irish health service.

TABLE 3.3. Reports Influencing the Work of Public Health Nurses

Author/Publisher	Year	Title
Department of Health	1975	Survey of the Workload of Public Health Nurses
Department of Health	1980	Working Party on General Nursing Report
Department of Health	1986	Public Health Nursing Services in Ireland: a discussion document
Institute of Community Nursing	1986	Survey of the Workload of Public Health Nurses Institute of Community Health Nursing
Department of Health	1994	Shaping a Healthier Future: a plan for the health service's into the 1990's
National PHN Committee	1994	A Service Without Walls: an Analysis of Public Health Nursing
Department of Health	1995	A Health Promotion Strategy
Department of Health	1996	Health Amendment Act
Department of Health & Children	1997	A Plan for Women's Health
Department of Health & Children	1997	Public Health Nursing: a review (unpublished)

The findings demonstrate that many public health nurses perceive a lack of clear role definition, lack of boundaries to their caseload and lack of structures for collaboration and linkages with other services in the community. The resultant role ambiguity was seen to pose a challenge when considering management of the service. This is compounded by the fact that other nurses are now providing services in the community, these include; general nurses, psychiatric nurses, practice nurses, palliative care/home care nurses and specialist nurses. There were criticisms of the rigidities of management in the public health nursing service.

In February 1994, the Department of Health established a committee to review the role and responsibilities of the grade of public health nurse and to make recommendations. All public health nurses were given an opportunity to make submissions. In total 100 were received. The findings of the review group were presented to the Department of Health in July 1997. The committee makes forty-seven recommendations covering all aspects of the work of the public health nurse.

Part three of the report addresses the management structure and organisation of the public health nursing service. The report suggests that the role of the superintendent public health nurse needs to change to exclude all duties relating to the day-to-day operational management of the service. It was recommended that "the role should be much more focused on service development introducing new and more efficient and effective methods of service provision" (Department of Health, 1997, p. 27). The report gave a detailed account of the responsibilities of the superintendent. They were to: provide a flow of information downwards and upwards for the purposes of planning and the motivation of the workforce; provide evidence of targets achieved; provide statistical analysis of the service; devise systems to improve work processes; identify serious managerial problems, foster participative decision making and take responsibility for

budgetary control of the service. The functions and responsibilities outlined suggest a new style management and for this reason it was recommended that the title Superintendent Public Health Nurse be changed to Principle Public Health Nurse.

In relation to organisational structures, the report recommends the establishment of Area Teams to ensure efficient management of the delivery of the service. Each team could be composed of an area public health nurse, one or more registered general nurses, and home care attendants/home helps on extended duties. The team would be led by the area public health nurse and managed by the senior public health nurse who would have a number of area teams to manage. To overcome the isolation in which many public health nurses work, the report recommended the formation of professional teams to provide a forum for the exchange of views, sharing of ideas and development of common practices and standards. It was perceived that the professional teams could operate in parallel to the area teams.

The management function of the senior public health nurse was addressed in the report which suggests that the post should be located close to staff, in an outlying centre in the area they manage. The senior should not have more than a ratio 1:10 nursing staff to manage or a population of more than 25,000. The report suggests that the senior should be instrumental in developing new initiatives among the staff making contact with local general practitioners and voluntary organisations and supporting public health nurses.

Management of Nursing in Paediatrics, Midwifery and Mental Handicap Services

Traditionally in Ireland, paediatric and midwifery services have operated from large general hospitals, although some specialist hospitals have operated independently in Dublin since the 18th century (Scanlan, 1991). Nursing within these hospitals has been managed as part of, or in a similar way to that in general hospitals. As the nursing structure, roles and responsibilities are very similar to the three levels of nursing management – first-line, middle and senior management – described for general hospitals, this review does not examine the structure in the specialist areas in any further detail. The mental handicap services have always maintained an independent service. The nursing management structure is also broadly similar to that of general hospitals and therefore is not explored in greater detail in this review.

Having reviewed the management function of the nurse in hospitals and in the community, the next section examines the issues of nursing promotion and strategic policy formation in Ireland.

3.4 Issues for Nurse Managers in Ireland

During the literature review the author identified a number of recurring issues which effect the role of the nurse manager. The first issue relates to lack of involvement in policy making at national and hospital level and the second involves the perceived barriers which nurses encounter when seeking promotion in the Irish healthcare system. These issues are discussed in this section of the review.

Policy Making

The focus of this section of the review has been on the management function of the nurse within specific health institutions. Nurses have an equally important contribution to make in the wider field of health care management. Representation of nursing at the

highest level of the health services has been sought and debated since the beginning of the century (Madden, 1997).

Nurses appear to have restricted ability to influence policy making at hospital level. In 1990, when launching their position paper on the role of nurse managers in the development of an efficient health service the Irish Nurse Organisation commented, "except for some of the major voluntary hospitals, matrons/directors of nursing do not form part of the central or senior management team in the health services" (Irish Nurses Organisation, 1990, p.10). The editorial comment made was, that while the director of nursing is responsible for the management of the vast majority of staff in a given work situation, it is perceived that the most senior nurse is excluded from central management, policy formulation, analysis, review and development.

The Irish Matrons Association, in their submission to the Commission on Nursing, propose that nurses can make a substantial contribution to the overall corporate management function, as they bring to the table a familiarity with the product which non-clinical administrative managers could not possibly be expected to have. It is strange therefore that, despite this central role, nurses in Ireland are still not sufficiently involved in policy, strategy and planning. It is essential that a nursing presence at the decision making tables of the Department, health boards, hospital institutions and other decision making fora be guaranteed and fostered.

In 1947, the Irish Department of Health was established. A nursing officer was appointed to the Department in 1949 (Department of Health, 1980). It was not until 1980 that this role was reviewed and expanded and as a result three posts for nursing advisers were created on the staff of the Department. The post holders were given different areas of responsibility: one each for general hospital services (management and planning) psychiatric services and community services. The function of these posts was to advise the Department on the organisation, staffing and development of the nursing services in respective areas. The posts were located in the appropriate service division rather than in a special nursing division (Department of Health, 1980).

The Working Party on General Nursing reported that the Department was to establish a fourth position with a remit for education and research. Eighteen years later this post has still not been created. The Working Party highlighted the fact that the nursing structures at government level in many European countries are headed by a chief nursing officer. The Irish Matrons Association (1993) also called for the establishment of such a post. However, the call for a position at this level was not answered until 1997. Until very recently, nursing representation within the Department of Health has been very limited; there has only been one full-time nursing advisor (general nursing), one full-time nurse advisor (public health) and one half-time nurse advisor (mental health nursing).

In 1980 the Working Party expressed concern with regard to communication difficulties existing at health board level between programme managers and matrons of specific hospitals (Department of Health, 1980). The Working Party recommended that there should be a nurse based at health board headquarters, to provide the nursing input to the decision-making process. Eighteen years later this position has been created on a pilot basis in the North Western Health Board but remains to be introduced in the other seven health board areas.

In health boards, the senior management team consists of the chief executive officer, programme manager and personnel officer. In hierarchical terms, the next tier in descending order is that of general manager/hospital administrator and matron/director of nursing. While the director of nursing is responsible for the management of fifty per cent

or more of the staff, they are perceived as excluded from; central policy formulation, analysis, review and development as they are not represented on the most senior management team (Irish Nurses Organisation, 1990).

When addressing the Annual Delegate Conference of the Irish Nurses Organisation in 1997, the Minister for Health and Children said that he wanted to see an "integrated and strengthened nursing function within the Department which would provide added impetus at this important stage in the development of nursing in this country" (Horan, 1997, p.8) He announced that arrangements have been made to bring together in one dedicated unit within the Department, all matters relating to nursing and develop for the first time a principal nursing officer post. Following representation by the profession the title of the position "Principal Nursing Officer" has been changed to "Chief Nursing Officer." In the background information supplied to the Commission on Nursing by the Department of Health and Children, the nursing positions within the Department were described as follows: Chief Nursing Officer (new position 1997); Nursing Survey Officer (General Nursing); Community Nursing Advisor (Public Health Nursing); and Nurse Advisor (Mental Health) part-time.

Opportunities for Nurse Representation

Nurses from all divisions of the register have lobbied for a stronger voice for nursing in policy making at local and national level. However there appears to be a discrepancy between what nurses are calling for and the profession's ability to respond. The results of the recent An Bord Altranais elections and the health board elections indicate that nurses are not aware of, or perhaps not interested in, the opportunities (limited as they are).

The nursing profession has an opportunity to elect seventeen members to the twenty nine member Nursing Board – An Bord Altranais. In 1997 forty three nurses stood for election. The electoral role is divided into five categories: General and paediatric, psychiatric, midwifery, mental handicap, and public health, with one or two seats allocated to nurse managers in each panel. In total seven of the seventeen (41%) seats are allocated to nurse managers, working in administration or first-line management positions. The level of interest in the election is evidenced by the fact that four of the positions were uncontested and the nominees were automatically elected, two in administration and two tutors. Of the 40,466 nurses eligible to vote only 9,417 (23%) exercised this right. When broken down by panel an alarming disinterest can be seen in the largest panel. The percentages by panel returning ballot papers is as follows: General and paediatric 17%, midwifery 18%, mental handicap 33%, public health and psychiatric panels 46%.[14]

A similar level of disinterest was apparent in the 1997 Health Board elections. Two seats are reserved for nurses on each of the eight Health Boards. In the 1997 election seats in three of the eight Health Boards, were uncontested and candidates were automatically elected. The percentage vote was minimal. Seventy five percent of the contested seats were won by candidates supported by nursing unions.

Barriers to Promotion in Nursing in Ireland

When examining the grades and categories of nurse managers employed in the health service in Ireland the figures presented in Table 3.2 suggest that there are very limited promotional opportunities available to Irish nurses. The issues which appear to affect

[14] Figures supplied by An Bord Altranais, November 1997.