promotional opportunities are: changes in womens' working role, the promotional structure in nursing, lack of financial incentive to seek promotion, methods of recruitment, gender issues, and insufficient career planning.

*Change in Women's Working Role*

In 1974 the "marriage bar" was lifted for women working in the public service and this was extended to nurses. The Employment Equality Act 1977 provided for, equal treatment between men and women and between single or married persons, in access to employment, in training and working conditions. These provisions meant that vacancies occurred much less frequently than heretofore in nursing. This has resulted in limiting an individual nurse's freedom to choose where she/he worked, thus horizontal and vertical career flexibility was adversely effected. Fewer promotional positions became available as nurses remained in life long nursing positions. However, since the 1980's the introduction of job sharing has offered nurses greater flexibility when combining work and family roles. However, the availability of job sharing for nurse management positions is limited.

*Promotional Structure in Nursing*

Currently there are only eleven positions available at director of nursing level in band one hospitals. There are no further nursing management promotional opportunities open to the directors of nursing, unless they opt to leave the health services or move laterally within the service. Many stay in positions until retirement. As the current post holders are often in long term positions, which commenced in their early forties, they could hold the position for approximately 20-25 years. This could be resolved if more positions were available in general management, if nurse-managers choose to compete for these positions or if contract posts were introduced. Similar problems can be seen at middle and first line management levels. Although there may be slightly more flexibility at these levels, there are still relatively small numbers of positions.

When addressing the Irish Matrons' Association Biennial Conference in 1988, Dwyer described the hierarchical hospital nursing structure which she regretted had remained fundamentally unaltered for almost a century. She suggested that there is a need for both a clinical career ladder and a career ladder in nurse management with greater opportunities for nurses wishing to pursue a career in management (Dwyer, 1988). Perhaps this could be realised if in the future more nurses move into general management.

*Lack of Incentive to Seek Promotion*

The Irish Nurses Organisation when making a submission for a pay claim in 1993 for senior nurse-managers stated that "we have now reached the stage where people of high calibre are not competing for senior nurse managers posts simply because the levels of responsibilities are so high while the salary levels and differentials between the manager grade and clinical grade are so low" (p.2). There appears to be little incentive to seek promotion in an environment where the capabilities and management skills of nurses are clearly either unrecognised or undervalued by employers as expressed in failure to award an appropriate remuneration package.

*Methods of Recruitment*

Many nurses have expressed the view that the recruitment and interview process operated by several hospitals and health boards is unequitable (submissions to the Commission on Nursing). The Irish Nurses Organisation reported in 1995 that there was a perception amongst nurses that favouritism still persists. The lack of transparency and veil of secrecy in relation to interview performance and resultant panels, creates an additional lack of credibility in the current interviewing system. In relation to interview boards the INO recommended that all members of interview boards; are trained in interviewing skills, are aware of equality legalisation, recognise the relevance of equal opportunity policies, and are suitably qualified for the positions being interviewed. It is also recommended that the composition of interview boards are gender balanced (Craughwell, 1995).

*Gender Issues*

The nursing profession is predominantly a female one, but a disproportionate number of men are employed in managerial grades (see Table 3.2). In 1994 the Chief Executive Officer of the Midland and Mid-Western Health Boards commissioned a study to ascertain the views and advice of women on their perception of the barriers to promotion in the Boards' employment and how these can be removed (O'Connor, 1995). The study focused on three groups: women at the middle and senior levels of the administrative hierarchy (grade IV upwards); the nursing hierarchy (ward sister level upwards); the paramedic hierarchy (basic grade upwards). A stratified random sample (N = 222 of 677) of middle and senior levels in each of the sectors was selected. The reponse rate amongst the effective sample was 76% (162/213). The main findings in relation to nursing management were as follows:

- Within the administrative sector women were competing within what was still, especially at senior levels, a male world. Men's actual chances of promotion from Grade III to Grade VI or above, were four times greater than women's (roughly one in two for the men and one in eight for the women).
- Statistically women's actual possibilities of promotion from (permanent) staff nurse to matron were very low indeed and twice as low as men's (28:1 for women as compared with 14:1 for men)
- Barriers were seen as lying in the differential treatment of women and men within nursing, as well as in the chasm which was perceived to exist between the work of professional caring and the world of administration (O'Connor, 1995, p. 91-113).

This study clearly documents that promotional gender bias is operational in the health services. The findings indicate that men have a profound advantage when seeking promotion.

In the same year the Department of Equality and Law reform 1994 highlighted the fact that women occupied only 7% of management, and no senior management positions in the health boards. The first female CEO of a health board was appointed in 1997. The issue of the effective utilisation of women's skills and talents is particularly relevant however in health boards since almost three quarters (71%) of the employees are women.

The discussion document *Developing a Policy for Women's Health* (Department of Health, 1995) also recognised the under-representation of women in positions of responsibility in the health services. It is recognised that the majority of senior posts in both the nursing and paramedical categories are held by women, while only a minority of medical consultant posts and senior management posts are filled by women. Three years later the document, *Plan for Women's Health 1997-1999* (Department of Health, 1997) reported a small improvement in overall terms. Approximately 11.5% of senior management posts in the Health Boards are filled by women. The *Management Development Strategy for Health and Personal Social Services in Ireland* noted that there was a particular need for health service employers to provide opportunities for women to develop their experience and careers within the local system (Dixon and Baker, 1997). These reports present an increasing awareness of the gender issues of equity and equality in relation to appointments to senior management positions in the health services. However this has not yet resulted in a consequential change in the numbers of female staff employed in senior management positions.

*Insufficient Career Planning*

When addressing the issue of career development at a 1997 national education conference *Growing Your Own Career in the 21st Century,* Dwyer commented that women take a longer time than men to get to a senior post. She suggested that this often resulted from: the impact of their partner's career; the fact that nurses may make more sideways moves, which can be interpreted as a lack of focus or direction and that men tend to have career progression while women have career development (Dwyer, 1997). She advised nurses to take control of their own career advancement, not to rely on employers but rather to steer a path which embraces the values and the path which is most likely to realise their ambition. She challenged nurses when she said "you're deadly talented people and you don't have to confine yourselves to progressing within the narrow confines of nursing" (Dwyer, 1997, p.6).

## 3.5 The Role of the Nurse in Managing the Health Service – Irish Research

Despite extensive manual and computer searches of the literature it was not possible to locate a single large scale study which specifically addressed the issue of the nursing role in the management of the health service in Ireland. Studies in related areas have been carried out, one of which, relating to promotion, has been discussed earlier in the review (O'Connor, 1995). However, the author identified a number of studies pertaining to nurse management. Some of the research is masters degree level work, conducted with academic rigor while other smaller studies were conducted with specific groups of nurses in specific locations. The reader is cautioned to treat the material as information on the topic and not to generalise from the findings reported for the studies. This advice is given as many of the studies were based on small sample sizes and relate to specific situations or institutions. The findings are unpublished and have not been peer reviewed. Table 3.4 lists the Irish research relevant to the role of nurse-managers and includes the published study discussed earlier. While the table presents Irish research in sequential order, the findings are discussed under the headings of: nurse management role, career opportunities, management education, organisational structure and related issues.

**TABLE 3.4. Irish Research with Relevance to the Role of the Nurse Manager**

| Author | Year | Title |
|---|---|---|
| Brigid Tierney* | 1988 | Stress in Irish Nursing |
| Work Research Centre | 1993 | The experience of stress amongst Irish Nurses a Survey of Irish Nurses Organisation Members |
| Aileen Henderick* | 1994 | Directors of Nursing/Matrons Satisfaction: Dissatisfaction MSc (counselling psychology) |
| Margaret McCarthy* | 1994 | Managing change in general nursing practice, M.Ed. |
| Ann Judge* | 1994 | The Missing Careers: A Study of a Hospital's Absenteeism Causes and Control Methods. MBS (management and organisation studies) |
| Pat O'Connor | 1995 | Barriers to Women's Promotion in the midland and mid-western Health Boards |
| Yvonne O'Shea* | 1995 | Resource Management and the Clinical Directorate Model – Implications for St. James's Hospital Dublin, MScEcon (Policy Studies) |
| Gervaise Maher* | 1995 | An examination of the management and professional aspects of the ward sisters role, M.Sc. (Ecom) and Social Science. |
| Mary McCarthy* | 1995 | Senior nurse managers perception of the opportunities for career mobility in nursing, MA (University of Keele) |
| Emir Jennings* | 1996 | Perception and evaluations of management courses by Irish Nurses, M.Ed. |
| Helen Flint | 1997 | Continuing Research Education Development (CRED) Eastern Health Board |
| Brigid Howley* | 1997 | An analysis of the continuing education/training needs of ward sisters "A timely Study", M.Sc.(Econ) Management of Care |
| Dr. Loraine Joyce* | 1997 | Changes in nurse management – recognising the challenge Institute of Public Administration (IPA) Working Paper |

*Unpublished research

## Management Role

Three of the studies located relate to the management role of the nurse; Hendrick's (1995) study relates to senior management, Maher (1995) examines the role of first-line nurse managers and Joyce (1997) explores the changes facing nurse management in general. This section gives an overview of the study findings.

Hendrick in 1995, studied the psychological aspects of satisfaction and dissatisfaction related to the director of nursing role. The purpose of the study was to examine the relationship between role conflict, ambiguity, overload, anxiety and job satisfaction. The main findings of this study were that Irish directors of nursing experience role conflict and role overload and a small number experience role ambiguity. Self reported stress was not statistically significantly related to the three constructs.

The sample consisted of 190 Directors of Nursing from general, psychiatric and specialist, publicly funded hospitals.[15] One hundred and twenty eight completed questionnaires were returned giving a response rate of 65%. When considering role conflict: 71% reported insufficient recovery time; 57% reported an awareness of problems within the nursing service and a lack of resources to correct them; 55% commented on

[15] 190 appears to be more than the total number of directors of nursing employed in the country, this statement was not qualified in the report of the research.

being forced to practice against their better judgment and 52% reported a sense of inexperience in certain areas of the work expected. In relation to role overload: 60% responded that they could not satisfy the conflicting demands of various staff and departments within the hospoital; 82% considered that they were perceived as universal problem solvers. Hospital administration was perceived to cause stress in 55% of respondents. A significant number (41%) reported lack of positive reinforcement for work.

The qualitative data on personal support and coping skills revealed that directors of nursing relied on and supported each other. They rarely used direct methods to deal with stressful aspects of their job, preferring to use personal coping strategies, rather than attempting to change the organisational structure or environment.

Hendrick concluded that stress at the top of the organisation had a far-reaching and potentially deleterious impact on the whole system than distress at the lower level. As a result of the study she recommended training, in relation to industrial relations and counselling skills; group work to help the directors of nursing to share their difficulties; participation in personal development programmes which value personal needs equally with organisational demands. The findings of this study are of interest. It appears that Hendrick grouped all respondents as directors of nursing. Additional useful information could have been obtained had the sample been differentiated by role and function.

In 1996, Maher examined the professional and managerial aspects of the ward sisters role. The study emphasised the intrinsic relationship between the managerial and professional aspects of the ward sisters role and the difficulty in attempting to separate the role into its component parts. The study highlighted the need for adequate and appropriate education for nurses prior to undertaking the complex role of ward sister.

Data triangulation was used for the study; structured formal interviews were conducted with three groups: five ward sisters, nurse managers and staff nurses working at five acute teaching hospitals in Dublin. The purpose of the interviews was to establish the respondents perceptions of the ward sisters role. Job descriptions for orthopaedic ward sisters roles were examined for content format and phraseology. When considering length of time in current position 80% of the managers had been in post longer than 10 years, 40% of ward sisters were in the position less than 4 years and 80% of staff nurses were in position for 5-9 years.

During the interviews the role of the ward sister was reported to be manifold. The managers and staff nurses identified the qualities required of individuals undertaking the ward sisters role, these were reported as; good – organiser, communicator, counsellor, listener, clinician and teacher. While the ward sisters reported responsibility for managing the ward, all three participant groups regarded the provision of good patient care as the ward sisters main priority. They stated that the sister should have direct input into patient care. The managerial responsibilities identified in the job description covered a very extensive range of activities. However, there were only four areas common to the five job descriptions, these are; providing good patient care, training student nurses, reporting/appraisal of staff and staff development.

The managerial style that pervaded in the study findings could be classified as bureaucratic with a high degree of control. Ward sisters reported experiencing conflict while undertaking their role, relating to non-nursing duties, clerical work and supervision of cleaning staff. The differences in value systems adopted by nursing and management were suggested by Maher to have added to the sense of conflict. Maher contends that control operational in the organisations may have undermined the individuals confidence

in their decision making ability. Maher reported that the ward sisters in the study seemed to lack self esteem which weakened their position and militated against building a strong team.

In 1997, Joyce in examining the changing role of the nurse manager and the manner in which the Institute of Public Administration (IPA) could address training and education for this group. Her findings were presented to the IPA in a working paper. The key point which emerged was that because nurse-managers have no guaranteed role at a senior level, they have to prove their own value and contribution in terms that relate to improved patient care and greater effectiveness. It was recognised that in Ireland there were limited opportunities for nurses to move into general management. Joyce recognises that nurses are extremely skilled at people management and have a deep understanding of clinical areas, however many lack broader general management experience.

She convened an expert group of senior nurse managers called the *Nurse Management Development Strategy Group* to assist in the task. The fifteen member group was made up of seven directors of nursing/matrons; two deputy directors of nursing; two superintendent public health nurses; two education and research officers; a chief nursing officer from the Eastern Health Board, psychiatric services; and the chief executive officer of An Bord Altranais.

The group met six times and was addressed by representatives of nurse management in Northern Ireland, The King's Fund Management College and the European Health Management Association. The group interaction provided an opportunity to collect rich experiential information and made it possible to examine in a meaningful way the forces for change in nurse management, the implications of such change, leadership in nursing and the need for enhanced management development programmes.

The group determined that the factors which most directly affect nursing management in Ireland are: the growing consumer movement; new hospital structures such as that proposed for the new hospital in Tallaght; developments in nurse education; developments in general management; the national health strategy; the industrial dispute in nursing (1996) and the establishment of a Commission on Nursing. Following discussions the group agreed the implications of the changes for nurse managers were as follows:

- The traditional career paths of the nurse manager are likely to change dramatically.
- Flatter organisational hierarchies for nursing will be introduced.
- The role of the middle line nurse manager may change to include the management of services other than purely nursing services.
- Nursing itself will change as nurses will enhance role and specialise in particular areas of care.
- The way in which patient care is delivered will be examined critically and re-engineered to ensure that care is provided by the most appropriately skilled personnel.
- The role of many directors of nursing, particularly in larger hospitals, will shift from being that of the manager of nurses to the manager of nursing, assuming responsibility for quality of patient care and patient services generally.
- Nurses will no longer necessarily be managed by nurses (Joyce, 1997, p.4).

The group agreed that directors of nursing have a responsibility to plan career paths with and for nurses and that flexibility in career paths be fostered to enable nurses to move in and out of nursing. The work concluded with the production of a suggested professional and personal development programme for nurse managers at three different levels. The strong background of the strategy group in educational, management and

policy making dimensions inspires confidence in the programme content and methodology designed by the group.

The three research studies discussed above reveal that the present day senior nurse managers experience role overload and conflict. The lack of a guaranteed role at senior management level requires potential nurse-managers to prove their ability beyond the clinical setting. Nursing needs to examine each level of nurse management and decide what its expectations are of the various roles. At present there appears to be an inseparable, intrinsic relationship between the managerial and professional aspects of the ward sister's role. The extent to which this bio-accountability should be maintained needs to be carefully considered. There are some opportunities emerging for nurses to move into general management. As nurses are extremely skilled at people management and have a deep understanding of clinical areas, it is important that some nurses make the transition. The studies highlight the need for adequate and appropriate education for all nurse managers and particularly ward sisters prior to undertaking such a complex role.

**Nurse Management Career Opportunities**

In 1995, McCarthy (M) examined the perception of senior nurse managers to the opportunity for career mobility within nursing and wider health service administration.

A sample of twenty eight senior nurse managers (grade above ward sister and directly below matron/director of nursing) working at five large teaching hospitals were asked to complete a fifty-two item self completion questionnaire. Follow up interviews where held with five of the ten (50%) who agreed to participate. Additional interviews where held with five senior managers (matron, personnel manager and union representatives).

McCarthy found that there was a lack of ambition among the study group to either move vertically or horizontally in their careers. Only one respondent aspired to the position of director of nursing and one expressed an ambition to move into the broader management arena of clinical directorate or CEO. Barriers to promotion were perceived to be: employment inequality, lack of guidance on career planning and inadequate attention to the development of a career plan. Gender was not perceived as a factor in pursuing career progression.

The majority of the respondents were single 17 (85%), all but one worked full time, ages were evenly distributed between 25-65 years, 11 (55%) had occupied their position for more than six years, 75% were qualified over twenty years and had obtained a second qualification and 90% of the respondents had completed a formal management course. This suggests that the respondents are following a traditional female career path, single and childless and supports the view of nursing as a highly sex-segregated occupation. Sixty percent of the study group did not think they would be a nurse if they had been born male. It is interesting to note that the majority of respondents in this study did not believe that males achieve senior nurse management positions more quickly than their female colleagues. This finding conflicts with the findings of the major study conducted by O'Connor (1995) for nurses working in a health board environment. However, it must be remembered that the sample for McCarthy's study is comprised of a small homogenous group of nurse-managers working in voluntary hospitals. The respondents believed that job promotion was more readily available in health board hospitals as there were more job opportunities. Most of the respondents (70%) declared that nurse education does not prepare nurses for management positions. McCarthy concludes that the findings of this study raise serious issues in relation to the development of future leaders in nursing.

**Management Education**

Three of the Irish studies identified relate to the educational preparation of nurse managers, this section gives an outline of the major findings. In 1994, a working group was established between An Bord Altranais and the Eastern Health Board to review the continuing education needs of nurses. Part of the work involved conducting a training needs analysis for all nursing personnel working in the Eastern Health Board (3,507 nurses were included in the study). The working group published the findings of their investigations and recommendations for future practice in a document called *Continuing Research Education Development (CRED)* (Nursing Research and Development EHB. 1997).

Three thousand five hundred and seven questionnaires were distributed by the local nurse managers throughout the Eastern Health Board. In total 1,167 (33%) were returned, the response rate was relatively low and there were marked variations from speciality to speciality. When analysing the findings management was reported as one of the seven courses most often taken by respondents. Over a quarter of the courses (6/23, 26%), for which nurses received financial support from the Eastern Health Board, related to management. It is interesting to note that the majority (59%) of respondents who had completed management courses still listed management topics/subjects as required by them to improve practice.

In relation to access to courses the group found a widespread practice where nurses were forced to apply to commercial firms for sponsorship for study days as there was no managerial support forthcoming. A major recommendation as a result of this study was that an Eastern Health Board policy for access to study leave be formulated and agreed at board level, granting equity to all members of staff, including some clear criteria for applicants. Following the research the group held plenary session meetings with sub-groups of the various nursing divisions within the Eastern Health Board. During these sessions it was suggested that a more practical approach to the teaching of subjects such as management was necessary.

In 1996, Jennings conducted a study to seek a better understanding of the motives for the demand by post-registration nurses for managerial courses (Jennings, 1996). The design of the study was descriptive and comparative in nature. Self-reporting questionnaires (N=327) were distributed to a convenience sample of registered nurses in Dublin. A response rate of 82% was achieved. The most important factor that emerged from this study was the lack of formal evaluation by senior management of their employees participation in management courses.

The prime motive for course attendance was identified using the *expectancy theory* of Porter and Lawlor III (Porter and Lawlor, 1968). Two hundred and seven nurses (79.9%) foresaw that holding a certificate or diploma in management offers a route towards promotion beyond that of a staff nurse's position together with its monetary reward of extra increments in salary. Of the respondents, 68 nurses identified with Vroom's (1964) value system as the motivator for attendance. The theory holds that people will be motivated to do things to reach a goal, if they believe in the worth of that goal and if they can see that what they do, will help them in achieving it. A small number, twenty-two cases, identified with McClelland's (1976) *needs theory*, in particular the concept of need for achievement. Achievement need was defined as "behaviour toward competition with a standard of excellence".

Howley conducted a study in 1997 to assess and examine the continuing education needs of ward sisters relevant to the existing needs of the service and their own future

development. In preparation for the study two ward sister focus groups were convened to devise a framework for identifying the perceived training needs of ward sisters. The rich experiential information gathered during the focus group discussions was used to inform the questionnaire content. In total, 106 nurse-managers from a stratified sample completed a descriptive postal questionnaire: 97 ward sisters (69% response rate) and 9 divisional nurse managers/matrons and assistant matrons (100% response rate) working at five acute hospitals.

In the study respondents identified budgeting as a top training need, Howley suggests that since nursing accounts for up to 40% of the hospital budget, it is understandable why budgetary needs are perceived as a priority. Of the respondents, 82% were in favour of the introduction of performance appraisal linked to a model of continuing education. This finding is of particular interest as some nursing unions currently advise their members not to co-operate with the introduction of such systems. Ward sisters described the work that gave them most satisfaction as being predominantly related to patient care and well being, while the work which gave least satisfaction related to administrative duties. A small but significant number of respondents commented on problems in relationships with management and consultants.

In relation to their own continuing education needs, ward sisters considered budgeting as a major priority (51.47%), legal aspects (42.6%), counselling skills (33.8%), clinical update (33.8%), new technology (32.4%), research application (25%) communication (23.5%) and time management (14.7%). A large proportion of ward sisters (83.3%) indicated that they were in favour of mandatory continuing education and 82.1% agreed that formal staff appraisal should be linked to a model of continuing education. While nurse managers identified leadership as a training necessity it was not reflected in the ward sisters' response regarding their own training needs.

Based on the finding of the research, the author makes thirty-eight recommendations in relation to the continuing education of ward sisters. The recommendations relate, not only, to the continuing education needs of ward sisters but also to nurses in general. The recommendations are diverse and wide ranging and relate to issues such as: the type and level of courses; delivery methods; the need for applied learning; funding for continuing education; study leave; the need to develop a strategy for continuing education; accreditation of approved courses; the role of An Bord Altranais in continuing education; the possibility of introducing mandatory requirements in relation to continuing education for ward sisters; and the importance of leadership development programmes for ward sisters. Subjects suggested for inclusion in continuing education programmes included; budgeting, communication, counselling, legal and ethical issues, management and research methodologies. Howley (1997) concludes with general recommendations in relation to the recruitment and continuing education needs of ward sisters:

- Ward sisters should have a job description which is meaningful and accurately reflects their role and responsibilities.
- Staff nurse development programmes must take cognisance of the need for preparation for ward sisters role.
- Recruitment policy should reflect the criteria for entry to the post.
- All identified training needs must be addressed within a management development programme for ward sisters.

- New Government policy initiative which have implications for the role of ward sister should be communicated to them in a structured manner and related training needs addressed.
- Practice based learning and development should be encouraged such as setting up Nursing Development Units.
- Innovation in nursing practice should be fostered within an organisation culture that allows permission to fail (Howley, 1997).

The above studies highlight that although nurses are taking courses in management for promotional and achievement reasons, they still identify a need for more professional development in this area, in particular for budgeting, legal and counselling skills. An important consideration is access to further training in terms of organised study leave and funding which must be flexible to ensure that individual nurses needs are accommodated. At present, nurse-managers appear more satisfied with the management of professional nursing rather than administrative duties. The studies did not reveal if this was a consequence of the respondents greater training in clinical practice as opposed to management. Further education in this area may lead to greater competence and therefore satisfaction.

**Organisational Structure**

Only one of the listed studies relates to organisational structure. In 1992, the Department of Health approved a proposal for the institution of a major organisational and management structural change at St. James's Hospital – changing the structure of the hospital from a predominantly centralised hierarchical and functional structure to a decentralised flatter product/service focused structure with a market bias. In 1995, O'Shea, a nurse manager at the hospital conducted a study to analyse in detail the introduction of clinical directorates (described in Chapter 2) at St. James's Hospital.

The author visited five hospital sites; three in England, one in Northern Ireland and one in Southern Ireland where clinical directorates had been introduced. Detailed interviews were conducted at each site. In total forty-seven interviews were conducted, thirty-four with; chief executives, directors of nursing, clinical directors, nurse managers, business managers ward sisters and personnel managers at the hospitals visited and thirteen interviews at the researcher's parent hospital. A uniform pre-prepared instrument was used to guide the interviews.

The researcher found general agreement at all sites about the management roles within directorates, which are summarised as follows:

**The Clinical Director:**
is accountable to the chief executive or group director as appropriate and is usually offered a three year appointment. The Clinical Director represents the clinical management team at board/executive level and has overall responsibility for the management of all staff in the directorate. In practice the management of non-medical staff is delegated to the nurse-manager, business manager or directorate manager. The director has overall responsibility for business plans, service developments and budgets.

**The Nurse Manager:**
is managerially accountable to the clinical director or directorate manager and professionally accountable to the director of nursing and quality. The nurse has responsibility for operational management of nursing staff, managing the nursing budget, staff development and quality initiatives.

**The Business Manager:**
is accountable to the clinical director the responsibilities include clerical staff, directorate office management, business planning support, finance, identifying information needs and analysing information.

**The Directorate Manager**
if such a post exists it combines the function of the nurse and business manager (Department of Health, 1994).

The study revealed that across hospitals at corporate level, quality was viewed as a continuous improvement process and was usually the responsibility of the director of nursing services. The role of the director of nursing in a directorate system was seen to involve significant changes from that of the traditional director of nursing. The role encompasses the dual function of professional responsibility for nursing and overall responsibility for quality initiatives within the hospitals. In the study it was reported that the role included responsibility for: casemix; risk management; standards and utilisation review; patient satisfaction; feedback and complaints procedures; and line management responsibility for the school of nursing.

The study revealed that budget accountability at all sites rested with the clinical director who delegated this to the business and nurse manager. In a number of sites, few consultants were willing to take on the role of clinical director. At two sites budgets had been devolved to some ward sisters. Cross charging was in operation at two of the sites, for services such as pharmacy, radiology, dietetics and theatres. It was suggested that communication is central to the success of the clinical directorate system. Many communication problems were identified, one being that nurse-managers were isolated within directorates. The researcher identified good vertical communication but no horizontal communication. The key issues for the success of clinical directorates identified during the interviews were that:

- it is important for senior management to drive the changes;
- changing the culture is critical with the service provider involved in the management of resources;
- a strong sub-unit structure is important with devolved budgetary responsibility;
- an information system needs to be developed to support the work of clinical directorates;
- systems need to be put in place to ensure communication across the site; and
- training and development is critical (O'Shea, 1995).

The reaction of those involved in the change programme at the parent hospital was very positive despite the difficulties encountered. Emphasis was given to the provision of appropriate support staff for the nurse and business manager. The key issues emerging from the interviews held at the parent hospital were:

- the importance of flexibility in the development of structures;
- the need for clarity in defining roles;
- the need to appoint senior nurse managers to bed holding areas;
- the importance of recruiting nurse managers and business managers at an appropriate level of experience and maturity; and
- the importance of succession planning rather than breeding indispensability.

At the parent hospital the triumvirate (directorate manager, nurse manager and business manager) structure was preferred. After an initial period of triumvirate structure, other hospitals in the survey, moved towards shared resources across a number of directorates and combined roles. Their experience suggests that a senior nurse must be involved in whatever structure ultimately emerges. Two of the sites, initially, did not appoint a senior nurse and experienced a deterioration in the quality of nursing care to such an extent that appointments had to be subsequently made. The author indicated that in large hospitals the introduction of a triumvirate model across all directorates could result in actually increasing the middle layers of management rather than flattening the structure.

O'Shea concludes that there are a number of issues which are of particular importance to any change management initiative. These are; communication, managing the change process itself, quality, training and development changing the culture of organisations. In relation to changing the culture she recommends the provision of powerful leadership and the involvement of those who know what is really happening. This research demonstrates the major contribution nurse managers can make when redesigning the organisational structure and planning the management of health care delivery in an acute hospital.

**Issues Related to Nurse Management**

During the literature search the author located four Irish studies dealing with issues pertinent to nurse management; change management; stress in nursing and absenteeism. The findings of the studies relevant to the nurse management role are presented in this section.

McCarthy in 1994 conducted a study to investigate the methods adopted by senior nurse management to implement change in general nursing practice (McCarthy, 1994). Semi-structured interviews were conducted with a sample of ten ward/department sisters employed in general nursing. The organisation of nursing at the hospitals was described as bureaucratic and administrative with a hierarchical authority structure. It was found that senior nurse managers adopt a top-down approach to implement change in general nursing practice. From the data collected, it emerged that the adoption of power-coercive strategies helped senior nurse management maintain centralised control. Despite staff involvement in nursing changes, there was a pattern of centralised and autocratic decision-making. Participants accepted that there was an urgent need for nurses to innovate and experiment with current developments in nursing.

The interviewees identified the necessary factors to facilitate the effective implementation of planned change: involvement; communication; development of a plan for change; and provision of adequate resources. The study indicates that when change is implemented, prompt feedback is critical to reinforce the new methods. McCarthy concluded that the implementation of change demands a well organised strategy and suggests that decentralised decision making could facilitate meaningful participation when change is being implemented.

The Department of Health commissioned a study to identify those situations at work which Irish nurses find stressful. The findings were reported in 1988 (Tierney, 1988). A large scale descriptive correlation study was conducted to identify the source of stress perceived by nurses in the Republic of Ireland, and their behaviours and attitudes/feelings when dealing with difficult situations at work.

The sample (1,390) included a representative group of staff nurses, public health nurses, ward sisters, charge nurses working in hospitals and in community areas throughout the country. Job satisfaction and health status were used as outcome measures of a stressful experience. The nurses' perception of stress was measured using a stress scale. The results show that nurses were most stressed by problems associated with the organisation of their work and their working environment. This is of particular relevance to nurse-managers. The most stressful events were related to: inadequate staffing; constant interruptions; inadequate notification of staff changes; demand and pressure to undertake multiple tasks that are often in conflict; administrative task loads, interfering with the nurses' care of a patient.

Tierney suggested that the findings of the study have implications for nursing management, education and practice. She makes twelve recommendations for improving conditions of work for nurses. Unfortunately the findings of this study were not published by the commissioning body, the Department of Health, and so valuable information which could have assisted nurse-managers in the organisation of nursing services was lost to the profession.

In 1993, the findings of the initial study on stress were confirmed by a major study commissioned by the Irish Nurses Organisation. It aimed to validate the claim that nurses and midwives were subject to stress (Wynne et al. 1993). A 10% stratified random sample was used to generate the sample group from the total membership of the Irish Nurses Organisation, 777 of the 1,662 postal questionnaires were returned (response rate 46.8%). The finding indicated high stress levels throughout nursing, students being the most stressed. A lack of professional development, high levels of assault, strong occupational socialisation, inappropriate forms of shift work, and large wasteage from the profession, particularly for health reasons. It was suggested that these findings should be examined carefully by nurse-managers when considering the organisation of nursing work.

Judge (1994), a nurse manager, conducted a study to establish the causes of absenteeism, focusing on different occupational groupings at a large Dublin hospital. The author identified occupational stress, domestic and family responsibilities along with a belief of "entitlement" to use sick leave as contributory factors to absenteeism in the hospital. The findings demonstrated that increased managerial control of absenteeism was essential in the pursuit of improvements in the hospitals sick-absence rates.

An in-depth case study was conducted involving triangulation of qualitative, quantitative and documentary data. The percentage absentee rates identified in 1994 were as follows; nursing (3.52%), attendants/porters (4.48%) and household/catering (6.66%). Recommendations for improvement were offered as follows; establishment of a hospital wide computer information system of absence data, employment of a training manager, implementation of an attendance lottery to motivate attendance, introduction of a system where an employee has to formally apply for sick pay, initiatives in stress management and team building. The findings of this study are of particularly relevance to nurse-managers. The advent of decentralisation of personnel management extends the responsibilities of nurse-managers and scope in relation to the organisation of the interdisciplinary health care team.

### Summary of Research

It was disconcerting to find so little written and published on the topic of nursing management in Ireland. This may be explained with respect to the education of nurses to date and preparation for research or publication. The identification of relevant research was hampered by the lack of nursing journals and a comprehensive, centralised database for nursing management literature in Ireland. Much of the work conducted by students for university degrees in disparate university departments remains uncatalogued. For this reason, important research may have been omitted from this review. The author relied on manual searches, personal contacts and networks to locate the thirteen reports of relevant research. It was often difficult to interpret the findings of the studies located; because of inadequate or complicated reporting methods. However, it is encouraging to find the beginnings of a larger body of research in this important area. The commitment of the individual researchers must be acknowledged; many undertaking large projects while still maintaining full-time jobs. Because of the diverse nature of the studies it is not possible to draw comparisons. The findings of the studies located are summarised in the following section.

Thoughout the studies hospital management structures have been described as bureaucratic, centralised and controlling – clearly impinging on the expanded role which nurses could have in the management of the health services. Many studies called for a re-organisation of the management structure by decentralising and flattening reporting arrangements, to allow nurse-managers a more meaningful role in managing the services rather than simply acting as gatekeepers. Much advice is offered on change management when redesigning work roles. It appears vital that change and the change-process are both planned for, well in advance of organisational or role redesign. In the studies reviewed, the issue of promotion within nursing management without prior competency assessment and education was acknowledged. Across all studies there was an emphasis on the need for pertinent and focused education and training. A need was also identified for a shift from theoretical instruction to management development programmes which emphasises continuous personnel and management development.

## Summary

Current nurse management emerged from the matron's role: the original nurse-manager. This chapter began by identifying the role and outlining the hospital structures within which management is now performed. Policy documents which influence nurse management were reviewed. Although these documents have dealt with the overall health structures recommendations for nurse management were also made. Many of the suggested changes although recommended some time ago are only now being implemented, resulting in a rapidly changing environment for nurse-managers. Some recognition of the changing nature of management roles is evidenced by the retitling of the Irish Matrons Association as the Association of Irish Nurse Managers, the emergence of a new association for middle managers – The Irish Nurse Managers Network and the new focus of the Association of Administrative Psychiatric Nurses. This demonstrates a response to the rapid changes resulting from policy documents.

A number of documents which addressed the current role of nurse-managers in Ireland were reviewed. It was found that the shape of the management structure in nursing was that of a cenotaph illustrating perceived barriers to promotion. There have been

substantial developments in middle nurse management roles in a small number of hospitals. However, the piloting of such roles is in process and no detailed information on the new structures is yet available. The largest body of Irish literature pertaining to nurse management was found to be policy documents and commentaries rather than research studies. A small amount of Irish research on nurse management was located.

The documents reviewed in this chapter suggest that at present, Irish nurses have a limited role in managing the health services at the highest level and this function is increasingly being conducted by general managers. The role of matron was initially that of leader and manager in the health service, however, this role has been refined to that of one specifically relating to nursing management. It is recognised in the literature that if nurses are to influence the future development of the health service there is a need for them to move towards working in general management. Whilst the preference of nurse managers is that nurses should be managed by nurses, it is also recognised that this model is under threat and that nurses must demonstrate their general managerial ability and be able to compete for posts with non-nurses.

While change to date has been slow, due mainly to the restrictive structures within which nurses operate, there are real indicators that important transformations are imminent in hospital and community nursing structures in Ireland. This is evidenced by: the preservation of the central role of the nurse manager in the education of future nurses; the various management initiatives which strengthen and expand the role of nurses in middle management; the commitment of An Bord Altranais and the Department of Health and Children to develop career paths for nurses; the recognition of the barriers which women face when seeking promotion; the development of a distinct nursing unit within the Department of Health and Children providing access for nurses to policy making; and the commitment of the Office of Health Management to develop current and future nurse leaders. All of the above allow the potential for nurses to make a significant contribution to health management. Future recommendations will determine the pace at which the potential is realised. This section of the review shows that Ireland is now facing many of the issues which have been dealt with by international health services. The next chapter examines the role of the nurse in managing the health services from an international perspective.

CHAPTER 4

# THE ROLE OF THE NURSE IN MANAGING THE HEALTH SERVICES INTERNATIONALLY

## Introduction

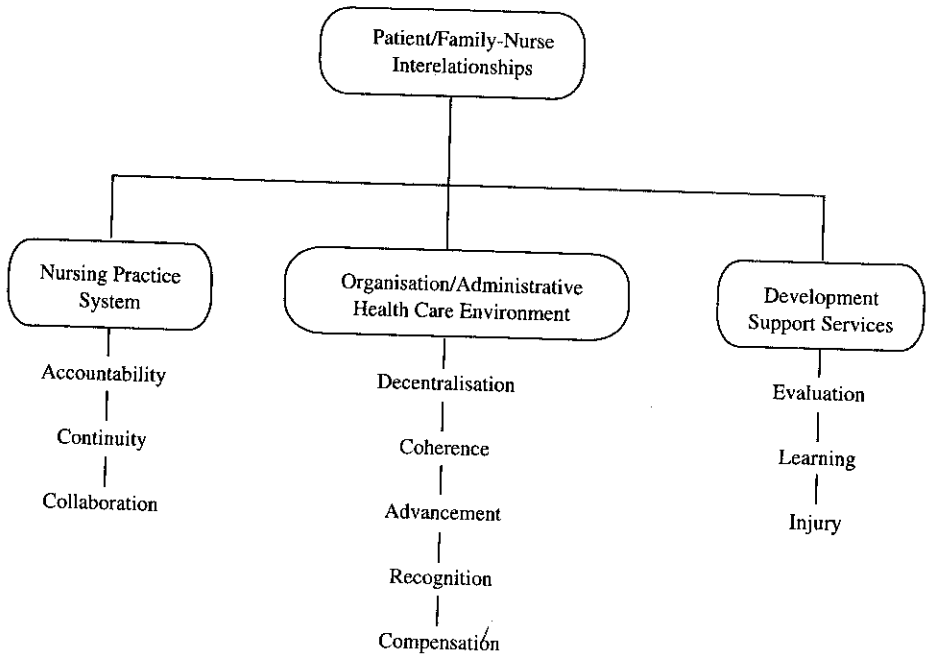
The world in which current nurse-managers gained their experience has changed dramatically. Internationally nurse-managers and administrators are being challenged by the changes in health-care delivery systems. The recent literature suggests that the hospital is no longer considered the centrepiece of care, the focus is now on a more seamless continuum of care based on an integrated health system. The extent of the literature describing innovations in nursing management provides evidence of the contribution that proactive visionary nurses have made in redesigning and redirecting their own and other's activities (del Bueno, 1991) and (Flarey, 1998). The international literature permeates the entire review and for this reason this chapter is confined to presenting models for nursing care delivery and an overview of nurse management structures in, the United States of America (USA), Canada, Australia, New Zealand, Europe and the United Kingdom (UK).

## 4.1 Nurse Management Structures – United States of America

A significant number of journals specialising in nursing management are published in North America. As a result, more literature on nursing management is published in the USA than in any other geographical region. The main focus of the American research appears to be on financial concerns and control of scarce resources. The literature reflects significant changes made in the organisational structure for nursing management, particularly, nurse management roles. The findings of the American literature in relation to nurse management have been included in chapters one and two of this work, therefore this section of the review is confined to presenting a sample of the organisational structures in American hospitals.

The Beth Israel hospital is described as a 545-bed tertiary care, teaching hospital at the Harvard Medical School, Boston. The professional nursing practice model at Beth Israel is a conceptual model that represents the principles and relationships that are central to the nursing practice system (Horvath, 1990, see Figure 4.1). In 1990, when this model was published, primary nursing formed the foundation of Beth Israel's professional model of nursing practice.

**FIGURE 4.1 The Beth Israel Hospital Professional Nursing Practice Model**




*Source:* **Horvath, K., (1990) Professional Nursing Practice Model. In: Mayer, G., Madden, J. and Lawrenz, E., *Patient Care Delivery Models*. Maryland: Aspen Publication, p. 215.**

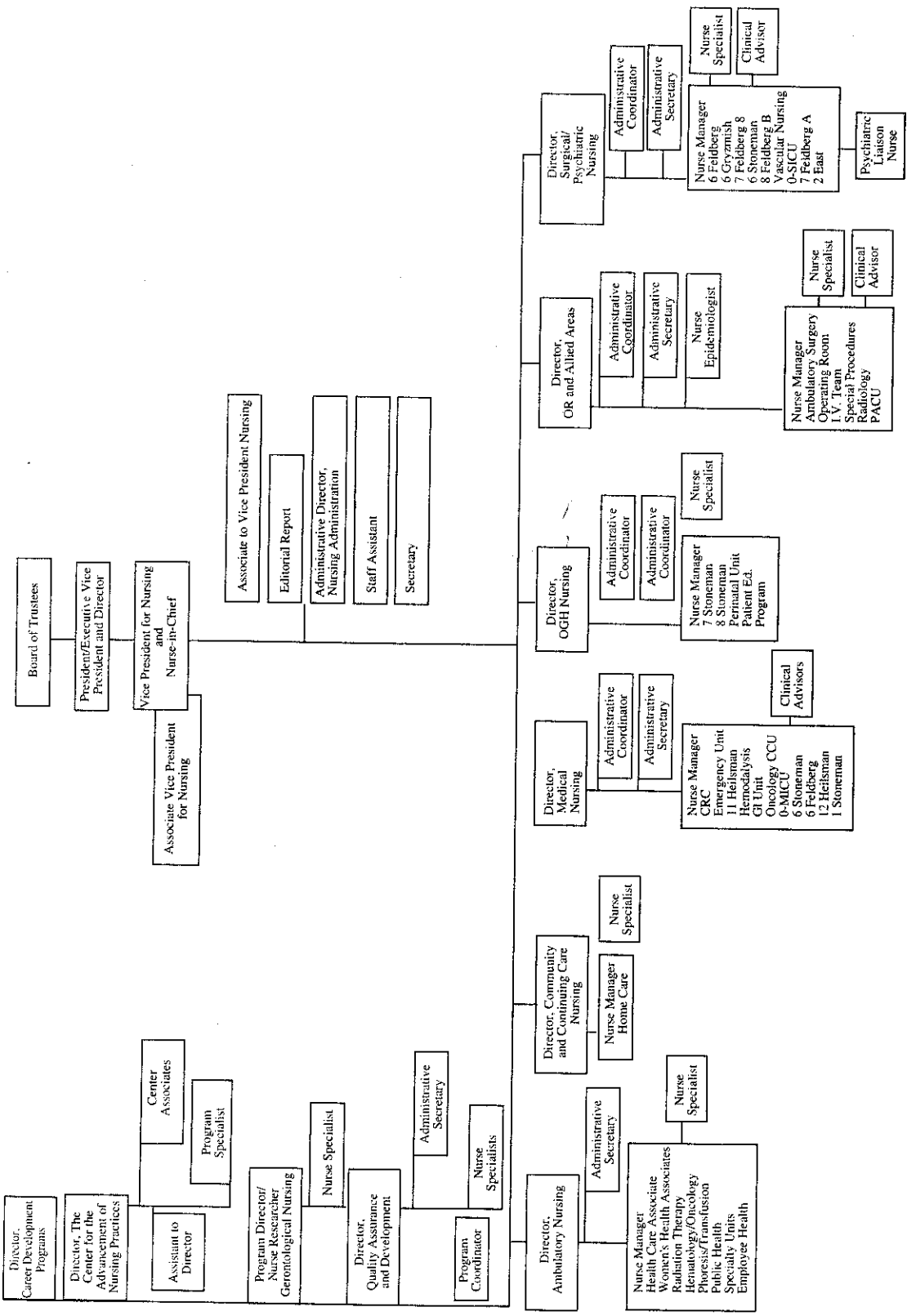
One of the first objectives articulated was to increase the use of registered nurses in the provision of direct care to patients and to concurrently decrease the utilisation of non-professionals. In the Beth Israel hospital nursing assistants/co-workers provide assistance to nurses, who in turn provide the direct care to patients. The central concepts of accountability, decentralisation, and evaluation can be seen in the model. These are consistent with values now expressed as central in the Irish health care system.

Horvath (1990) reported that the organisational chart representing managerial structures for Beth Israel's nursing services had changed many times in the previous fifteen years. The chart for 1990 is illustrated in Figure 4.2. A review of the chart suggests that there are three main levels of nursing management: senior (vice-president and associate vice-president of nursing); middle management (ten directors of nursing – six responsible for direct service areas and four support services) each director is assisted by an administrative co-ordinator and/or an administrative secretary; first-line management (unit nurse-managers) who are supported by nurse specialists/clinical advisors. As this chart was published seven years ago it is very likely that the structure has been refined and some of the support roles reduced.

Townsend reported on the reorganisation of the nursing division at Kaiser Permanente Medical Centre, in Anaheim, California in 1990. The reorganisation involved reducing administrative levels from four to three, adding a totally new nursing management role (Clinical Nurse Specialist) to the institution and redefining all remaining first and second-line management positions. The old and new structures are presented in Figure 4.3.

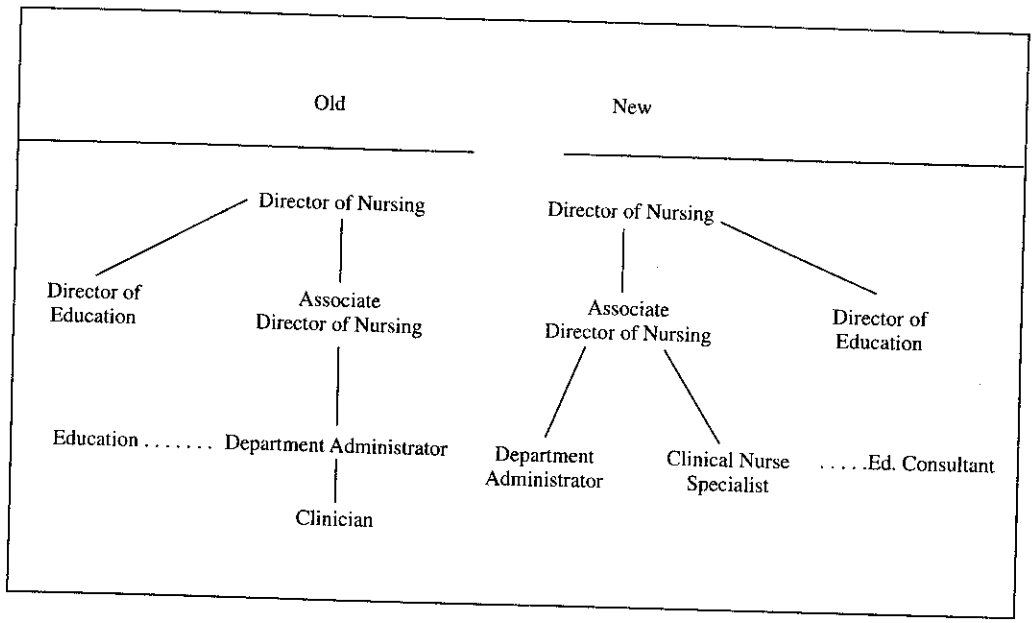
The report suggested that in the new structure every department administrator (DA) shared responsibility for their unit with a clinical nurse specialist, reporting in tandem to an associate director of nursing (ADN). Townsend suggests that the new structure was designed to elevate clinical issues to the same importance as resource issues, with potential conflicts being mediated by the associate director of nursing.

**Figure 4.2 Beth Israel Hospital Nursing Services Organisational Chart.**




*Source:* **Horvath, K., (1990) Professional Nursing Practice Model. In: Mayer, G., Madden, J. and Lawrenz, E., *Patient Care Delivery Models*. Maryland: AnAspen Publication p.233.**

**FIGURE 4.3 Organisational Chart of Typical 36-bed unit, Kaiser Permanente Medical Centre.**

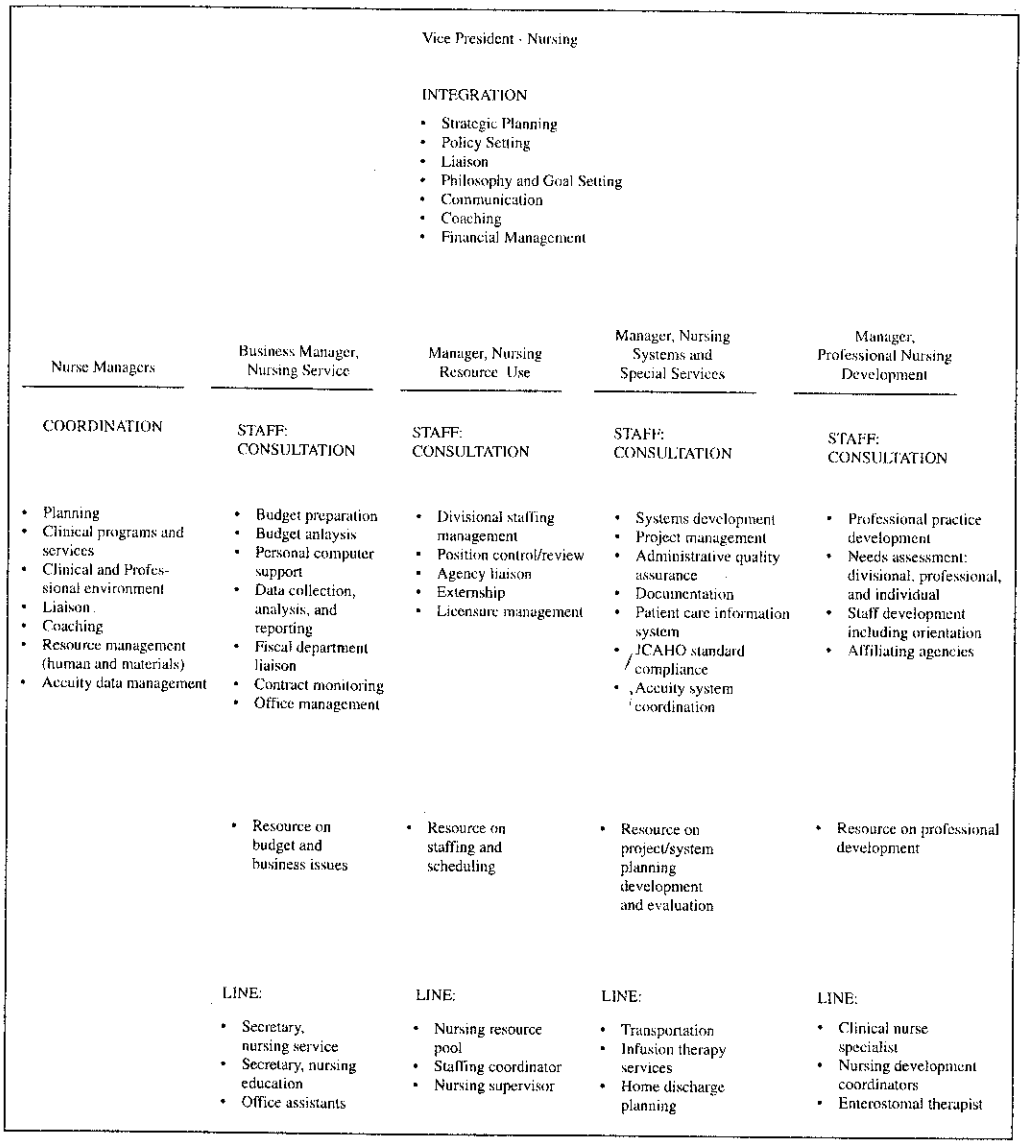



*Source:* **Townsend, M. (1990) A Participative Approach to Administrative Reoganization.** ***Journal of Nursing Administration*** **20, p. 12.**

In Columbia hospital, a 394-bed facility in Milwaukee, Wisconsin, the nursing structure in 1986 was reported to be similar to many other hospitals: there was a vice-president for nursing services, directors of nursing, nurse-managers, and associate nurse-managers (Eichelberger et al. 1994). The role of the nurse-manager was gradually changed to one with responsibilities to manage larger budgets, address strategic business planning, and to devote attention to the care environment while decreasing involvement with daily operations. These changes resulted in notable role confusion and stress for nurse-managers. To address this issue, administrative support team roles were developed to provide specialised internal consultation and support to a flattened and decentralised nursing division. Four new administrative support team roles were introduced: Business Manager (nursing service); Manager (nursing resource use); Manager (nursing systems and special services) and Manager, (professional nursing development). Figure 4.4, presents the new division of nursing functional organisation chart (1994) with an outline of each role. From the diagram it appears that there are two levels of management that operate in the organisation; senior and middle. The registered nursing workforce is not included in the illustration. The structural innovation was based on the concept of nursing shared-governance and total quality management. When evaluated 15 (93%) of the managers interviewed, found this structure to be the most satisfying of all the different structures in which they had worked.

The authors suggest that lessons learned in the organisational redesign may be helpful to organisations seeking structural solutions to leadership role ambiguity. Other issues addressed by the redesign were, insufficient visibility and accessibility of the nurse executive and lack of organisation alignment and multiple leadership levels. An additional reported advantage of the flattened organisation is that it provides the vice-president with direct knowledge of patient care issues rather than information that is relayed by another management layer.

**FIGURE 4.4 Division of Nursing Functional Organisation Chart, Columbia Hospital Milwaukee.**




*Source:* **Eichelberger, K. Behl, S., Lees, Ml, Peterson, S. and Taylor, A. (1994) Administrative support team: a structural innovation.** ***Journal of Nursing Administration*** **24, p. 44.**

The sample of organisational charts for American health-care organisations presented in this section of the review indicates a diversity in organisational design, which has developed and changed over the last ten years, throughout hospitals and at unit level. The common element appears to be a drive to flatten the structure, decentralise and reduce the number of hierarchical layers and create a more integrated health care system. Middle management as we currently know it in Ireland, has virtually been eliminated in the USA with a requirement for all professional and specialist staff to engage in administration and management as part of their normal duties. The objective was to remove barriers between employees and senior executives who act as coaches to assist clusters of self-governing groups to function.

## 4.2 Nurse Management Structures – Canada

Over the last five years major changes have been introduced in the health services in Canada resulting from an economic recession. In the mid 1990's, the Ministry of Health in Canada was required to make dramatic cuts in the health budget. The nursing profession has been seriously affected by these events. The traditional departments of nursing appear to have been dismantled and new management structures introduced, based on an integrated-delivery-systems.[16] There are large variations in the care delivery models adopted by hospitals. Some are reverting to an "All RN" service and others are concentrating on downsizing the nursing workforce and introducing nurse extendors (assistants). Redundancies have been experienced by nurses who are in some instances replaced by lower paid generic workers. It was reported that one Toronto-area hospital replaced almost 100 full-time Registered Nurse (RN) jobs with registered practical nurses (RPNs) and unregulated generic health care providers (Wood and Grinspun, 1996). The title "nurse" appears to be under threat as it is being used by other unregistered grades of staff. A concern was expressed by Grinspun (1996) in relation to the general public ability to differentiate between carers who are registered professional nurses and those who are generic workers.

Through conversations and a review of the literature, it is apparent that the role of the nurse and the management of nurses in Canada is influenced by managed care model introduced from the USA. The literature search revealed a small number of incisive Canadian research studies which have been included earlier in this report. At the time of writing the review organisational charts for nursing structures in Canada were not available to the researcher.

## 4.3 Nurse Management Structures – Australia.

Australia has three levels of government: Federal, State/Territory and Local. The Federal Government, through the Department of Health and Family Services, sets national health policies and subsidises service provision by State and Territory Governments and the private sector (Commonwealth Department of Health and Family Services. 1997). In Australia, nursing is organised almost independently in each state/territory. The nursing profession is regulated by a Nurses Registration Board, one for each state, which liaise with the federal overarching group – the Australian Nursing Council (ANC Inc). Nursing care is delivered by registered nurses and enrolled nurses (second level nurses). In parts of the health system, nursing work is also shared by assistants in nursing (AIN).

> An assistant in nursing is a person, other than a registered nurse, student nurse trainee or enrolled nurse, who is employed to undertake, under supervision, nursing duties in a hospital or health care centre. There are no formal educational courses to become an assistant in nursing, however, preparation for the role is usually provided by employing authorities (Meppem, 1995).

In 1994, 63% of all nursing staff in Australia were registered nurses, 23% enrolled nurses and 13% assistants in nursing (at a similar time in the UK 28% of the nursing workforce were health care assistants) (Reid, 1994).

[16] Personal conversations with nurse managers during a visit to Toronto in August 1997. Doris Grinspun (executive Director), Charlotte Noesgaard (President )Registered Nurses Association of Ontario; Sherry Espin (Operating Room, Clinical Resource Unit Manager – teaching) The Toronto Hospital; and Margaret Fitch (Head of Oncology Nursing) Toronto Sunnybrook, Regional Cancer Centre.

Nurse management functions, roles and titles vary considerably across Australia. At the most senior level, the Health Department for each state employs a senior nurse who leads the nursing unit within the department. The role of the chief nursing officer for the New South Wales Health Department is described as "providing a professional interface between the Minister, Director-General, the Health Department and the Public, Private and Academic sectors of the nursing profession" (Meppem, 1998, p.2). The State of New South Wales (NSW) is divided into seventeen different area health services, the nursing services for each area are lead by an Area Director of Nursing with varying titles Director of Nursing Services; Director of Nursing and Human Resources, Area Director of Nursing and Clinical Services, Director of Nursing and Community Development, Area Director of Nursing and Service Quality. The Area/District Director of Nursing is described as a senior nursing administrator who has the responsibility for planning, development and implementation of nursing services across an area/district health service (Meppem, 1995).

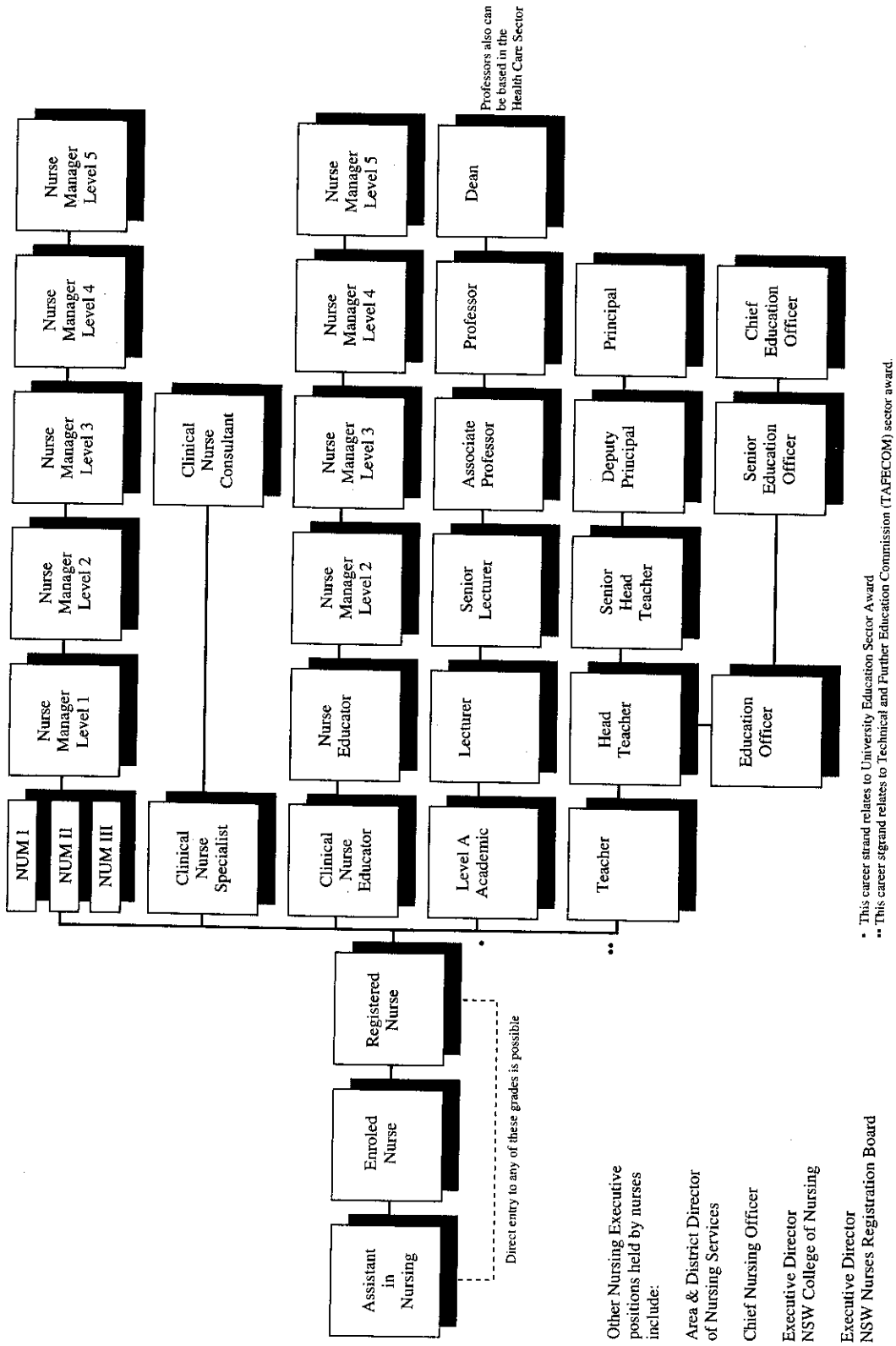
Figure 4.5 illustrates the various career pathways in; management, clinical, education, academia (university and technical/further education sectors treated separately) open to nurses in NSW. The nursing management structure within hospitals is divided into two groups, nurse unit managers (NUM) and nurse-managers (NM). Unit nurse managers are described as first-line nurse managers, in charge of a ward/unit/group of wards/units in a hospital or health service. There are three levels of first-line managers – NUMs (NUM I, NUM II, and NUM III), depending on the level of responsibility, not all levels are employed in each unit. The nurse unit manager is equivalent to the ward sister in the Irish context.

The nursing management structure for NSW does not identify a distinct middle management level, all nurse managers above first-line are grouped together and referred to as Nurse-Managers, of which there are nine grades. The grades range from deputy nurse manager of a small facility to the area director of nursing for a complex health service (see table 4.3). The nine grades are not all used within a single health facility, rather the health services determine the number and level of nurse-manager grades appropriate for each organisation. This depends on the requirements of the position and the complexity of the roles and services provided. The core knowledge and skills expected for each grade of nurse-manager are identified in the Nurse Managers State Award (1997). The level of knowledge and skill for each grade are given under the following headings: leadership, communication, knowledge, performance management, planning and resource management (see Appendix 6).

During a meeting with the Commission on Nursing, the management structure for nursing in acute hospitals in Queensland was described.[17] There appear to be three main levels of management: senior management – director of nursing; middle-management – assistant director of nursing and clinical-nurse-consultants; first-line management – unit managers and clinical-nurse-specialists. Clinical-nurse-specialists were concerned with the development and management of "nursing" at unit level, while clinical-nurse-consultants operated across units. The reported structure suggests that a parallel exists between clinical and business management.

[17] Tom Meehan RPN, Senior lecturer at Queensland University of Technology, presentation made to the Commission on Nursing on developments in nursing in Australia, 29th October 1997.

**Figure 4.5 Overview of Nursing Career Pathway for Nurses in New South Wales.**
**⊙review of Nursing Career Pathways for Nurses in New South Wales (May 1995)**




*Source:* **Meppem, J. (1995)** ***Nursing Career Pathways for Nurses in New South Wales.*** **Sydney: New South Wales Health Department, p. 8-9.**

Williams described a different structure for Western Australia. She reported that "charge nurses or unit managers are no longer employed in the area, the rationale is that professional nurses should be able to function as a team, with different team leaders, called the shift co-ordinator." Williams reported that the move has not been successful, but as union co-operation is required to make further changes (which is not forthcoming), some hospitals have introduced clinical-nurse-manager positions who are "de facto" charge nurses.[18]

**TABLE 4.1. Schedule 1: Work Level Statement – Nurse Managers, NSW**

**Grade 1**
Deputy nurse manager in a small health facility or hospital and is responsible to an on-site Nurse Manager; or supervisor in small health facility or hospital on evenings, nights and/or weekends.

**Grade 2**
Deputy nurse manager, and is responsible to a nurse manager who has responsibility for the management of two or more hospitals; or co-ordinates and manages a function, service or section within a health facility or hospitals.

**Grade 3**
Deputy nurse manager in a medium-sized health facility or hospital; or co-ordinates and managers a nurse education service of a hospital/group of hospitals/health facility or is responsible for the management of nursing services in a small health facility or hospital; or co-ordinates and manages a complex function, service or section within a health facility/hospitals.

**Grade 4**
Deputy nurse manager in a complex hospital; or is responsible for the overall management of nursing services across a group of small hospitals or facilities or health services; or co-ordinates and manages a hospital wide function or service in a tertiary referral teaching hospital.

**Grade 5**
Responsible for nursing operations in a major clinical division (e.g. surgery or medicine) of a teaching hospital; or co-ordinates and manages a complex nursing education function; or is the on-site executive officer in addition to responsibility for the management of nursing; or management of nursing services in a medium sized health facility or hospitals.

**Grade 6**
On-site executive officer in addition to responsibility for the management of nursing services in a facility or hospital (or group) or is responsible for the management of nurse education in an area health service; or deputy nurse manager in a tertiary referral teaching hospital; or a major clinical division of a tertiary referral teaching hospital.

**Grade 7**
Management of nursing services in a complex hospital; or management of nursing services across a group of medium sized hospitals/facilities/health services; responsible for the management of nurse education in an area health service.

**Grade 8**
Management of nursing services across a group of complex hospitals/facilities/health services.

**Grade 9**
Area director of nursing services in a rural Area Health Service; or responsible for the nursing services in a major teaching hospital providing tertiary referral services.

***Source adapted from:*** **New South Wales Health Department (1997) Public Hospital Nurses (State) Award – Nurse Managers.**

It was reported to the Commission, that the involvement of nurses in management in Australia is constantly under threat as the positions become more and more "generic" in nature. This is evidenced by the fact that the Victorian Council of Peak Nursing Organisations (comprised of Australian College of Nurse Management Inc., Australian Nursing Federation, Victorian Heads of School (Nursing) and Royal College of Nursing Australia) published a collaborative and agreed position statement on the role of the director of nursing in Australia in 1997. The basis of the statement is that, in organisational structures all health service facilities must include the position of director of nursing (however titled) who must be a registered nurse. In the statement, details concerning the

[18] Correspondence from Susanne Williams, Office of Chief Nursing Officer, Health Department of Western Australia, 24th September 1997.

essential roles and functions of the director of nursing position are set out (see Table 4.4). The position statement is underpinned by nine concepts which support the rationale for retaining the director of nursing position.

**TABLE 4.2. Position Statement Director of Nursing**

The position of the director of nursing must maintain the following:

| | |
|---|---|
| Executive role: | participation in corporate planning, organisation and evaluation with Board of Management/Board of Directors, Senior Executive and Advisory committees involving patient care – nursing service. |
| Divisional role: | is accountable and responsible for standards of patient care and nursing practice, through nursing personnel management, communication, financial management, staff development/education, quality activities including peer review and research. |
| Unit level management structures: | where decentralised clinical groups are established, to reflect equal and complimentary relationships among registered nurses, medical practitioners, allied health professionals and managerial personnel. Nursing position in these units must reflect a professional relationship with the appropriate authority of the director of nursing. |
| Delegation of nursing care responsibilities: | which must only be to registered nursing practitioners in compliance with the Nurses Board of Victoria Guidelines. |

***Source adapted from:*** **Victorian Council of Peak Nursing Organisations (1997)** ***Position Statement – The Position of Director of Nursing in the health services organisational structure.*** **Victoria: Victorian Council of Peak Nursing Organisations.**

From the available literature and from conversations with nurse-managers it appears that their has been a concerted effort to flatten the management structures in hospitals in Australia. A variety of management models have been used to achieve this which are generally based on the concept of resource management/clinical management evident in the clinical directorate model (Kearney, 1998). In the Central Sydney Area Health Services separate vertical professional management streams are maintained, while services are grouped as follows: cancer services; cardiovascular services; neurosciences; respiratory and critical care services; gastroenterolgoy and liver services; bone, joint and connective tissue disorders; general, geriatric and rehabilitation medicine; women's and children's health; mental health services; and primary health care services (Horvath, 1996). Each service is lead by an area clinical director, nurse co-ordinator and business manager. Departments, such as physiotherapy and operating theatres, remain centralised with individual department heads. Kearney (1998), describing the establishment of functional units at the Royal Adelaide Hospital, suggests that the director of nursing, for each functional service, has a significant increase in responsibility for both nursing services and a wider role in the management and provision of patient care services. However, he also suggested that there is a need to retain a strong central nursing bureaucracy responsible for selection and recruitment of senior nursing staff, maintenance of professional nurse standards and management of central services such as accident and emergency.

In a major review of nursing education in Australia it was reported that substantial changes in health-care delivery, have increased the importance of the management function of nurses in all aspects of health-care, including systems management, institutional management, case management, teamwork (management of collaboration and collaborative management) and self-organisation. The authors recognised that

because of management changes, postgraduate management education in nursing is paramount to the development of the profession (Reid, 1994).

## 4.4 Nursing Management Structure – New Zealand

It was not possible to locate detailed published material pertaining to nursing management structures in the health services in New Zealand. However, two directors of nursing working in New Zealand gave very detailed personal accounts of changes in the management structure in their country (in correspondence).[19,20] A summary of their comments can be found in this section of the report.

They reported that health-care in New Zealand has undergone considerable change over the past decade. In the 1980's organisation of health-care moved from hospital boards and health departments to eighteen area health boards which combined both hospital and public health functions. In 1993, the era of the health reforms began in earnest and a move was made to four Regional Health Authorities (RHA) (the purchaser of health services across a region) and to twenty three Crown Health Enterprises (CHE) (the providers of health services for a smaller geographical area/population base). At this point CHEs began contracting with regional health authorities for the provision of service. In 1997 the regional health authorities (now called the Transitional Health Authority) are increasingly contracting with GP groups for primary health care in a New Zealand version of managed care or GP fund holding.

During this period of change, most area health boards also removed their chief nurse role and a number of organisations for several years had no clearly defined senior nurse position. Since the development of crown health enterprises this trend has gradually been reversed and now all but two of the twenty-three CHEs have an identified senior nurse role. These are primarily staff function/advisory positions.

Nurses function within services (directorates), e.g. mental health; medical; surgical; community; women's, child and family services; etc. and report to the service director/manager of their respective directorate. In public health organisations, nurses are managed by individuals in general management roles at directorate level (i.e. service managers or service directors), but are managed by nurses within each ward/unit setting. The person in the generic management role may well have a nursing background but the role is identified as a management role not a nursing one. The number of general managers from nursing backgrounds was reported to be increasing. The change from nurses being line-managed within a traditional nursing hierarchy to the general management model occurred during the introduction of Area Health Boards (AHBs) and CHEs.

The senior nurse position in most CHEs in New Zealand is called the director of nursing or the director of nursing and midwifery. The rest are either nurse executives, or professional nurse advisors. It was reported that, in most organisations the director of nursing reports directly to the chief executive officer. This placement in the structure was considered to be an advantage. In organisations where this structure does not exist, the director of nursing reports to the human resource manager or a clinical service director (the Grey hospital structure is presented on Figure 4.6).

[19] Catherine Cooney Professional Nurse Advisor, Lakeland Health ltd, Rotorua Hospital , Rotorua, New Zealand.
[20] Mary Gordon , Professional Nursing Advisor, Health South, Canterbury Ltd. Timaru, New Zealand.

At the second level there are clinical-nurse-consultants and clinical-nurse-specialists. There may also be:

- Nurse Practitioner type roles: e.g. Neonatal Nurse Practitioner, Independent Nurse Practitioner, Rural Nurse Practitioner;
- Nurse Educators: e.g. Cardiac Nurse Educator, Asthma Educator, Diabetes Educator;
- Resource Nurses: e.g. Infection Control, In-Service Educators.

The next management level comprises the nurses managing the wards/units. The term ward sister has not been used in New Zealand for about fifteen to twenty years. Titles for this position vary, the title selected relates to the type of unit or service manager role; charge nurse, ward/unit nurse manager or clinical nurse leader/manager. Nurse managers of a ward/unit have responsibility for both clinical practice, standards of care and for human and financial resource management. Increasingly moves have been made to flatten structures. The aim of this is to ensure that every nurse practitioner takes more responsibility and accountability for their own practice. Using the title clinical-nurse-leader (CNL) for ward manager positions, signals this move. In almost all hospitals in New Zealand, the charge nurse/CNL has a significant level of budget accountability. Those with the title ward nurse manager have the greatest budget responsibility. In organisations, where CNLs are employed, financial support is provided to a group of CNLs from an operations manager who takes responsibility for the day-to-day budget which enables CNSs to focus on clinical standards.

At ward/unit level staff nurses, enrolled nurses and health-care assistants are employed. No enrolled nurse training has occurred in New Zealand since 1990 and the second level nurse position is being phased out. Work is being conducted to clearly define the scope of practice/role of health-care assistants for allocation and managerial purposes.

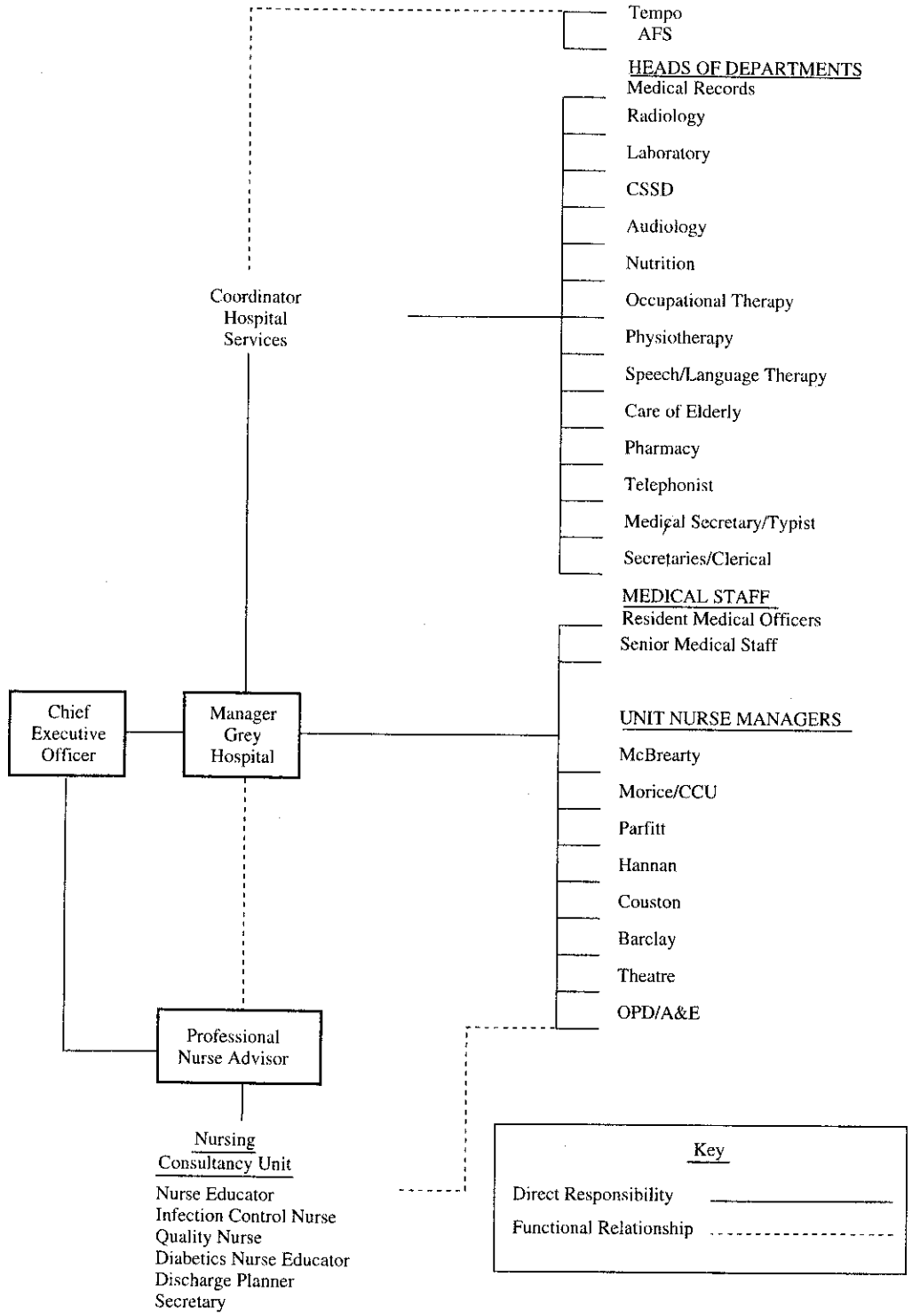
Gradually most CHEs in New Zealand are establishing career paths for nurses. The New Zealand nurses organisation and colleges support this development which has not yet been implemented nationally.

## 4.5 Nurse Management Structures – Europe

The literature search for this project identified a paucity of research relating to nursing management structures published in English, in mainland Europe. It is possible that some studies exist published in national languages and are therefore inaccessible for the purpose of this review. The International Council for Nursing (ICN) and The World Health Organisation have published some useful documents.

The ICN's (1990) document *Preparation of Nurse Managers and Nurses in General Health Management* has been discussed extensively in chapter three of this review. In 1994, the ICN published a document on *Planning Human Resources for Nursing* which gives a review of methods used to estimate workforce requirements and skill mix (ICN, 1994). This document is a useful resource for nurse-managers considering human resource issues.

**Figure 4.6 Grey Hospital Organisation Chart, Health South Canterbury, New Zealand.**

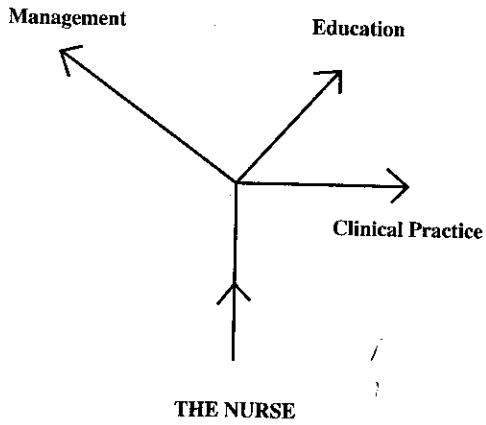



*Source:* **Gordon, M. (1997) Professional Nursing Advisor, Health South, Canterbury Ltd. Timaru, New Zealand.**

In 1995, the ICN published a working document *Career Development for Nurses.* In this document the ICN recognised that traditionally, nurses demonstrating clinical excellence and in search of career development have been obliged to seek promotion in either management or education (see Figure 4.7).

**Figure 4.7 Traditional Career Structures for Nursing**

TRADITIONAL CAREER STRUCTURE




*Source:* **International Council for Nurses (1995)** ***International Council of Nurses working Document Career Development for Nurses.*** **Geneva: International Council of Nurses, p.5.**

The authors of the report suggest that due to a lack of recognition and valuing of clinical nursing care and its outcomes there is an absence of clear clinical pathways for nurses in Europe. The ICN recommend, as a priority, the introduction of career structures that accommodate the public's demand for a quality health service and nurses' need for professional advancement opportunities in clinical practice. The ICN define a career structure as:

> a professional framework designed to facilitate the provision of improved health care, develop excellence in nursing and allow career advancement and remuneration for demonstrated competence, experience and education preparation at different levels within all fields of nursing: nursing management, nursing education, clinical practice and nursing research (International Council for Nurses, 1995, p.5).

While the ICN task force on international nursing research (1990) recommended that mechanisms be created to sustain a research career in nursing, no specific structures have yet being developed (International Council of Nurses, 1990). In the document the ICN give examples of models of clinical career structures in New Zealand: *Clinical Career Structure* (5 levels), United Kingdom: *Clinical Grading Structure* (7 levels), United States: *Dual Track Ladder* (5 levels). In both the USA (see Appendix 7) and the UK (see Appendix 8) a separate ladder for management is presented.

The contribution of nurses to the management of health-care was examined by the World Health Organisation in 1992. The findings indicated that problems relating to management include: a shortage of well-educated nurse managers; a work environment

consisting of inadequate information systems and a lack of inter-professional collaboration and teamwork (World Health Organisation, 1992).

In 1993, the World Health Organisation (WHO) published a text *Nursing in Action.* Issues such as policies and principles, developing a regulatory framework, reorienting nursing education and preparing for leadership, were addressed (Salvage, 1993). In the introduction Salvage describes fifty member states in the new Europe who employ over five million nurses. She reports that in no country of the region do nurses play a full part in policy-making and decision making at all levels of the health care system. Many countries, in all parts of the region, have no nurse in a senior ministry position, in fact, the person in charge of nursing affairs is often a doctor. Salvage contends that health ministries alone do not change the world, however she suggests that the strength of nursing at ministry level is important in both symbolic and political terms, and is a fair indicator of the formal power nurses have in a country.

A chapter of the text is devoted to changing nursing practice. The role managers and educators can take in this process is set out, Salvage suggests that if nurse-managers use their roles imaginatively, they can act as change agents by helping to create a climate that enables change to take place. They can support staff in the creation of a vision of a better future. She suggests that the manager often controls the budget and so ensures that resources can be made available when needed. Salvage concludes that the nurse-manager has a key role in the schemata of change. Practical advice on the preparation of nurses for leadership and management are given in the text.

The Nursing and Midwifery unit of the WHO spent four years collecting data and constructing nursing and midwifery profiles for the new Europe of which there are now forty-six profiles (Salvage and Heijnen, 1997). The findings of the survey are presented in *Nursing in Europe: a resource for better health.* The data showed huge variations in nursing and midwifery across the region. In particular they show a wide gap in the quality of care between west and east, caused partly by the crisis now engulfing the health care system of many eastern countries but also by the historical neglect of nursing and midwifery. No direct correlation was found between the socio-economic condition of a country and scope of nursing practice. To combat the problems identified it was suggested that people with good management capabilities be identified and trained to create a core of managers with modern management skills, – a combination of leadership and administrative expertise. The importance of decentralised management, devising action plans for nursing and creating chief nursing posts in the Ministry of Health were emphasised (Salvage and Heijnen, 1997). Nurses' participation in all aspects of planning at every level of the health care system is relatively strong in only a few countries, such as Iceland, Israel and the United Kingdom. In other countries, nurses are not yet seen as a vital part of the policy development group. From the document it is evident that, in general, the management of nursing in Europe is not at a sophisticated level of development to provide examples of best practices.

In Spring 1993, the WHO launched the LEMON project (LEarning Material On Nursing) to provide a package of materials to all nurses and midwives (particularly to countries of central and eastern Europe and the newly independent states of the former USSR) in their own official languages. The short-term aim of the project was to make a core package of material available to as many nurses and midwives as possible. The long-term aim was for countries to become self-sufficient in selecting, writing and producing their own material. The final document was published in 1996 as a result of extensive and intensive collaboration between country LEMON groups, Lemon international advisory

group, subject experts, compilers, editors and others (World Health Organisation, 1996). The extensive pack consists of thirteen different chapters (booklets): twelve of the chapters deal with all aspect of nursing, chapter eleven specifically addresses management and leadership (leading the change in nursing), indicating an awareness of the need for management development at a very early stage in every nurses education.

## 4.6 Nurse Management Structure – United Kingdom

As our closest neighbour, the health service in the UK has been carefully examined for relevant experiences whenever similar developments are being considered in Ireland. Significant changes have been made in nursing in the UK in the last decade: particularly in the management of nursing. For this reason, this section of the review gives a brief historical account of the changes in nurse management roles, an overview of the most recent reports which effect the role of nurse-managers and an outline of the organisational structures in which nurses operate.

*Recent History of Nurse Management in the United Kingdom*

The Salmon report 1966 was critical of the nursing management and introduced an industrial management model (Ministry of Health, 1966). The reforms introduced a hierarchical nursing structure within hospitals and hospital groups. The functions of nurse-managers were seen as, providing clinical support, managing nurse staffing and providing the nursing contribution to overall hospital management (Strong and Robinson, 1988). Problems were encountered in the introduction of the reforms: the absence of a skilled cadre of nurse-managers to take the new posts; and the speed at which the proposals were introduced which left very limited time for management training; the new structure meant that nursing career advancement required a move into administration after ward sister level; and training used industrial and business models which nurses found of limited relevance to their work (Strong and Robinson, 1988).

In 1974, a new administrative structure for the National Health Service (NHS) was created, (known as the "greybook" reorganisation) with district, area and regional tiers. Each level was managed by a consensus team, with nurse management input in teams at each level. So called, Salmon-style nurse-managers were introduced into the new three tiered structure, as well as within individual units. In the reorganisation it was found that the hierarchical nursing tradition militated against effective innovation in nurse management. In 1982, the area tier of NHS administration was abolished (Strong and Robinson, 1988).

The Griffiths Report, 1988 attacked the wisdom of clinical management and began the implementation of general management, effectively bringing about the birth of a new business-oriented culture in the NHS (DHSS, 1983). Chief Nurse Advisor (CNS) posts were developed to give advice on clinical matters (Robins et al. 1989).

In 1986, the Department of Health and Social Security (DHSS) formally announced a national pilot of management structures in six acute hospitals. The experiment became known as the resource management initiative (RMI). The overall aim of the resource management initiative was to enable the NHS to give a better service to patients by helping clinicians and other managers to make more informed judgements about how the resources, which they control, could be used to maximum effect (DHSS, 1986). The involvement of clinicians and nurses was from the beginning one of the distinguishing

characteristics of the RMI. In April 1989, resource management became an approved policy and provided the impetus for the widespread introduction of clinical directorates in the UK.

In the UK, the health services are divided into purchasers (e.g. GP fund holders) and providers (trusts/directly managed units) of health services. Hospital and community services (the providers of health services) are required to have a board-level post for a nurse, while commissioners of health (the purchasers of health services in the UK) are not required to have a board-level senior nursing post within the organisation. The NHS and Community Care Act 1990 set the legal framework for the requirement of a nurse executive director on each trust board (Department of Health, 1990).

The NHS review of the functions and manpower of nursing (1994) provided for the introduction of professional nursing staff in the NHS executive to support the chief nursing officer and the introduction of nursing expertise in regional offices of the NHS executive. The nurse executive role concentrates on providing nursing advice and generally excludes line-management responsibility. This role also includes a corporate function such as a clinical service management or strategic co-ordination of corporate initiatives in quality assurance, risk management, re-engineering, or development of primary care (Malby, 1997). Although nurses and midwives comprise 49.5% of the National Health Service workforce, their representation in strategic-level leadership positions remains small (Malby, 1997). Despite the number of senior level positions there are concerns about the profession's current ability to supply appropriate leaders.

**TABLE 4.3. Reports Effecting Nurse-Managers Roles**

| Author/Publisher | Year | Title |
|---|---|---|
| King's Fund Centre | 1988 | Developing the Role of the Ward Sister. |
| Department of Health (nursing) | 1989 | A Strategy for Nursing |
| King's Fund Institute | 1990 | New for Old? Prospects for Nursing in the 1990's |
| Audit Commission | 1992 | The Virtue of Patients: Making Best Use of Ward Nursing Resources |
| Audit Commission | 1992 | Caring Systems: A Handbook for Managers of Nursing and Project Managers |
| Audit Commission | 1993 | Making Time for Patients: a Handbook for Ward Sisters |
| NHS Management Executive | 1993 | A Vision for the Future – The Nursing, Midwifery and Health Visiting Contribution to Health and Health care |
| NHS Management Executive | 1994 | Testing the Vision a Report on Progress in the First Year of "a vision for the future" |
| NHS Executive | 1994 | Shadowing: Management Development for NHS Staff |
| Department of Health | 1995 | Managing in the NHS: a Study of Senior Executives |
| NHS Women's Unit | 1995 | Creative Career Paths in the NHS – Senior Nurses |
| Sheffield Centre for Health | 1995 | Catching the Tide: New Voyages in Nursing? and Related Research |
| Health Services Management | 1996 | The Future Health-care Workforce – the Steering Group Unit, University of Manchester report |
| Council of International | 1997 | Executive Summary – Clinical Grading, Competencies Hospitalsand Roles |

*Major UK Reports Pertinent to Nurse Management*

Both general managers and nurse-managers have written extensively about management in the UK. There have been a number of large scale studies conducted by University Departments on behalf of the Department of Health. In this review, an attempt was made to identify the major reports, published in the last decade, which effect nurse-managers roles. Fourteen such reports were located and are listed on Table 4.3 by title. The listing is not intended to be exhaustive, rather to present a sample of the work which has been conducted in the area. The range of reports suggests that there has been a significant investment in the last decade in the examination of nursing management in the NHS. This section of the review presents the findings of the reports that are pertinent to nurse management. The reports are discussed in chronological order.

*Research in Action Developing the Role of the Ward Sister*

In 1981, the King's Fund Centre convened a peer group of nurse researchers (12 in total) whose recent past or present research concerned the ward sister's role, training needs or ward learning environment (Alexander et al. 1988). The results of the project were published in 1988, *Research in Action Developing the Role of the Ward Sister*. The group started by sharing their research findings and then with a wider professional audience through conferences and workshops. The common themes throughout the research were: the power of the ward sisters role; attitudes and expectation of the role, conflict between the management and clinical aspects of the role; and sister as change agent. The aim of the group was to share their work with others (ward sisters, nurse managers and nurse teachers) and find ways of putting the research findings into action. The project represents a novel way of making nursing research more visible and useful for the practical concerns of nursing.

*A Strategy for Nursing*

In 1989 the Department of Health's Nursing Division published a unique blueprint for the nursing professions in the UK *A Strategy for Nursing*. A total of forty four targets for the nursing profession were set out in the strategy under the headings of practice, manpower, education, leadership and management. The key targets from the strategy were set for completion by 1991. The leadership and management targets were as follows:

- Nurses, midwives and health visitors should have access to an experienced senior practitioner for advice on professional issues; procedures should be in place to resolve ethical issues arising from individual clinical practice.
- Management should ensure that policies, practices and procedures meet the objectives of the organisation.
- Practitioners should be afforded personal appraisal of their performance and potential, advice on career options and appropriate training opportunities.
- Staff with special potential should be identified and given appropriate opportunities for development (Department of Health, 1989).

The strategy presents a very clear vision of aspirations for nursing, and articulates in a practical way the necessary steps that are required to reach the target. It is interesting to note that the strategy emanated from the nursing division at the Department of Health.

This would appear to add strength to the status of the strategy. No such document exists for Irish nursing.

*New for Old? Prospects for Nursing in the 1990's*

In 1990 the Kings Fund Institute published a research report *New for Old? Prospects for Nursing in the 1990's* aimed at clarifying key issues in British nursing for other health policy makers. It was particularly aimed at a non-nursing audience, in the hope that it could illuminate important aspects of workforce planning, management and health-care delivery for the NHS. A section of the report is devoted to the management of nursing (Beardshaw and Robinson, 1990). It was commented that the nursing management, and the quality of nursing advice available to general managers within the NHS left a great deal to be desired, in terms of both content and effectiveness.

The report described the issues for management of nurses as: bureaucratic management styles; the absence of a clinical career structure; deficiencies in nurse education; under-investment in nursing research which combined to encourage a ritual-centred, routine based approach to nursing care and discouraged clinical innovation and individual initiative. The report advocated a new approach to management by:

- Developing an explicit career path for nurses.
- Working for clinical effectiveness.
- Reassessing skill-mix and the need for a wider view of human resources.
- Improving the calibre of untrained staff.
- Making nursing work more rewarding and attractive.
- Finding new skills and approaches to nursing in the community (Beardshaw and Robinson, 1990).

This report highlights the importance of publishing material that presents and interprets nursing issues for a wider audience than just nurses.

*The Virtue of Patients: Making Best Use of Ward Nursing Resources*

In the UK, the Audit Commission became responsible for external audit of the National Health Service (NHS) in October 1990. As well as reviewing the financial accounts of all health service bodies, the Commission's auditors have a duty to examine the economy, efficiency and effectiveness of health authorities' use of resources. Each year several health service topics or service areas are selected for special study. In 1992, the Commission set up a project team to examine the management of ward nursing in acute general hospitals. The project team looked in detail at thirty nine wards in ten NHS hospitals. They also paid brief visits to other NHS and private hospitals in the UK, France and USA. The purpose of the visits were to explore specific developments in nursing management or organisation of care.

The results of this very comprehensive review were published by the Audit Commission in *The Virtue of Patients: Making Best Use of Ward Nursing Resources*. The report presents an in-depth analysis of the problems encountered in delivering patient care, staffing wards and managing nursing services in hospitals. It called for leadership at senior management level, support for "bottom-up" approaches to change-management and quality-improvement, and proposed a framework for action for senior managers to improve the service to patients (Audit Commission, 1991). The project team suggested that nursing management structures need to be leaner and more clinically based, whilst retaining

responsibilities of nursing advice at senior management level. A chapter of the report is devoted to managing the nursing service.

The major recommendations emanating from the work were: delivering better patient care by: quality-assessment, quality-assurance, making care more patient centred and improving continuity of care; staffing the ward by: employing the right number and mix of staff, improving recruitment and retention, developing clinical skills and making better day-to-day use of ward staff; managing the nursing service by: clinical involvement of middle managers of nursing, development of day-to-day management of staff and budgets to ward sisters, making explicit the objectives of nurse management systems and ensuring that each hospital has a head of nursing with a seat on the management board. Although conducted in 1992 many of the findings of the report could apply to ward nursing in Ireland today. It is essential that a similar project be conducted in Ireland.

In addition to the report the Audit Commission published two further papers targeted at those directly involved in managing wards and nursing services. The first on improving patient care on acute general wards, *Making Time for Patients* the second on the effective use of nurse management systems, *Caring Systems: a handbook for managers of nursing and project managers.*

*Making Time for Patients a Handbook for Ward Sisters*

In *Making Time for Patients*, the Audit Commission called for greater clarity in management roles and relationships particularly those of ward sisters and their immediate superiors. The research for the handbook was conducted in a representative sample of thirty-nine wards at ten NHS hospitals. The Commission found that many ward sisters were struggling to reconcile a number of roles: the traditional ward sister role (the boss who knows every thing and everybody and makes all the decisions); the ward sister as clinical nurse; the sister as manager-administrator and the sister as manager-leader (the leader who constructs the framework for practising professionals) (Audit Commission, 1992). The study found that:

- The sisters managing the more patient-centred wards in the study sample were not all the same age, they trained at different times and they were at different stages in their careers.
- Sister's of the patient-centred wards had two things in common: they saw their role clearly, and they had enough authority and autonomy to bring about improvements in patient care.
- The sisters did not all have the same view of their role – some put more emphasis on clinical work, others on facilitating and developing staff.
- The sisters all agreed that skills in planning, delegating, negotiating and communicating were the most important skills for ward sisters (Audit Commission, 1992, p. 52).

The major finding of this study is that the ward sister holds the key to the ward, in terms of practice and care. The sister's management style determines the ethos and direction of the staff and their response to change. The report identifies the problems inherent in the split between responsibility for the ward and control over resources. Historically responsibility for ward resources and for the clinical activity that takes place on the ward has tended to split between the general managers who have access to financial resources and the ward sister who holds responsibility for patient care. The report advocates decentralised management structures. The fact that the majority of nurse management in Ireland has remained centralised enforces the split between financial management and standards of care delivered. Ward sisters have responsibility for the quality of care delivered but very little control of resources.

*Caring Systems: a Handbook for Managers of Nursing and Project Managers*

The Audit Commissions second paper on nursing in acute general wards entitled *Caring Systems* was published in 1992. The purpose of the handbook was to help project nurses and others choose and implement a ward nursing management and information system (NMS). The core elements of computerised ward nursing management and information systems were reported to be, "care planning and evaluation; workload assessment and rostering (planning and evaluation) including nursing personal and time-out analyses" (Audit Commission, 1992, p.3). The Commission advocated the use of computerised systems to assist in answering complex management questions. The report gives very detailed recommendations on: the initial assessment of information needs; care planning systems; workload assessment; rostering; and implementation of systems. This handbook could provide a valuable resource for nurse-managers in Ireland when considering the introduction of information systems.

**TABLE 4.4. A Vision for the Future – Targets**

| | |
|---|---|
| Target one: | **Individualised patient care**<br>Professional and clinical leaders, should ensure that there are systems in place to encourage and facilitate development of individualised patient care. In the first year each patient/client should have been assigned to a named nurse throughout their period of care. |
| Target two: | A consumer satisfaction survey on the quality of the partnership and users involvement in care should have been completed and the findings conveyed to the nurses concerned. |
| Target three: | **Monitoring the Quality and effectiveness of health care including outcomes**<br>All provider units should have identified three outcome indicators responsive to nursing and develop relevant clinical protocols with a framework of clinical audit to establish baseline data against which local targets can be set for the future. |
| Target four: | Purchasers and providers should be able to demonstrate that they are including value for money recommendations in their contracts for service. |
| Target five: | **Accountability for practice**<br>Clinical and professional leaders should have taken steps to discuss with each nurse how they might develop their practice. |
| Target six: | All nurses should be able to clearly identify the caseload for whom they are the named professional and for whom they bear the responsibility for care. |
| Target seven: | **Clinical and Professional Leadership , Clinical Research and Supervision**<br>Employing authorities should demonstrate what actions they have taken to identify and support those with the potential to develop leadership and management skills. |
| Target eight: | Professional leaders should be able to demonstrate the existence of local networks to disseminate good practice based on research. |
| Target nine: | Providers should be able to demonstrate at least three areas where clinical practice has changed as a result of research findings. |
| Target ten: | **Clinical Supervision**<br>Discussion should be held at local and national level on the range and appropriateness of models of clinical supervision. |
| Target eleven: | **Purchasing and Commissioning**<br>Good practice from leading edge purchasing authorities demonstrating the input of nursing should be drawn together and shared with other purchasing authorities. |
| Target twelve: | **Education and Personal Development**<br>Each provider unit should be able to identify particular pre and post resignation programmes planned to help nurses, acquire the necessary skills associated with the Patient's Charter/named nurse initiatives. |

***Source adapted from:*** **Moores, Y. (1993)** ***A vision for the Future – the nursing, midwifery and health visiting contribution to health and health care.*** **London: Department of Health NHS Management Executive.**

*A Vision for the Future*

In 1993, the NHS management executive published a document *A Vision for the Future* which extends the earlier *Strategy for Nursing*. The document provides a vision for nursing, midwifery and health visiting and provides a framework for action. According to the document, the future imperative for nursing, midwifery and health visiting was to work in partnership with other professionals, users of services and carers. The framework sets out five ways to achieve this. Individual measurable targets were set for each of the five areas (see Table 4.4). The time frame for achieving the targets was one year. The fact that the targets were measurable, set within a time frame, and that it was known that a review would take place, assisted greatly in obtaining co-operation for the introduction of the required changes. Practitioners in collaboration with regions and trust nurse executives were required to provide information on the progress made on the targets to the chief nursing officer at the Department of Health.

The major objectives of the report were: to develop clinical and professional leadership in a corporate management agenda; to provide care on an individual basis, with the outcomes charted and the delivery submitted to audit; and to develop an awareness of the duties and obligations connected with individual professional accountability.

*Testing the Vision: a report of the first year of a vision for the future*

To test the vision for the future in 1994 a monitoring questionnaire was designed piloted and mailed from the chief nursing officer to NHS staff (N= 669). Results of the monitoring exercise were published in a document *Testing the Vision* (Cumberlege et al. 1994). The exercise showed an encouraging response to the targets, with progress demonstrated in the following areas:

- 95% of units had developed a system to monitor the named nurse initiative.
- 96% of units were confident that nurses could identify the caseload of patients for whom they were responsible.
- 93% of units had identified at least one outcome indicator responsive to nursing and 83% had developed clinical protocols.
- 86% of units had changed areas of clinical practice as a result of research findings (Cumberlege et al. 1994, p. 9-17).

The following areas needing greater attention were identified: ensure that the vision targets become part of the corporate agenda and local business plans; and develop the professions input into purchasing. It was suggested that the development in five key areas should be consolidated and the twelve targets retained for further progress to be monitored in the following years.

*Shadowing: Management Development for NHS Staff*

In 1994 the chief nursing officer and the women's unit from the Department of Helath commissioned a report *Shadowing: Management Development for NHS Staff*. The report was prepared by the Royal College of Nursing ( RCN), the University of Wales college of medicine and a training consultant to the food, beverage and hotel industries. In the report, shadowing is defined, the key players are identified, a programme of shadowing for management development is described, guidelines for good practice in shadowing programmes are given and outcomes for the organisation are described (NHS Executive,

et al., 1994). This document might be a useful resource when designing management development programmes for nurses in Ireland.

*Catching the tide: New Voyages in Nursing*

*Catching the tide: New voyages in Nursing* presents a detailed evaluation of a project undertaken by the Trent Region UK to respond to the Government's commitment to improving conditions of work and training for junior medical staff (Read, 1995). Following the publication of the *new deal* agreement in 1991 regional taskforces were formed to tackle the issues surrounding the intended reduction in junior hospital doctors hours of work (NHS Management Executive, 1991). The report evaluates new nursing posts introduced in the Trent region to interface between nursing and medicine. The author suggests questions which providers, purchasers, educationalists and policy makers should contemplate, before new nursing roles are considered. The report also offers guidance about structures, processes, outcomes, safeguards and conditions for successful innovation and development of new nursing roles.

A post-study survey was conducted, questionnaires were sent to twenty post holders following the introduction of new roles. The findings indicate that many new nursing roles take time to develop and therefore the time-scale for evaluation should not be short – a minimum of eighteen months is suggested. It was advised that the nurse-manager responsible for the post allow time for regular reviews with post holders. It recommended that where the post lacked clear objectives and procedures this should be recognised early and remedied. The report concluded that the introduction of innovative nursing roles is not easy or cheap and requires good management support, detailed education and training and real enthusiasm for success. This report provides a very valuable resource to nurse-managers contemplating the introduction of new nursing roles. The report also includes a review of the relevant literature on nurse practitioner roles and advanced nursing specialists.

*Managing in the NHS a Study of Senior Executives*

The UK Department of Health commissioned a major research project which was concerned with practices and future requirements for senior management development and organisational development at local level in the NHS (Dawson et al. 1995). The project was undertaken by the Management School of the Imperial College of Science Technology and Medicine. It started in 1992 and reported in 1995. The title given to the report is *Managing in the NHS a Study of Senior Executives*. The study involved in-depth personal interviews with 271 senior executives employed at 21 organisations (118 general managers, 45 functional managers and 108 clinical managers) and self administered questionnaire sheets completed during the interview (response rate 81%). The sample comprised of 45 (17%) nurses. All the participants were located within the top three levels of their organisation with ninety-three being executive directors. The results of the study were presented in terms of six areas: career, past, present and future; managerial activity competence, roles and responsibilities; individual performance management and review; contribution to teams, sources of conflict and consensus; contacts, networks and information; and management development. Specific detailed recommendations were made in each of the six areas. The recommendations apply to all executives, including nursing. The major focus of the recommendations are on the importance of continuing, career long, inter-disciplinary, management development programmes.

*Career Paths in the NHS Report No. 4: Senior Nurses*

In 1995, consultants reported on a study of senior nurses conducted on behalf of the NHS Women's Unit. The findings are published in the document *Creative Career Paths in the NHS Report no. 4: Senior Nurses.* The specific objectives of the study were to:

- analyse the career paths of senior nurses, midwives and health visitors working in the NHS;
- analyse the role of nurse executive director in NHS trust and other senior nursing roles in terms of the changing nature of the roles and the skills and knowledge required; and
- establish the contribution of the nursing professions to general management in the NHS and propose how this might be increased (Ball et al. 1995, p2).

Two main methods were used to conduct the study. The first was a census survey of senior nurses in England 695 (72% response) nurses working in the Department of Health; Regional Health Authorities; Provider Units (trusts or directly managed units) and District Health Authority commissioning bodies. The second was semi-structured interviews with twenty-one nurse executive directors form the eight NHS regions in England.

Of the respondents, 71% were female. A disproportionally high number of men were found in senior posts in the Department of Health and commissioning organisations. On average the senior nurses were 45 years old, with men in senior positions being slightly younger. The survey revealed that senior nurses had been highly mobile during their career with frequent moves to different employers. The average time spend in positions during their career was 2.5 years. Promotion or broadening experience were the dominant reasons for changing jobs. Part-time work had featured in 40% of the women's careers and 6% of the men's. The senior nurses reported working an average of 52 hours per week.

The nurse executive directors roles differed considerably in both title and content. However almost all had relinquished direct line managerial accountability but retained a professional leadership funbction. It was reported that in some cases this lead to confusion about accountability for nursing practice and standards. The nurse executive directors role as a board member also differed. Some saw nursing as a key ingredient whereas others felt that a broader clinical input was the important contribution at the corporate level. Other functions attached to the nurse executive directors role included research and development, education, patient liaison, complaints, consumer relations, legal work, planning and development, quality assurance, risk management, chaplaincy and specialist nursing. The job titles of the senior nurses surveyed were analysed by identifying main types. Percentages within each of the different types of organisations are shown on Table 4.4.

From the table it is evident that only a third of the position titles for nurse executive directors reflect a purely nursing role. The most common position title combined nursing and quality. A significant proportion of the titles combine nursing functions with the management of clinical services and /or operations.

In Ireland there are 2.5 nurse advisor posts in the Department of Health together with the new post of chief nurse. The only nursing management post at regional health board level is a pilot post in the North-Western Health Board. Irish health-care is financed by the Department of Health and private insurance companies, nurses do not have a direct involvement in financing the health services. Senior nurses in Ireland head the nursing

services in hospitals and the community. As such, their roles could be compared to nurses working in provider units in the UK. The title nurse executive director is not used in Ireland. Unlike the UK, Irish senior nurses do not appear to have full corporate roles (see Chapter 3). Directors of nursing in Ireland have mainly a direct nurse management role. The opportunities which UK nurses have to influence strategic planning and policy making is evidenced from the extensive range of nurse executive director roles operational. However this opportunity does not appear to be readily available to Irish nurse-managers at the most senior level.

**TABLE 4.4. The Percentage of Senior Nurse, Job Titles, Reported for each Type of Organisation**

| | |
|---|---|
| **Working the in the Department of Health/NHS Executive** | |
| Nursing Officer (title of the vast majority of nurses working in the DOH) | |
| **Nurses Working at Regional Health Authorities** | |
| Regional Nursing Advice | 67% |
| Education | 20% |
| Quality | 11% |
| Planning | 2% |
| **Nurses Working in Commissioning Organisations** | |
| Quality | 37% |
| Purchasing/contracting/commissioning | 36% |
| Nursing only | 15% |
| Other (e.g. health promotion, planning projects) | 4% |
| **Nurses Working in Provider Organisations** | |
| Nursing and quality | 35% |
| Nursing only | 33% |
| Nursing and a clinical service or services | 16% |
| Nursing and operations | 6% |
| Patient care only | 3% |
| Nursing and other (e.g. corporate development, human resources) | 3% |
| Chief executive/general manager | 1% |

***Source adapted from:*** **Ball, et al. (1995)** ***Creative Career Paths in the NHS, Report No. 4 Senior Nurses,*** **a study by IHMS Consultants for the NHS Women's Unit. London: IHSM Consultants, p.117.**

*The Future Healthcare Workforce*

In 1996 a project group presented the findings of a study, *The Future Healthcare Workforce* which they conducted to examine staffing and training issues on behalf of the NHS. The study was conducted with a view to attempting to answer the question. "If we were designing the workforce today for tomorrow's health service, what would it look like?"(Schofield, 1996). The project reviewed the available literature to determine the most likely future structure of the health care workforce and also drew on the views of advisory panels. The service provision envisaged for the year 2005 was reported as follows:

- Considerable growth in the demand for services in all sectors.
- A shift in the proportion of work currently undertaken in hospitals to primary and community care.
- Additional pressure on primary care requiring changes in the ways GPs work.
- A growth in the revision of services to enable earlier discharge of people in hospitals.
- Continued downward pressure on average length of stay in hospitals and sustained growth in day surgery.

- Diagnostic departments will reduce in size to support only workload undertaken in hospitals.
- There may be some, but not extensive, reduction in the number of acute sites, largely in urban areas.
- Commissioning agencies will take the lead in developing integrated packages of care underpinned by evidence-based protocols (Schofield, 1996), p. 8)

The core workforce in the NHS increased by 18% between 1984 -94. The growth rate was reported to be slowing with the increase for 1993-94 at 0.8%. Medical and Dental staff in the NHS increased by 23% between 1984 – 94, hospital medical staff increased by 26%. During this period the core nursing workforce increased by a much smaller figure, 6%. In 1993-94 the nursing workforce actually reduced by 1%. The group identified serious recruitment problems for some professionals particularly doctors, occupational therapists and physiotherapists. The report suggests that the supply problems for medical staff, can only be addressed to any great extent by the transfer of a significant proportion of their workload to non-medical personnel. Particular problems in relation to the recruitment of nurses in London were noted. The authors suggest that the redesign of roles and training could ease the problem of making adequate provision for small specialist groups such as nurses in theatres or intensive care units.

The broad thrust of the report suggests the introduction of "generic carers" who would be responsible for the greatest component of patient care. The authors contend that education and training, from the outset, should be designed to deliver the "generic" professional rather then single occupations. The authors of the report envisage that by the year 2005 support staff will account for 40% of the "generic carer" workforce. Support workers in the UK currently account for only 28% of the nursing and midwifery workforce. The authors recognised the need to find an alternative title to "generic carer" although they do not offer suggestions. They recognise that the core of the new role is undoubtedly what would traditionally have been called the nursing function.

Many nurses would find the sentiments of this report alarming, however they are indicative of the economic climate in which health-care is likely to operate in the future. The standing of the report is not clear. In the introduction Professor Michael Scholfield reported that the project team received encouragement from the NHS Executive but the report has no status other than its own merits. It is imperative that Irish nurse-managers are aware of discussion/suggestions that could ultimately be considered for an Irish context.

*Clinical Grading, Competencies and Roles*

In March 1997, the Council of International Hospitals (UK) produced an executive summary – *Clinical Grading , Competencies and Roles*. The grading structure for nursing was introduced in the UK in 1988 the key objectives for the introduction of the nine-step wage structure included the following:

- Allow "flexible responses" to varying circumstances
- Allow for "sensible career progression"
- Allow for the increasingly diversifying variety of tasks that staff undertake
- Produce appropriate relationships within nursing, midwifery and health visiting
- Recognise the reality of the responsibilities carried out by different staff
- Simplify administration (Council of International Hospitals, 1997).

The scale is composed of nine grades:

- A – auxiliary nurse;
- B – auxiliary nurse;
- C – enrolled nurse;
- D – enrolled-nurse/staff-nurse/staff-midwife;
- E – staff nurse/staff-midwife/district-nurse (enrolled);
- F – sister/charge-nurse/health-visitor/district-nurse (enrolled);
- G – sister/charge-nurse/health-visitor/district-nurse;
- H – senior-nurse/charge nurse/sister/district nurse; and
- I – senior-nurse/tutor.

The G grade nursing group includes most ward sister level posts and thus H grade is generally the catch-all for slightly more senior posts. Such nurse are still expected to be significantly involved in clinical practice but also undertake teaching and managerial responsibilities, or be involved in specialised and more individualised functions. The clinical specialist nurse falls into the H category.

The roles taken by nurses throughout the health service are rapidly changing: clinical nurse specialists have developed and implemented individual roles within clinical teams; nurse practitioners are taking on many tasks traditionally within the domain of the medical profession; and the establishment of the directorate structure has brought about the development of the senior nurse-manager positions. The different directions of management, education and clinical specialisation require diverse skills, beyond those displayed in the initial generalist years in nursing. The authors suggest that the grading structure does not allow for major role changes and is perceived to be rigid and obstructive to the development of the nursing profession. There are important lessons which Irish nurse-managers can learn from the ten year experience of clinical grading in the UK.

*United Kingdom Organisational Structure for Nursing*

In 1996 the Council of International Hospitals produced three fact-briefs on organisational structures in the NHS: *NHS Trust Management Structures, Management Structures at Small Hospitals*, and *Nursing Structures at NHS Trusts*.

During the course of the research, the Council of International hospitals contacted NHS trusts across the UK to obtain information concerning the administrative and clinical management structures maintained within each of the trusts. *The NHS Trust Management Structures* document profiles five Trusts with between 700 and 1,000 beds (Council of International Hospitals, 1996). It is reported that the popularity of management structures based upon a clinical directorate model of service delivery and accountability has grown enormously in recent years, to a point where there are very few trusts or hospitals that have not adopted some variant of the clinical directorate model. The sub-unit grouping within a structure based around clinical directorates is typically multi-disciplinary, bringing together doctors, nurses, administrative staff and sometimes paramedical staff. This multi-disciplinary team, with its focus upon patient care, can be regarded as a natural focal point for accountability in relation to service delivery.

Figure 4.10, illustrates the organisational structure at an acute trust that maintains 1,000 beds. When illustrated, the trust was embarking upon a five year programme of acute services amalgamation from two main hospital sites to one. In trust C, the director of nursing was one of the four executive directors who sat on the Trust Board. A revised trust management structure was implemented in 1995, the underlying objective of the new management structure was to achieve a structure that is as flat as possible. Business units were devolved to smaller, more workable clinical service units with broad clinical divisions. Business managers and nurse managers were replaced with clinical service unit managers, who relate directly to ward sisters for day-to-day management purposes, and who are directly accountable to the trust's director of operations.

The document *Management Structures at Small Hospitals* profiles the organisational structure at five trusts with 400 or less beds (Council of International Hospitals, 1996). The authors reported that very few of the smaller hospitals have not adopted some variant of the clinical directorate model. The number of directorates, maintained by the small trusts profiled, is minimised by clustering specialities into broader directorate groupings, such as medical, surgical and women's and children's services.

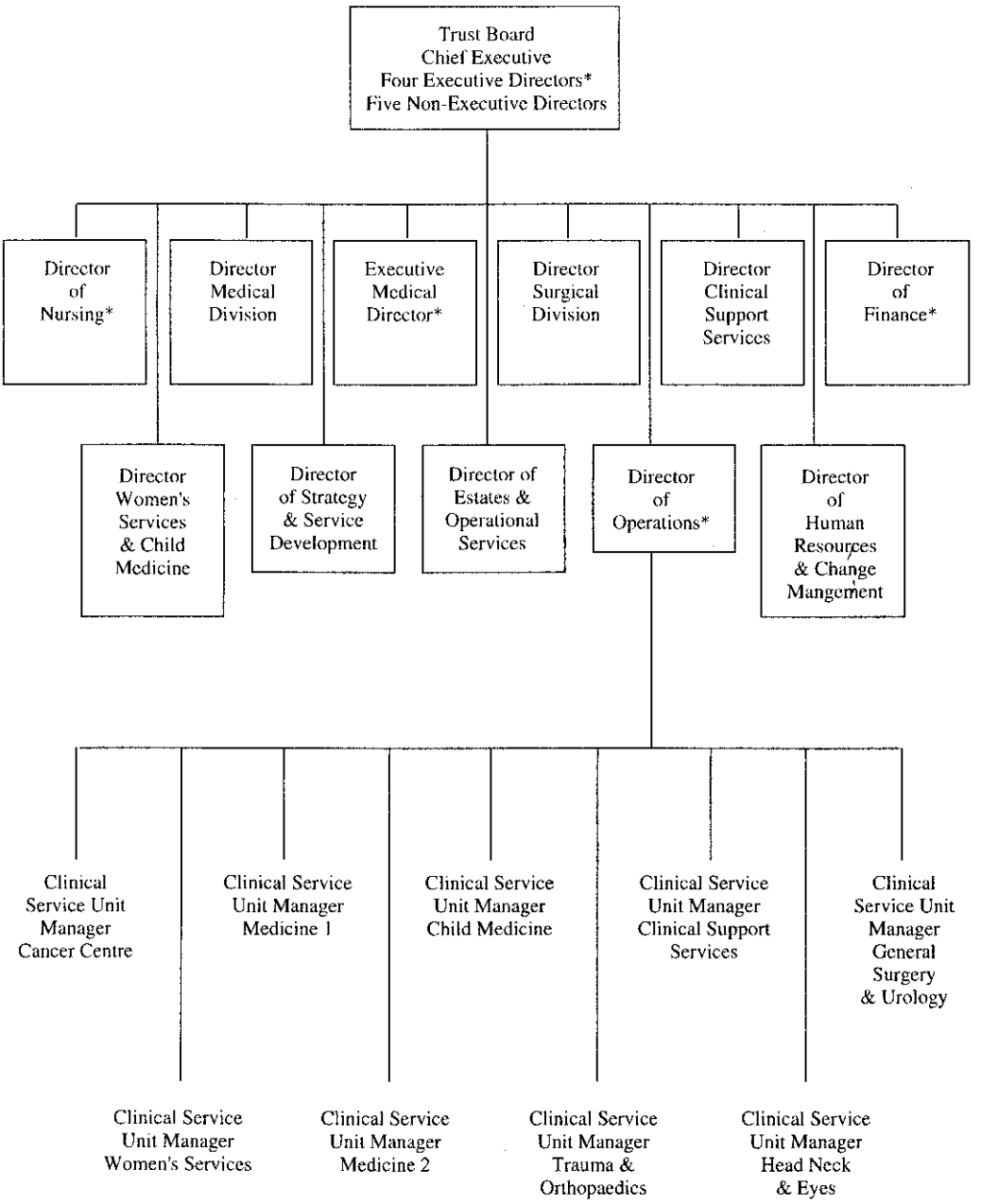
An example of the small hospital structure is trust D which is organised around seven directorates (illustrated on Figure 4.9). The director of nursing and service delivery was an executive director of the trust board. Each clinical director was responsible to the chief executive for their managerial performance, whilst being professionally and clinically accountable to the medical director. At ward level, nursing staff were accountable to their direct ward manager or senior nurse, who in turn, was accountable operationally to the service manager, and professionally accountable to the director of nursing and service delivery.

During the course of research for the document *Nursing Structures at NHS Trusts* the Council of International Hospitals contacted directors of nursing at NHS trusts across the UK (Council of International Hospitals, 1996). The nursing structure in four trusts was profiled. At ward level the nursing function can be organised in a variety of ways, task allocation, team nursing and primary nursing (see Chapter 2). The authors suggest that within primary nursing wards, power seems to be vested in individuals:

> the person who knows the patient best becomes the centre of communication for that patient, regardless of their grade or position in the hierarchy. Nurses seek less approval for their actions, rarely ask for guidance and generally act more autonomously than on traditionally managed wards (Council of International Hospitals, 1996, p.2).

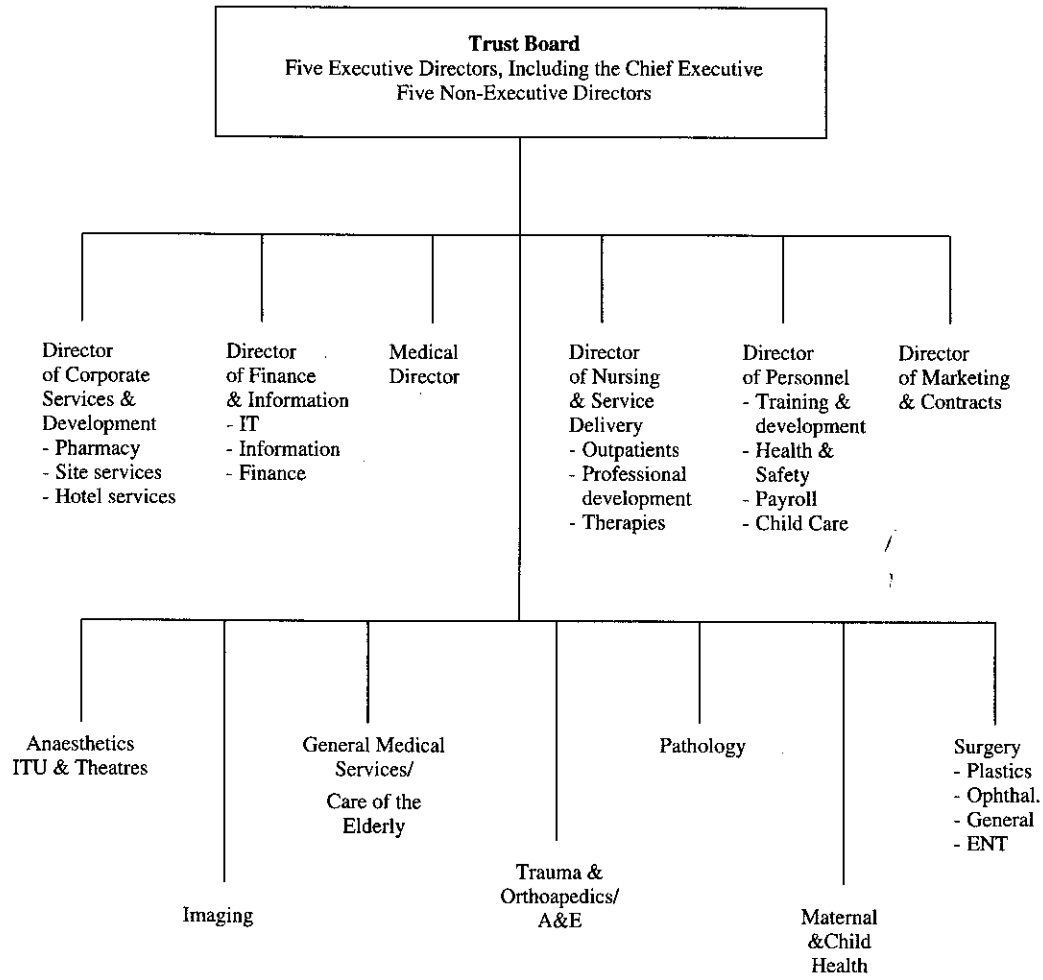
The devolution of responsibility to individual nurses, as opposed to a ward manager, was reported to be a feature of many trusts within the UK, including all four NHS trusts contacted for the purpose of the research. Devolving responsibility downwards to nursing staff at ward level ultimately resulted in a flatter, less hierarchical nursing structure which ensures that holistic patient focused care was being practised.

**Figure 4.8 Trust C - 1,000 bed Acute Hospital.**




***Source:*** **Council of International Hospital (1996) *NHS Trust Management Structures.* London: Council of International Hospitals, p.11.**

**Figure 4.9 Trust D - 400 Bed Trust Providing Acute Services.**



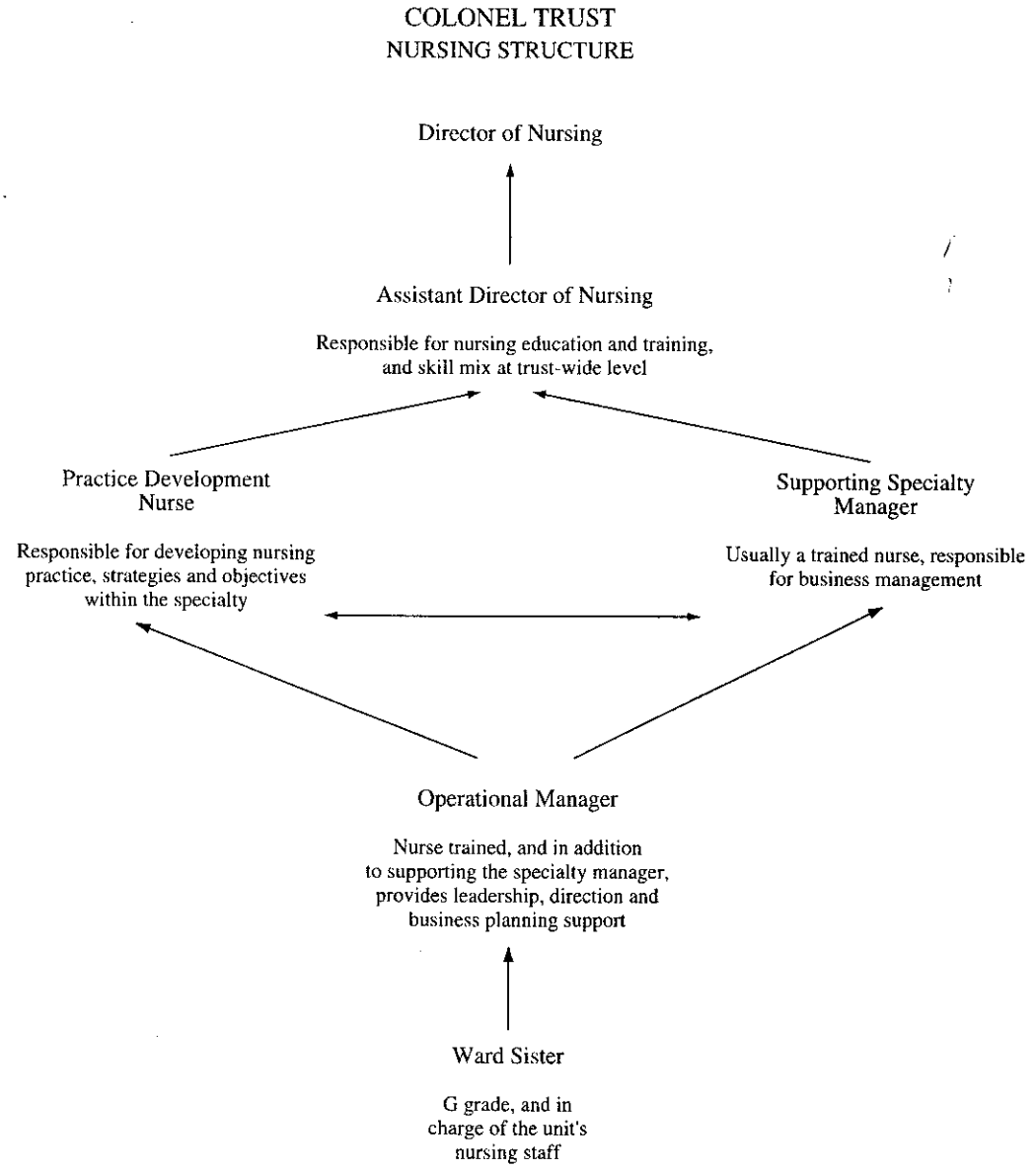

***Source:*** **Council of International Hospitals (1996)** ***Management Structures at Small Hospitals.*** **London: Council of International Hospitals, p. 9.**

Parallel to the growth in primary and team nursing, trust-wide nursing structures have similarly moved away from being hierarchical, to become flatter. In order to achieve a flatter structure, many of the senior nursing positions within the trust have been removed and responsibility devolved downwards.

The "Colonel" Trust provides a range of acute services and maintains 450 beds. Figure 4.11, presents the nursing structure at the trust. The reported advantages to this structure are: that it is less hierarchical than previous structures (although to some extent, dependent on the personalities); nurses are aware of their responsibilities and accountability; practice development nurses at senior level reap great benefits as they are able to develop action plans and objectives for every ward. The only disadvantage reported is that training has to be provided. In relation to generic workers, the assistant director of nursing commented that she was very much against combining cleaning and clerical work with caring she stressed that the work demanded of domestic and clerical workers is very different to that required of those providing care to patients.

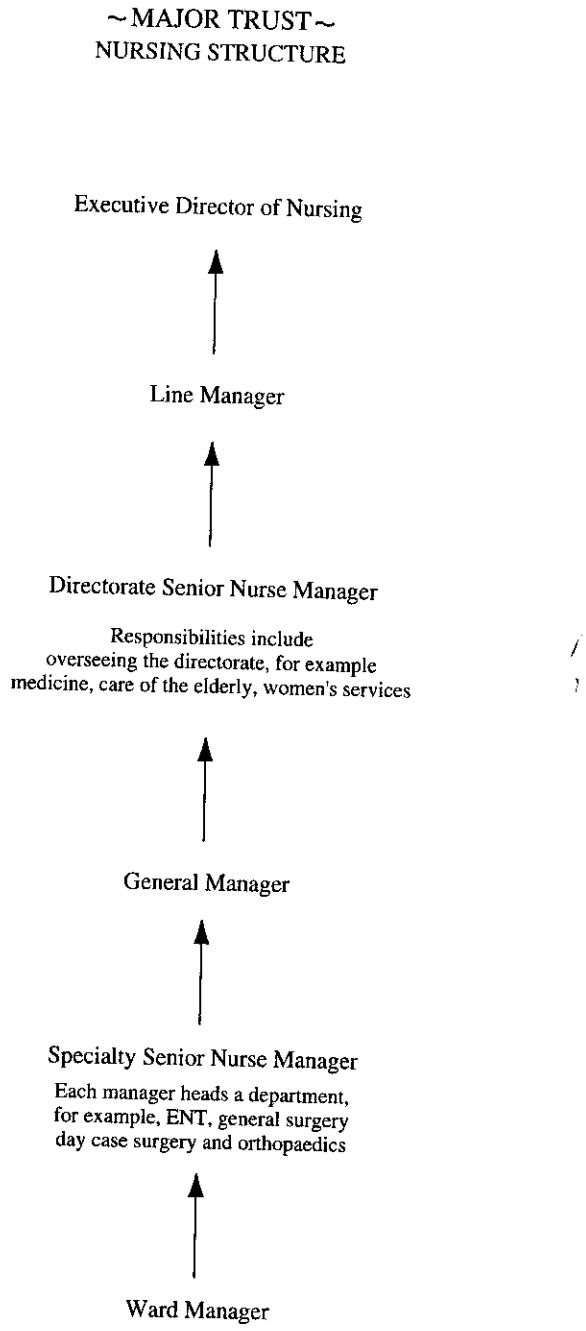
In the so called "Major" Trust the main advantage reported was that of flatter structures, and senior nurse-managers directly responsible to the director of nursing, which allows staff to vocalise problems easily (see Figure 4.13). There were no disadvantages reported. In relation to generic workers it was reported that the trust employs health care assistants at three levels: house keepers (responsible for cleaning and stock management); auxiliary "type" role (provides basic care, takes blood pressure, dress minor wounds and change intravenous drips); and auxiliary role "C" grade (nursing staff are gradually being replaced in the trust by auxiliaries who will be undertaking similar work) (Council of International Hospitals, 1996, p.10).

**Figure 4.10 Nursing Structure Colonel Trust - 450 beds.**




***Source:*** **Council of International Hospitals (1996)** ***Nursing Structures at NHS Trusts.*** **London: Council of International Hospitals, p.5.**

**Figure 4.11 Nursing Structure Major Trust - 600 beds.**




***Source:*** **Council of International Hospitals (1996)** ***Nursing Structures at NHS Trusts.*** **London: Council of International Hospitals, p. 7.**

**Northern Ireland**

At a recent workshop for senior managers convened by the Institute of Public Administration (IPA), Ms. Elizabeth Duffin Director of Nursing at the Royal Group of hospitals in Belfast explained how her role had evolved in recent years (Joyce, 1997).

Originally, as director of nursing from 1984 – 1990, she had reported to the director of nursing in the eastern health and social services board. She held a hierarchical line-management role with responsibility for the management of nurses and professional nursing issues. In 1990, with the resource management initiative, clinical directorates were established in the hospitals and she began to decentralise nursing administration, flatten the structure and shift more responsibility down the line. The number of nursing officers was reduced drastically (from 56 in 1984, to 16 in 1990). Nurse managers were appointed to each clinical directorate. In 1993, it was decided to merge the posts of nurse-manager and business manager in each directorate and in the majority of cases a nurse was appointed business manager.

The role of the director of nursing shifted as more staff management responsibility was shifted down to directorate level and within directorates, to ward sisters. Her title changed to that of director of nursing and patient services. She became a manager of nursing rather than nurses and was no longer the nursing budget-holder. Her role was primarily to provide leadership, provide professional advice and to ensure that professional standards were developed and maintained. Her first task within the new structure was to develop a new organisational structure to lead and support nurses and midwives in clinical practice throughout the hospitals. Within the hospitals she ensured that nurses became involved in policy development and standard setting. She admitted that she had found it difficult initially to stand back and let others do the work. She outlined the programmes which had been introduced within the hospitals to further develop the ward sisters. These included periods of secondment for three months to other non-nursing departments within the hospitals. The secondments are shadowing schemes and help sisters develop confidence and gain new skills. She reported that the sisters now have authority with an ability to control resources, make decisions and implement change.

## Summary

This chapter of the review highlights the varied organisational structures for nursing operating in USA, Canada, Australia, New Zealand, Europe and the UK. The basis of most structures presented is the devolvement of responsibility and accountability to individual professional nurses. The care-delivery-system is generally based on primary nursing. An integrated-delivery-system is used in some hospitals to organise the delivery of care at unit level (Canada and the USA). Many countries are planning to phase out the employment of second level nurses, most of the original courses for enrolled nurses are no longer being provided (UK, New Zealand and Australia). In some organisations, nursing is reverting to a system where direct care is primarily delivered by registered nurses, known as an "all RN service" (Canada and the USA). Very different systems appear to operate in the UK, Australia and New Zealand. In these countries, health-care assistants/assistants-in-nursing/co-workers are employed. Support workers are in fact employed in hospitals where an "all RN" service is used, the difference being that they are not involved in delivering direct patient care.

Most of the nursing organisational charts profiled in this review present three levels of nursing management, senior, middle and first-line. The constant feature of all charts is the employment of a head of nursing (director of nursing/vice-president). However this post is not always at board level. The review suggests that the position of director of nursing

has come under threat in many countries, particularly New Zealand and Australia. The roles responsibilities and job titles for the most senior nurse differ across countries. In many organisations, the directors of nursing (vice-presidents) no longer have line-management responsibility for nursing, they are more concerned with professional leadership, corporate activities, planning and policy making. In these organisations line-management responsibility has been devolved to middle-level nurse-managers. Some might consider this move as regressive, possibly leading to a reduction in the visibility of nursing within an organisation, others consider it a vital development, because, nursing may well be isolated, if nurses do not adopt a broader approach to management within the organisation.

The general trend across countries is to reduce the levels of nursing management and thus flatten the organisational structure. This involves removing a layer of either middle or first-line management. In organisations where nurses are adequately professionalised and operate as independent practitioners, the number of first-line managers has been reduced, while in other organisations, middle-management has been downsized. There also appears to be a move to separate the business and clinical management function of nursing. The level at which this happens varies. Many of the models presented show a divide of management function at unit/ward level, with the employment of unit nurse-managers, to manage the business element of the work and clinical-nurse-specialists to manage the professional side of the service (Australia, USA). Some hospitals continue a system where the unit nurse-manager retains line-management responsibility for both the business and clinical management of the nursing service but receives advice and support from clinical-nurse-specialists. A dilemma exists for unit managers who have responsibility for services without control of resource. In most countries unit nurse-managers now appear to have a direct role in budgeting. The key role of the unit nurse manager/ward sister is clearly highlighted in the literature.

Many hospitals have chosen to arrange the business of the organisation around a service model (clinical directorate) (UK, New Zealand and in some hospitals in the USA). Some countries have amalgamated the business and nurse manager posts for individual service units. This means that unit nurse-managers now report to general managers (who are not necessarily nurses) at service level (New Zealand and UK). This might be considered a regressive step which could lead to a fall in nursing standards.

The advantage of a developed Nursing Division at Department of Health level is demonstrated in the UK literature. Senior nurses working in the department have been very active in leading the profession. Some of this work involved publishing visionary guidance on the future of nursing, in the form of nursing strategies. The progress which can be made by the use of practical, audited, targets has been demonstrated. Although the legal framework exists in the UK to ensure that an executive nurse is employed at Trust Board level, there is still a concern among the profession about the ability to provide nurses with leadership skills and the ability to take on the corporate role.

The importance of investing in the independent evaluation of the management of the nursing services is evidenced by the work of the Audit Commission (UK). The findings of the detailed research conducted by the commission are presented in attractive assessable format which can be used by nurse-managers, internationally not just in the UK. The initiative by the Kings Fund to make research accessible and applicable could possibly be emulated in Ireland. The Kings Fund convened a group of nurse researchers who have a common area of interest and arranged regional workshops, for unit level nurses, to meet with researchers to discuss the application of research findings. A summary of the review is given in the next section of the work.

# SUMMARY AND CONCLUSION

In order to respond to local changes in health care it is advantageous to develop an awareness and understanding of global practices. International initiatives may have an application in Irish settings and can be assessed for strengths and weakness and their long term consequences. This literature search and review sourced a large body of international research and current Irish literature on: management theories; organisation design; leadership; and nurse-management role developments. These might be used to assist in understanding the forces shaping the role of nurses in the management of the health services. A summary of the main findings of the review and areas that require further investigation are presented in this last section of the report.

## Summary

The objectives for the review were to: locate and assess international examples of organisational structures for nursing management; describe the current roles nurses take in managing the health services in Ireland; and identify current Irish research related to nursing management roles.

The *classical, modern* and *motivational* management theories were outlined. These give managers a framework for examining management practice. Organisational structures, designs and culture were also discussed. These allow nurse-managers to identify the type of organisation in which they are working and so select an appropriate management style for that structure. The dominant theme in the literature has been the importance of a shift from the bureaucratic mechanistic form of management to a more open enabling and empowering management style. Nurses as managers have a significant role to play in empowering the largest professional group employed within the health services. Strategies such as decentralisation, participative-management, shared-governance, and professionalisation of nursing, are offered as examples of how this might be achieved.

*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 led the review to focus on job-title, job-description and competencies as indicators of the nurse-manager's role concept, role expectations and role behaviours. The international review of nursing management titles suggests that the role concept for nurse-managers falls into four categories: line-management positions; professional advisory positions; integrated line-management and advisory positions; and nurse-manager positions with additional non-nursing management responsibilities. From the review it is apparent that nurses have much

to contribute to the overall management of the health services. It is important that nurses do not confine themselves to a narrow management function but become more actively involved in the management of the broader health service.

The review highlights the often missed distinction between management and leadership. Managers can overlook many of the dynamics at play in a situation and focus on the immediate daily management issues rather than developing peripheral vision into long term strategies. Leaders have a special ability to influence and empower people to move towards a new and different future. The international literature suggested that the health services employ many effective nurse managers however, a dearth of visionary nurse leaders was identified. The literature recognises that nurses, as experienced carers, are particularly well placed to develop a participative transformational style of leadership. However, this potential is not being fully realised and there is a need for strong nurse leaders to represent nursing at policy making tables within health organisations.

There is a danger that involvement in clinical practice might be neglected as nurses take on more business related management functions. Nurses are advised to develop strategies to maintain clinical involvement. The literature suggested that the most powerful way for nurse-managers to maintain professional status is through clinical involvement. The debates about the management of "nurses" and the management of "nursing" could possibly splinter the nurse-manager's role and therefore reduce their potential strength. There is a need for a balance between clinical practice and business related outcomes. However, it is recognised that in the very complex health-care systems that now exist it might be difficult for one head nurse to cater for every aspect of the management of the total nursing service.

From the review it is clear that a wide range of competencies are necessary to successfully perform management functions. Some of the identified competencies might be considered 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, for this reason, management development should be continuous and structured. The value of applied learning through mentoring, shadowing projects, learning sets and networking are highlighted in the literature.

Very little literature pertaining to the role of the nurse-manager in Ireland was identified during the search. A small number of documents, mostly unpublished, which address the current role of nurse managers in Ireland were reviewed. It was found that the shape of the management structure in nursing can be illustrated as a cenotaph, with a large base and very few senior nurse management positions. This shape illustrates one of the perceived barriers to promotion identified in the literature – lack of a promotion structure. There have been substantial developments in middle nurse management roles, in a small number of hospitals, however, piloting of these is still in process and no detailed information is yet available. The largest body of Irish literature pertaining to nurse management was found to be policy documents and commentaries rather than research studies. The review reveals that a significant study on the role of the nurse-manager in Ireland has not yet been conducted. A small amount of Irish research relating to nurse management was located. Similar to the international literature it has been recognised that if Irish nurses are to influence the future development of the health services there is a need for some nurse-managers to move towards general management and a greater involvement of senior nurse-managers at corporate/executive level. While it appears that the preference of Irish nurse-managers is for nurses to be managed by nurses, it is apparent

from the literature that internationally this model is under threat. However it is unclear as to whether this is to the advantage or disadvantage of nursing.

It is important that nurses demonstrate their managerial ability and compete with non-nurses for general management posts. While change to date has been slow, due mainly to the restrictive structures within which nurses operate, there are real indicators that important transformations are imminent in hospital and community nursing structures in Ireland. The review demonstrates that Ireland is now facing many of the issues which have been dealt with by other international health services.

The varied organisational structures for nursing operating in USA, Canada, Australia, New Zealand, Europe and the UK are demonstrated in the review. The basis of most of the structures presented is on the devolvement of responsibility and accountability, to individual professional nurses. Most of the literature conceptualises the management of nursing in three levels; senior, middle and first-line. A constant feature is the employment of a head of nursing (director of nursing/vice-president). However, this position is not always at board level. The general trend across countries is to reduce the levels of management and thus flatten the organisational structure, this involves removing a layer, either middle or first-line management. In organisations where nurses are adequately professionalised and operate as independent practitioners, the number of first-line managers has been reduced, while in other organisations middle-management has been downsized. There also appears to be a move to separate the business and clinical management function of nurses, the level at which this happens varies. Many of the models presented show a divide of management function at unit/ward level, with the employment of unit nurse managers to manage the business element of the work and clinical-nurse-specialists to manage the professional side of the service. Some hospitals continue a system where the unit nurse manager retains line-management responsibility for both the business and clinical management of the nursing service but receives advice and support from clinical-nurse-specialists. In most countries, unit nurse-managers now appear to have a direct role in budgeting.

The paucity of Irish research on the role of the nurse-manager is highlighted in the review. This emphasises the real need for a significant investment in nursing research in Ireland. The development of research must be within a structured framework. Initial developments might include: the employment of nursing research co-ordinators; the development of a research strategy; establishment of a data-base of Irish nursing research; the identification of a central holding house for all nursing research conducted by Irish nurses; the establishment of an Irish nursing research journal; and financial support to develop a body of Irish research in nursing management.

## Conclusion

The purpose of this review was to identify the differing roles taken by nurses in the management of health services, nationally and internationally and from the available published material, assess the applicability of these roles to an Irish context. The review, has clearly identified the diversity of roles taken by nurses in the management of the health services internationally. The wider hospital organisational structure very much determines the parameters of the nursing structure within any organisation. Consideration must be given to the unique aspects of the Irish health service, as well as the population characteristics and culture, when considering the direct applicability of international roles

to an Irish environment. As is evidenced from the review, these are many international examples to draw from, but these would need careful adaptation to suit the Irish system.

When drawing inference from the findings of this review the reader is cautioned to consider: the lack of published Irish research; the focus of the review on acute hospital management; the American bias of the literature; and the fact that it has not yet been possible to conduct long term studies of many new management initiatives. However, this review brings together, for the first time, diverse developments in management theory and practice. Many of the initiatives reviewed are now shaping contemporary management practices. As such, the work should form a valuable and current resource for Irish nurses.

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# APPENDICES

## APPENDIX 1

# INTERNATIONAL COMPARISON OF TITLES APPLIED TO NURSE MANAGEMENT ROLES

## International Comparisons of Titles Applied to Nurse Management Roles

| Management level | Ireland | United Kingdom | United States of America | Canada | Australia | New Zealand |
|---|---|---|---|---|---|---|
| **Senior**<br>Heading up or directing an entire service | -Matron<br>-Director of Nursing (DON)<br>-Chief Nursing Officer<br>-Superintendent PHN | -Chief Nurse Director of Care<br>-Executive Director of Nursing<br>-DON & Quality Assurance (QA)<br>-Director of QA & Nursing<br>-Director of Patient Services | -Executive Nurse<br>-Chief Nurse Officer<br>-Vice-president Nursing<br>-Director of Nursing<br>-Director of Nursing Servcies<br>-DON & Quality Servcices | -Chief Nurse (programme manager)<br>-Vice-president of Nursing<br>-Director of Nursing | -Area DON<br>-DON Services<br>-Director of Nursing<br>-DON Administrator | -Director of Nursing<br>-DON and Midwifery<br>-DON services° |
| **Middle**<br>Co-ordinating across a number of service units or locations | -Deputy Matron<br>-Deputy DON<br>-Assistant DON<br>-Assistant CNO<br>-Directorate Nurse Manger<br>-Divisional Unit Manger<br>-Unit Nursing Officer<br>-Night Superintendent<br>-Theatre Superintendent<br>-Supervisor<br>-Welfare Home<br>-Senior PHN | -Deputy Assistant DON<br>-Assistant Director of Nursing<br>-Directorate Senior Nurse Manager<br>-Supporting Specialty Manager<br>-Operational Nurse Manager<br><br>-Clinical Nursing Officers<br>-Nursing Officers | -Director of Nursing (for a particular area)<br>-Associate DON<br>-Assistant DON (set area)<br>-Clinical Nurse Specialist | -Director of Nursing (per service)<br>-Nurse Manager<br>-Clinical Resources Manager (teaching) | -Deputy DON<br>-Assistant DON<br>-Nurse Supervisor<br>-Nurse Manager (grade 1-9)<br>-Clinical Nurse Consultant | -Clinical Nurse Manager<br>-Clinical Nurse Consultant<br>-Nursing Supervisor<br>-Duty Nurse Co-ordinator<br>-Resource Manager<br>-After hours Manager |
| **First-line**<br>Managing a single unit of service | -Ward Sister<br>-Nursing Officer<br>-Theatre Sister<br>-Night Sister<br>-Junior Ward Sister<br>-Deputy Nursing Officer<br>-Public Helath Nurse PHN<br>-Assistant Supervisor WH | -Ward Manager<br>-Ward Sister (G grade)<br>-Charge Nurse | -Unit Nurse Manager<br>-Nurse Manager<br>-Head Nurse<br>-Assistant Head Nurse<br><br>-Patient care co-ordinator<br>-Team Leader<br>-Case Manager | -Head Nurse<br>-Unit Managers<br>-Patient Care Co-ordinator<br>-Resource Nurse (specialist area) | -Nurse Unit Manager (level 1-3)<br>-Charge Nurse<br>-Associate Charge Nurse<br>-Clinical Nurse Specialist<br>-Shift co-ordinator | -Unit/Ward Nurse Manager<br>-Clinical Nurse Leader<br>-Clinical Nurse Specialist |
| Supporting Management Roles | -Nurse-Practice-Development Coordinator<br>-Quality Assurance Nurse. | -Practice Development Nurse<br>-Quality Assurance Nurse | -Staff Development Nurse Manager<br>-Assistant Director for Quality control | Titles not available | Titles not available | -Professional Nursing Advisor<br>-Nursing Consultancy |

## APPENDIX 2

# CHARACTERISTICS OF NURSE LEADERS

### Desirable

- Achiever
- Approachable
- Articulate
- Assertive
- Astute
- Clear thinker
- Coacher
- Committed
- Communicator
- Competent
- Compromiser
- Collaborator
- Confident
- Considerate
- Cost Conscious
- Courage
- Creative
- Credible and respected
- Critical
- Decisive
- Delegates
- Developer
- Discriminator
- Drive
- Dynamic
- Educated
- Empirically oriented
- Enjoys challenges
- Enthusiastic
- Expert
- Feminine, soft skills
- Fights the corner
- Fits in
- Flexible
- Fosters a team spirit
- Gets on well with others
- Gives Feedback
- Good listener
- Guides subordinates
- Has followers
- Honest
- Humorous
- Imaginative
- Inspirational
- Integrity
- Intelligent

### Desirable Continued

Initiative
It and M aware
Open-minded
Operationally sound
Organisational aware
Literate
Motivator
Numerate
Persistent
Persuasive
Policy maker/interpreter
Politically aware
Positive
Pragmatic
Progressive
Quick thinker and learner
Questioner
Reflective
Resolves conflicts
Respected
Risk taker
Runs a tight ship
Secure
Self respect
Sensitive
Sense of purpose
Shared goals and values
Socially assured
Sound clinically, managerially, and educationally
Sticks to agenda
Staying power and stamina
Strong values
Systems thinker
Takes criticism
Takes people along
Thoughtful
Tough
Tolerant
Trusted
Vision

### Undesirable

Arrogant
Bureaucratic
Controller
Embittered
Intellectually lightweight
Old boy's club member
Lacks vision
Maintains status quo
Mutually appreciation society member
Status conscious
Stifles innovation

### Misconceived

Colourful personality
Speeches that make good copy
Glitzy presenter
High profile
Power dresser
Recite platitudes
Gender imbalance

***Source adapted from:*** **Malby, 1997, p. 83.**

## APPENDIX 3

# NURSING MANAGEMENT DIAGNOSIS

Valid Nursing Management Diagnosis in Descending Order of Validity.

- Financial management ineffective
- Conflict resolution, ineffective
- Disciplinary methods, ineffective
- Collaboration skills, ineffective
- Negotiation skills, inadequate
- Orientation, inadequate
- Professional development, inadequate
- Quality evaluation methods, ineffective
- Budgeting skills, inadequate
- Communication, ineffective
- Decision-making, ineffective
- Evaluation methods, ineffective
- Legal accountability, knowledge deficit
- Role conflict
- Staff competence, inadequate
- System management ineffective
- Time management, ineffective
- Time management, ineffective
- Administrative support, lack of
- Ancillary support, inadequate
- Delegation skills, ineffective
- Job description, inadequate
- Leadership skills inadequate
- Organisational methods, ineffective
- Performance evaluation methods, ineffective

- Policy development, inadequate
- Political/legal awareness, ineffective
- Problem-solving, ineffective
- Staff utilisation, inappropriate
- Communication skills, inadequate
- Accountability, lack of
- Change management, ineffective
- Organisational climate, negative
- Priority setting, ineffective
- Problem-solving skills inadequate
- Productivity expectations, excessive
- Staff education, inadequate support
- Vision perspective, lack of
- Group process, ineffective
- Interpersonal skills, inadequate
- Leadership, ineffective
- Risk management, ineffective
- Customer relations ineffective
- Labour relations methods, ineffective
- Motivation, lack of
- Organisational skills, ineffective
- Stress level, excessive
- Finances, inadequate
- Management skills, inadequate
- Staff, inadequate numbers
- Ethics, conflicting perspectives
- Management, ineffective
- Priority setting, inadequate
- Input form nursing, lack of
- Policy ineffective
- Productivity decreased
- Quality care, inadequate
- Sociocultrual Diversity insensitivity.

***Source adapted from:*** **(Girvin, 1996).**

## APPENDIX 4

# IRISH NURSE MANAGEMENT – THE WAY FORWARD

### Strategy for the Management of Hospital Nursing Services

*Management of Nursing*

- To ensure the provision of a quality nursing service in each hospital there must be a senior nurse manager responsible for the nursing services.
- In each hospital there should be a clear statement explaining to whom and for what the Senior Nurse Manager is to be held accountable.
- The Senior Nurse Manager has a key role to play in hospital management and as such must be a member of the Senior Hospital Executive Management Team.
- These is a requirement for a Division of Nursing headed by a Chief Nurse within the Department of Health.
- There is a need to review and change the practices of recruitment / selection of Senior Nurse Managers.
- The Senior Nurse manager must be consulted on the implications of medical appointments and in the formulation of practice plans.
- As the task of managing the nursing service is becoming increasingly more complex there is a need for an educational management programme for senior nurse managers.
- Remuneration for senior nurse managers should be commensurate with responsibilities held.

*Management of Nursing Practice*

Ultimate responsibility for all professional nursing practice activities must be held by the senior nurse managers, to ensure that systems of care and nursing policies are implemented in accordance with good nursing practice, legal requirements and the guidelines laid down by An Bord Altranais.

*Personnel Management*

Senior nurse managers must be involved in personnel management functions in relation to; recruitment of nursing staff , nurse manpower, performance review and staff development

*Information Systems*

To enable senior nurse managers make informed decision pertinent information systems are required.

*Financial Management*

Nurse managers must be responsible for the nursing pay budget and given the authority to control the budget.

***Source:*** **Irish Matrons Association (1994)** ***Irish Nurse Management the Way Forward,*** **Dublin: IMA.**

**APPENDIX 5**

# OVERVIEW OF THE PILOT PROJECTS OF MANAGEMENT STRUCTURES AT ACUTE HOSPITALS

**(information supplied by Director of Nursing/Matron of the Relevant Hospitals)**

## Overview of Pilot Projects for Acute Hospital Management Structures

| Hospital | Number Beds (approx.) | Year pilot started | Changes in Nursing Management Structure (pilot projects) | Strategic Nurse Management role | Middle Nurse Management role |
|---|---|---|---|---|---|
| Adelaide & Meath hospital Dublin incorporating the National Children's Hospital | 443 | Not yet started | In October 1997 interim arrangements were made for a transitional nursing management structure when amalgamating the three hospitals. The interim measures were put in place to extend through the commissioning of the new hospital and until the introduction of programmes. For this period the hospital is divided into specialities. These are divided, the DON is responsible for half & the Director of Programmes for half. | Director of Nursing<br>Professional responsibility and leadership of all nursing strategy throughout the hospital. The portfolio encompasses direct management/administrative responsibility for specific services (A&E, ICU, Day Care, Endoscopy, Theatre, Medicine, CCU, HSSU, Palliative Care and the College of Nursing) including budget accountability. Member of the executive management team. | Nurse Managers (8) one for each specialty grouping.<br>Devolved responsibility for commissioning the new units and all matters relating to nursing within their speciality area. This structure will be reviewed and revised when programmes of management are introduced. |
| Beaumont Hospital* | 620 | 1991 | Requisite Management, based on Stratified Systems Theory (Eliot Jacques)<br>Purpose was to flattening the system to three levels of nurse management.<br>*Now beyond pilot stage* | Director of Nursing<br>Controls and manages the total nursing service at policy and executive level. | Divisional Unit Managers (6)<br>Devolved responsibility for all nursing matters in their division, including budget responsibility. Assisted by:<br>— Senior Assistant DON Personnel<br>— Nurse Practice Development Manager |
| Cork University Hospital (CUH)* | 552 | 1994<br>1997 | Nursing restructured to four separate functinal areas in CUH and three sites off campus<br>New Executive Management Board set up in 1997 (involving clinicians in management)<br>Divisional Management Team (DMT):<br>• Clinical Director<br>• Nurse Service Manager<br>• Business Manager | Director of Nursing<br>Strategic management and leadership on professional nursing issues. Member of Executive Management team | Nurse Services Managers (NSM) (4) responsible for two or more clinical divisions in CUH & 3 hospital Matrons on sites off campus<br>Responsible for managing the business of nursing & services. Matrons hold budgets, shadow budgets for clinical divisions have commenced. The NSM is a key member of the DMT. |

## Overview of Pilot Projects for Acute Hospital Management Structures

| Hospital | Number Beds (approx.) | Year pilot started | Changes in Nursing Management Structure (pilot projects) | Strategic Nurse Management role | Middle Nurse Management role |
|---|---|---|---|---|---|
| Letterkenny General Hospital* | 318 | 1994<br>1996 | Specialty Management Teams Chaired by senior consultant<br>Organisational redesign – nursing and services now more integrated<br>Four Specialty Services each managed, facilitate and co-ordinated by Unit Nursing Officer/Service Manager (UNO/SM). | Director of Nursing.<br>Direct line responsibility for nursing and allied services. | Nurse Service Managers – UNO/SM's (4)<br>Management of allocated service budget and development of service plans, delegated service and general management duties.<br>Provides services equally to three principal interests:<br>— Director of Nursing<br>— Speciality Consultants<br>— General Management |
| Mater Misercordiae Hospital* | 548 | not yet started | A facilitator has been appointed to work with the Nursing Executive and the Nursing Council in the development of new management structures.<br>*The process commenced in 1998* | Members of the Nursing Executive are visiting other sites in Ireland to examine management structures. A draft document on the proposed management structure will be presented to the Hospital Board. | |
| Merlin Park Hospital* | 345 | not yet started | Services managers now have responsibility for non-clinical services. | Matron | Assistant Matron's<br>Currently the traditional role of assistant Matron. Changes are being planned for the role. Will follow the UCHG model. |
| Regional Hospital Limerick* | 374 | 1997 | New nursing management structure amalgamating the acute servioces provided at: the Regional Hospital (374 beds), Regional Maternity Hospital (117 beds) and Croom Orthopaedic Hospital (90 beds) now called Limerick Regional Hospital Complex. | Matron<br>Role extended to responsibility for all three hospitals. Nurse leader, strategic management, policy development and operational management of all matters relating to nursing in the three hospitals. | Assistant Matrons (3) for Limerick Regional; Deputy Matron (1) for Reginal Maternity, and Divisional Nurse Manager (1) for Croom Orthopaedic Hospital.<br>Traditional nursing management roles as set up in 1955. Changes are being planned. |
| Sligo General Hospital | 326 | 1997 | General Management Structure Hospital divided into four service areas. | Director of Nursing<br>Nurse leader, strategic management, policy development, deals with patient complaints and industrial relation matters. | Unit Nursing Officers/Nurse Service Manager (4) UNO/SM's<br>Prepare service plans, delegated responsibility for all nursing matters except complaints and union issues. |

## Overview of Pilot Projects for Acute Hospital Management Structures

| Hospital | Number Beds (approx.) | Year pilot started | Changes in Nursing Management Structure (pilot projects) | Strategic Nurse Management role | Middle Nurse Management role |
|---|---|---|---|---|---|
| St. James Hospital* | 762 | 1993 | Clinical Directorates<br>• Clinical Director (Doctor)<br>• Directorate Nurse Manager<br>• Directorate Business Manager<br>Four bed holding directorates operational – three more to be established in 1998<br>*Now beyond pilot stage* | Director of Nursing<br>Executive member of management team, policy maker, nursing leader, agrees nursing budget & devolves it, responsible for all professional nursing matters. | Nurse Manager per directorate (4) (Assistant Director of Nursing level)<br>Responsible for all day to day issues effecting nurses within the directorate, budget responsibility, assisted by grade 5 clerical officer. |
| St. Vincent's Hospital Elm Park* | 472 | not yet started | A facilitator has been appointed to work with senior nursing personnel, medical and general management to review the nursing structure, thereby strengthening the nurse management team in working with Clinicians and General Managers towards a common goal.<br>*The process commenced in June 1998* | | |
| University College Hospital Galway (UCHG)* | 531 | 1994<br>1996 | General Management Structure<br>Reviewed – propose introduction of Clinical Co-ordinator posts<br>UCHG together with Merlin Park form Galway Regional Hospitals | Director of Nursing Services and Patient Relations Manager.<br>Nurse leader, strategic function, agrees nursing budget. Patient Relations Manager for Galway regional hospital, includes: dealing with complaints, quality initiatives, ensuring patient focus is maintained, identification & implementation of measures to improve patient services whether clinical, nursing or non-nursing. Deciding Officer for Freedom of Information Act. | Divisional Nurse Managers (3)<br>Operational management of nursing is being delegated to Divisional Nurse Managers. Role being developed will have responsibility for the co-ordination of all services, nursing, clinical support & support within the divisions. |
| Waterford Regional Hospital | 470 | 1998 | Propose Clinical Directorates – one medical directorate established in March 1998<br>• Clinical Director (Doctor)<br>• Nurse Manager<br>• Business Manager | Matron<br>Head of nursing, overall responsibility for the maintenance/development of the professional standards of nursing in the hospital. | Nurse Manager for medical directorate responsible for all day to day issues effecting nurses within the directorate, budget responsibility being discussed. Assistant Matrons (3) – traditional management role for the remainder of the hospital. |

## Overview of Pilot Projects for Acute Hospital Management Structures

| Hospital | Number Beds (approx.) | Year pilot started | Changes in Nursing Management Structure (pilot projects) | Strategic Nurse Management role | Middle Nurse Management role |
|---|---|---|---|---|---|
| Wexford General | 220<br>(300) | 1996 | Clinical Directorates (2)<br>Medial & Surgical Directorate<br>Tripartite management:<br>• Director (medical)<br>• Nuse Manager<br>• Services Manager<br>(the nurse and services managers works across both directorates). | Matron<br>Head of nursing, overall responsibility for the maintenance/development of the professional standards of nursing in the hospital.<br>Member of the Hospital Board of Management. | Nurse Manager (across both directorates)<br>Responsible for ensuring the effective management of nurse resources in the hospital<br>Also three Assistant Matrons who are responsiblie for:<br>— deputising for Matron<br>— nursing development<br>— non-nursing personnel |

*The Department of Health has approved the creation of a management structure comprising: Chief Executive Officer/General Manager; Deputy Chief Executive Officer/General Manager; and four Functional Managers in each of the Hospitals identified by an astrix*

***Source:* this table was constructed by the author of the review to give a brief overview of the pilot projects in nurse management across Hospitals. The information set out on the table was given, in correspondence, by Directors of Nursing/Matrons in response to the Commission on Nursing's request for information on the nature of the pilot project on nursing management within their organisation.**

**APPENDIX 6**

# NURSE MANAGERS STATE AWARD: SCHEDULE 1 CORE KNOWLEDGE AND SKILLS (NEW SOUTH WALES)

## Core Knowledge and Skills

| Group | Leadership | Communication | Knowledge | Performance Management | Planning | Resource Management |
|---|---|---|---|---|---|---|
| Grade 1 | Ability to provide leadership as a resource person and role model in the clinical setting and in professional relationships and act as a mentor for less experienced staff | Ability to represent nurses and consult with staff and other health professionals appropriately.<br>Ability to identify to and mediate potential and actual conflict between individuals. | Ability to utilise and share knowledge and skills relating to nursing practice. Ability to contribute to and utilise research. | Ability to assess the competence of staff, and identify strengths and limitations. Ability to facilitate professional development of staff.<br>Ability to facilitate activities which enhance the practice of staff. | Ability to set goals, formulate and implement plans to achieve identified outcomes.<br>Ability to contribute to the implementation of organisational change. | Ability to effectively allocate and manage nursing resources and set nursing priorities. |
| Grade 2 | Ability to lead the development of policy relating to nursing practice and provide leadership through direction and support to staff. | | Ability to acquire and utilise a sound and contemporary knowledge of nursing professional and management issues. | | Ability to contribute to an operational plan for the nursing service and coordinate the process of organisational change. | Ability to develop, monitor and evaluate nursing resource-allocation. |
| Grade 3 | Ability to develop leadership and management potential in staff.<br>Ability to identify the need for and initiate the development of policy relating to the nursing service. | Ability to utilise a broad range of communication skills selectively in a variety of settings. | Ability to facilitate the acquisition of knowledge by individuals and groups. | Ability to undertake planning for and monitor performance in areas of responsibility for both individuals and teams.<br>Ability to undertake a range of performance management activities appropriately. | Ability to develop an operational plan for the nursing service. | Ability to develop a staffing profile appropriate to service needs.<br>Ability to develop nursing service budget within prescribed parameters. |
| Grade 4 | Ability to evaluate and adjust policy. | Ability to represent the nursing service inside and outside the organisation at a local level.<br>Ability to identify and mediate potential and actual conflict between groups. | Ability to acquire and utilise a sound and contemporary knowledge of health management and organisational issues.<br>Ability to foster quality research activities. | Ability to develop performance assessment indicators and skill development tools. | Ability to coordinate planning across a range of services.<br>Ability to manage the process of organisational change, evaluate the outcome and adjust direction. | Ability to identify nursing and/or health service budget requirements and negotiate for funding allocation. |

## Core Knowledge and Skills

| Group | Leadership | Communication | Knowledge | Performance Management | Planning | Resource Management |
|---|---|---|---|---|---|---|
| Grade 5 | Ability to develop an environment which promotes continuous improvement in practice. | Ability to manage media relations related to local issues within a policy framework.<br>Ability to represent the organisation at a local level. | Ability to identify, evaluate and incorporate where appropriate emerging trends within the profession of nursing. | Ability to coordinate performance management activities within a range of services. | Ability to contribute to a strategic plan for the nursing service. | |
| Grade 6 | Ability to develop a culture within the organisation which is open to critical reflection and change. | | | Ability to monitor and evaluate performance management across the organisation and identify opportunities to realise enhanced performance. | Ability to develop a strategic plan for the nursing service and contribute to the development of a strategic plan for the organisation. | Ability to assess nursing and/or health service resource utilisation and make recommendations. |
| Grade 7 | | Ability to represent the nursing service in a range of forums including Stage and National. | Ability to identify, evaluate and incorporate where appropriate emerging trends within health care. | Ability to enhance organisational performance through collaboration with other health facilities. | | |
| Grade 8 | Ability to vision and articulate the potential for the organisation. | Ability to represent the organisation at a State and National level. | Ability to identify, evaluate and incorporate where appropriate emerging trends within the broader service and business industry which have the potential to enhance nursing and/or health services. | | Ability to generate and develop a strategic plan for the organisation. | |
| Grade 9 | Ability to contribute to and influence emerging trends within nursing and health. | Ability to negotiate on behalf of the organisation. | | Ability to enhance organisation performance through collaboration with other organisations both within and outside the area of health. | Ability to analyse the strategic plan of the organisation for continuing relevance and adjust direction.<br>Ability to contribute to a strategic plan for health care in a range of forums including a State and National level. | Ability to identify additional funding sources and negotiate funding as required. |

Represents core knowledge and skills. Each grade represents a higher level of function than those beneath. An assumption is made that those at Grade 8 (for example) will already have the knowledge and skills outlined in Grades 1-7.

## APPENDIX 7

# UNITED STATES: DUAL-TRACK LADDER

### United Kingdom: Clinical Grading Structure

| Management | Clinical | Education |
|---|---|---|
| Director of Nursing Services (levels III – I+) | | Education grades (levels 3-7) |
| Director of Nursing Services (levels V and IV) | Scale I | Educational grades (level 2) |
| Senior Nurse (levels IV and III) | | |
| Director of Nursing Services (level VI) | Scale H | Educational grades (level 1) |
| Senior Nurse (levels VI and V) | | |
| | Scale G | |
| | Scale F | |
| | Scale E | |
| | Scale D | |
| | Scale C | |

***Source:*** **International Council for Nurses, 1995, p.11.**

## APPENDIX 8

# UNITED STATES: CLINICAL GRADING STRUCTURE

### United States: Dual-Track Ladder

| | |
|---|---|
| **V. Clinical Nurse Coordinator**<br>Applies theories from physical and behavioural sciences; coordinates patient care for assigned area; functions independently in a line position. Roles: practitioner, manager, teacher, consultant, researcher. | **V. Administrative Nurse Coordinator**<br>Highly competent in nursing and the application of management skills in the attainment of patient care goals; functions manager, consultant, practitioner, teacher, researcher. |
| **IV. Nurse Clinician**<br>Advanced generalist or specialist functioning primarily as a practitioner; secondarily participates in unit staff development, patient/family teaching programmes, learning experiences for students. Roles: practitioner, teacher, manager, researcher. | **IV. Nursing Unit Coordinator**<br>Manages administrative nursing problems and coordinates the nursing activities of a specific area; acts as a liaison in interdepartmental and intradepartmental activities. Roles: manager, practitioner, teacher, researcher. |
| **III. Primary Clinical Nurse**<br>Experienced practitioner able to assess 24-hour health needs of patients, implement a plan to meet them and anticipate less predictable outcomes. Roles: practitioner, teacher, manager. | **III. Nursing Unit Leader**<br>Experienced practitioner able to manage patient care and coordinate the nursing staff for an 8-hour tour in an area of assignment. Roles: practitioner, manager, teacher. |
| **II. Clinical Nurse**<br>Nurse who, under general supervision, identifies, implements and evaluates the results of nursing interventions for a patient population.<br>Roles: practitioner, teacher. | |
| **I. Associate Clinical Nurse**<br>Nurse beginning practice, changing to area with no experience in that area, or returing to clinical practice; functions under direct supervision.<br>Role: practitioner only. | |

**Note:** At level V there are also clinical nurse specialists, staff development coordinators and administrative nurses.

***Source:*** **International Council for Nurses, 1995, p. 9.**

## APPENDIX 9

# CAREER DEVELOPMENT MODEL FOR NURSING PRACTICE IN SOUTH AUSTRALIA

| Dreyfus Skill Acquisition Levels | | Dreyfus Model of Skill Acquisition | LEVELS | Career Structure Positions |
|---|---|---|---|---|
| | | • Expert knowledge base in specialty field of practice<br>• Broad knowledge base in contemporary nursing<br>• Experience<br>• Highly developed skills in:<br>Practice-management or clinical or education<br>Decision making<br>Communication<br>Leadership<br>Policy formulation<br>Research<br>Strategic and operational planning | V | Director of Nursing |
| | | | IV | Assistant Directors of Nursing<br>• Management<br>• Clinical<br>• Education |
| 5 | EXPERT | • Performance holistic<br>• Highly skilled analytical ability<br>• Intuitive grasp of situations<br>• Wide range of appropriate strategies | III | Nurse Manager<br>Clinical Nurse Consultant<br>Nurse Educator |
| 4 | PROFICIENT | • Holistic understanding improves decision making<br>• Recognises unexpected events<br>• Identifies important aspects of a situation<br>• Expects typical events in a given situation<br>• Modifies plans in relation to strategies | | |
| 3 | COMPETANT | • Two or three years development in specific work<br>• Efficient and organised<br>• Able to cope and manage many contingencies of nursing<br>• Plans by conscious, abstract and analytical contemplation of problems<br>• Perceives action in terms of long range goals | II | Clinical Nurse |
| 2 | ADV BEGIN | • Acceptable Performance<br>• Operates on General Guidelines<br>• Uses experience to recognise meaningful situational components<br>• Needs help in setting priorities | I | Registered Nurse |
| 1 | NOVICE | • No experience with current situations<br>• Uses context free rules<br>• Discretionary judgement undeveloped owning to lack of experience<br>• Does not use fules in real situations | | |

*Source:* **Australian, (DPS Consultancy Team, 1992).**