**ANGLIA RUSKIN UNIVERSITY**

**THE ROLE OF THE WARD SISTER IN THE CONTEXT OF SUPERVISORY STATUS AND THE IMPACT THAT THE ROLE HAS ON QUALITY OF CARE**

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**A thesis submitted in partial fulfilment of the requirements of Anglia Ruskin University for the degree of Professional Doctorate in Health and Social Care. DProf.**

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ABSTRACT

FACULTY OF HEALTH, SOCIAL CARE AND EDUCATION

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The aim of this study, is to explore factors that influence the supervisory status of ward sisters in an acute hospital Trust and examine the impact that the role has on the quality of care both perceived and actual. Specifically, the study explores the lived experiences of ward sisters who move from non-supervisory to supervisory status, and the impact this has on the quality of patient care.

Using case study methodology, ward sisters from five different wards participated in a 12-month study during which they underwent a role change from non-supervisory to supervisory status. Managerial interventions created structural changes, first to their role and working environment via a professional development programme, and secondly, through the design of the new supervisory role. The supervisory role facilitates enabling of time, access to resources and to lines of support. Using semi structured interview techniques and a hermeneutic approach to interpretation, the lived experiences of ward sisters were captured first in their non-supervisory states (their roles formed part of the clinical care team), and later, in their new supervisory role. In addition, to establish the impact of the role change on patient outcomes, nursing quality indicators were observed over the course of the study period.

The findings of the research provide empirical support for propositions derived from Kanter’s theory of work empowerment. Whilst fluctuating clinical staffing challenges did not always enable the participants to manage with 100% supervisory status, when empowerment was operationalised in the organisational setting, ward sisters perceived increased levels of control, authority and support, as well as feelings that patient outcomes had improved. Quantitative data analysis of the nursing quality indicators showed no significant relationship with the role change; however closer inspection of the indicators revealed organisational inaccuracy of data capture.

The research makes a unique contribution to practice by providing guidance to enhance ward sisters’ contributions to the quality of patient care and draws our attention to the way in which we measure this.

Key Words: Ward sister; empowerment; quality; supervisory; outcomes.

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# CHAPTER 1

# Introduction

### 1.0 Background

The ward sister role is key to facilitating high standards of quality in health care. In order to manage the ward environment and ensure the delivery of safe and effective patient care the ward sisters’ leadership role is an essential skill (Douglas, 2011; Francis, 2013; Kings Fund, 2013). Literature has shown that both nationally and internationally, senior nurses are not always prepared for ward sister roles and are frequently without effective resources to deliver the expectations of the role (Buckner, et al., 2014; Herman, Gish and Rosenblum, 2015; Rich, et al., 2015). Health care policy and reform in the United Kingdom, continues to acknowledge the pivotal role the ward sister plays and the importance of investment in development and support to the role (Department of Health, 2013). Despite this acknowledgement, evidence continues to show gaps in support and training for ward sisters and continued lack of consistency in the expectations of their role and resources to undertake it (Willis, 2012; Francis, 2013).

Of specific importance in terms of resources is having time in the form of supernumerary status in order for ward sisters to undertake their role in a supervisory capacity. Whilst the focus on recent failings in the NHS has seen an increased interest in ensuring ward sisters are employed as an additional resource to a ward establishment, and as a consequence are not counted in the numbers of staff assigned to deliver direct patient care, in reality 100% supervisory status remains an ambition for most ward sisters (RCN, 2015). Seers, et al., (2015) examined baseline activity of ward sister roles in relation to supervisory time and found continued evidence of varying degrees of implementation of supervisory status which was largely dependent on financial challenges within organisations along with high nursing vacancy factors inhibiting the ward sisters’ ability to work in a supervisory way.

The structure of this thesis commences with a review of the extant literature in relation to the ward sister role and discusses relevant policy within the current context of the NHS. Theoretical underpinnings for the study are then discussed. A statement of the research questions guiding the study is then presented in light of these theoretical and policy insights. This is followed by the methodology and research approach taken in the study. The unique findings are then presented as the themes and sub-themes, as the visible and hidden meaning of the interpretation. The discussion, which follows, sets the findings in the context of the theoretical underpinnings for the study, highlighting the implications of the findings and recommendations and the overall contribution of the research. The final chapter also provides the researcher's reflection on this doctoral programme of study.

### 1.1 Introduction to Chapter 2 – Review of literature and conceptual framework

To inform this thesis, chapter 2 sets out the industry and policy background to the empirical setting. The chapter discusses the historical backdrop of nursing leadership, providing an overview of NHS reforms since its inception in 1948 with emphasis on nursing policy context. The chapter discusses the ward sister role, and its relationship with quality of care.

Chapter 2 then introduces the theoretical orientation underpinning the study - empowerment theory. Extant literature in this field is founded on the work of two key theorists. The work of Kanter (1985) provides insights for notions of structural empowerment which suggests that if employers provide tools with which employees can access structures of power and opportunity, they are able to mobilise information, resources and support to get things done in an organisation. Conger and Kanungo, (1988), Thomas and Velthouse, (1990) and Spreitzer, (1995) developed Kanter’s work on theory of empowerment to account for more than just the conditions of the work environment, they extended their focus towards the employees’ reactions to these conditions (Lashinger, et al., (2001b). In so doing they developed the theory in relation to psychological empowerment. Spreitzer identified four distinct components of psychological empowerment: a] autonomy, b] self-efficacy, c] job meaningfulness and d] the ability to have impact on the wider organisation. When combined with feelings of psychological empowerment, employees find meaning in their work, feel competent in their capacity to perform their job, are self-determined to achieving desired outcomes and believe they can make impact in the organisation (Spreitzer, 1995).

The chapter illuminates the current challenges in the NHS and specifically those facing ward sisters - building on the assertion that the ward sister role has a positive influence on patient outcomes. Using theory of empowerment, the study seeks to strengthen the evidence base using an empirical study of a defined group of ward sisters who transition from an interventional change in leadership model from non-supervisory to supervisory status to explore if and how the status intervention may influence specific patient outcomes over the study period.

### 1.2 Introduction to Chapter 3 - Methodology

Chapter 3 presents the methodological approach – a hermeneutic interpretation of the lived experience. This approach exposes the constraints and/or enablements that help or hinder a ward sister’s capacity to do the job effectively - and in so doing – to influence positively – nursing quality indicators. The selected methods of data collection and analysis in this study enabled greater understanding of what is happening at the operational or service delivery level to impact management decisions and actions that ward sisters make.

The methods address the research aim of the study, which is to explore factors that influence the supervisory status of ward sisters in an acute hospital Trust and examine the impact that the role has on the quality of care both perceived and actual. This research aim is driven by the following research questions:

Research Question -1: What is the lived experience of ward sisters who move from non- supervisory to supervisory status?

Research Question 2: What is the impact of supervisory role change on quality of patient care?

The study uses an empirical case study located in a large NHS teaching hospital and captures the lived experience of five ward sisters – considered for the quantitative and qualitative analyses as embedded units within the case. Chapter 3 explains the rationale for taking a case study approach as well as for capturing the lived experience of ward sisters for hermeneutic interpretation within their wider context.

The key method comprised one to one in-depth semi-structured interviews, undertaken before and after management interventions. In line with the philosophical orientations underpinning the claims that are made in this study, data analysis was iterative using the hermeneutic approach as suggested by Crist and Tanner (2003). This approach seeks to uncover hidden meaning within the data by exploring the lived experience of ward sisters in a ward setting and against hospital and national policy contexts. To measure impact on patient outcomes, data were collected from nursing quality indicators. To establish the impact of role change on these indicators as per the second research aim, these data were subject to a series of quantitative statistical analyses.

Chapter 3 also presents the formal ethical approval and research and development approval for the study.

### 1.3 Introduction to Chapter 4 - Qualitative findings of the study

Chapter 4 presents the qualitative findings of the study. Based on a hermeneutic analysis of transcripts for each of the five cases (semi-structured interviews of ward sisters before and after their status change) a number of themes emerged. The interpretation was iterative, beginning with an explicit first reading and then by circling between text and context a deeper understanding began to develop. Four main themes emerged in relation to ward sisters’ feelings and experiences over the course of the study as the intervention was implemented:

1. **Feeling (un)prepared for the role**

* Variation in training and role of the in-house programme
* Finding one’s own way

1. **Moving from disempowerment to empowerment**

* Loss of control of the ward
* Competing demands
* Becoming empowered

1. **Perceptions and relationships**

* Confusion about what the role meant
* Navigating the hierarchical structures, including support from matron
* Patient and family relationships

1. **Relationship between supervisory role and quality of care**

### 1.4 Introduction to Chapter 5 - Findings of the quantitative data analysis

Findings for the study are presented over two chapters. Chapter 4 presents the qualitative findings and chapter 5 the quantitative findings from analysis of the 13 nursing quality indicators, which were observed over the period of the study alongside the ward sisters’ transition to supervisory status. Surprising to note are the results of quality indicators as observed over the study period. There was an expectation that there would be some statistically significant differences between quality care measures and percentage of supervisory time, based on the assumption that ward sisters would have time as a resource to work more effectively. There were no statistically significant findings. This chapter explores the quantitative findings in some detail and the implications of these findings together with possible explanations for the findings are considered in chapter 6.

### 1.5 Introduction to Chapter 6 - Discussion

Chapter 6 discusses the themes outlined in the previous chapters through the lens of structural and psychological empowerment theory. The findings demonstrated that structural empowerment and structural power play a significant role in developing psychological empowerment (Spreitzer, 1995). The opportunity and power structures which Kanter (1995) suggested were crucial to empowering employees were represented by the supervisory status change and the development programme that was introduced alongside the change in the practice model. The impact of these structural interventions became clear as the ward sisters described the ‘step change’ they considered necessary to progress effectively from staff nurse to ward sister, and from non-supervisory to supervisory status. The findings are theorised through the lens of Kanter’s and Spreitzer’s empowerment theory by revealing the psychological empowerment experienced by ward sisters once structural empowerment was enabled through the managerial interventions relating to status change. Chapter 6 integrates the qualitative and quantitative findings in relation to the policy, theory and conceptual framework underpinning the study. The discussion is in two parts; the first part looks at theeffects of structural role change on ward sisters’ perceptions of their role; and the second examines the impact of this supervisory role change on quality of care and patient outcomes – as per the research questions.

### 1.6 Introduction to Chapter 7 – Conclusion

Chapter 7 concludes the study and also draws upon the three stage one papers completed as part of my professional doctorate studies. It identifies the research contributions, recommendations and limitations of the study. The findings contribute directly to ward management practice and to the empowerment literature. Practical implications of the study suggest supervisory status has a positive impact on the ward sister role when the ward sister is supported to work in an empowered way. The research contributes to the body of knowledge by reinforcing the notion that structural empowerment creates psychological empowerment.

Significant effects on patient outcomes were not supported by the NHS tools of measurement (nursing quality indicators) but were evidenced by the changes in feelings of self-determination, competence, job meaningfulness and perceived impact on the organisation reported by the participants.

Limitations to the study are discussed in relation to the research design and recommendations for furthering this study. The chapter concludes with researcher reflections on the experience of undertaking the professional doctorate and a primary piece of research. The chapter includes an explanation of why I chose to undertake the professional doctorate and the reasons for my interest in the topic.

**CHAPTER 2**

# Review of Literature & Conceptual Framework

### 2.0 Introduction

This chapter introduces the conceptual framework for the study. The goal of a conceptual framework is to categorise and describe concepts relevant to the study and map relationships among them (Miles and Huberman, 1994). After describing the literature searching process, this chapter develops the conceptual framework, which is presented in three sections.

The first section introduces the historical backdrop of nursing leadership, providing an overview of the NHS Reforms since 1948 with emphasis on the nursing policy context in England. These issues are important to the thesis as the current unprecedented financial challenges facing NHS leadership provide a contextual introduction for the reader from which conclusions can be drawn regarding the usefulness of the findings of the research study to his or her own area of interest. This body of literature has its foundations predominantly within health policy, health services and health care sciences.

The next section explores in detail the role of the ward sister in the UK and its relationship with quality of care. Quality is defined, and the wider impact of quality of patient experience, and safe and effective care are discussed. The literature review goes on to focus on the experience of ward sister roles in relation to supervisory versus non-supervisory status as well as preparation for the role across the UK. The literature review examines the value of supervisory status, both in terms of the impact on quality of patient care and on the impact on the individual ward sister role.

A key theme that arose from the literature review was Empowerment. The final section therefore discusses Empowerment theory as a branch of organisational studies which provides a theoretical lens through which to view the experiences of the ward sisters in this study.

Throughout the thesis, the term ward sister and ‘she’ is used which encompasses the role also held by a Charge Nurse. Within the classification of nursing roles, a total of 24% are Ward Sisters/ Charge Nurses, of which 92% are female Ward Sisters and 8% male Charge Nurses (National Nursing Research Unit, 2012).

2.1 **Literature searching process**

The literature search adopted for this research was conducted using an integrated approach, drawing on various types of literature including peer-reviewed articles, research studies, grey literature such as commentaries and opinion pieces, NHS policy and relevant guidelines. The aim of the search process was to identify current and established literature relating to the ward sister role in the current context of health, the relationships with supervisory status and the ward sister role and the impact of such relationships on the quality of patient care. The aim of this approach was to ensure that a solid background in relation to this topic was presented as well as serving to highlight the gap in knowledge within the chosen area of research (Holland and Rees, 2011).

Phase one of the literature search was completed using search terms that had emerged through key reading in the preceding assignments leading to the research study. These included the key terms ward sister, quality of care and leadership. This introduced a plethora of literature, specifically around the ward sister and quality of care. Phase two refined the searches with a more focussed approach, combining the terms with supervisory status and relationships with quality outcomes, factors affecting nursing leadership and the influences of empowerment theory. Fast internet access and search engines facilitated the review, including databases such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE (Medical Literature Online), along with hand searches of relevant journals to ensure most recent articles books and studies were accessed. Prior to completion of the research, a further search of the literature was completed. The literature searching process was refined by examining the titles and reading abstracts, and continuing to repeat this process as the thesis was developed.

Exclusion and inclusion criteria were identified as follows:

* Written in English – it would not have been possible to translate works for the purpose of this thesis.
* Peer reviewed literature, including research.
* Policy documents from 2010 to 2018.
* Current materials (historical and seminal works accessed).
* University academic journals/ conference proceedings/online resources.

Whilst the evidence found from this literature review, identified a significant number of studies pertaining to the ward sister, supervisory status and relationships with quality of care, gaps were identified in the search process in relation to structural interventions that change leadership practices in this role (Gilmartin and D’Aunno, 2007). One study emerged from the RCN during the study period which specifically focussed on this aspect of research (RCN, 2015a). Recommendations of this specific study included the need to examine further the impact of supervisory role change on the individuals, in terms of empowerment and the impact this may have on their role, their teams and quality of patient care. My research study aimed therefore to contribute to this gap in the literature.

A summary of the scholarly search engines and journal databases along with key words utilised is identified in tables 2.1 and 2.2.

Table 2.1 Databases and search engines.

|  |  |
| --- | --- |
| British Nursing Index  OVID  SAGE Journals Online  ERICS  Internet sources included:  Google  Google Scholar  University websites  HEA  UK Government | The Cumulative Index of Nursing  and Allied Health Literature (CINAHL)  Medical literature on line (MEDLINE) |

Table 2.2 Search Terms

|  |  |
| --- | --- |
| Ward Sister | Nursing |
|  | Quality |
|  | Supervisory Status |
|  | Care |
|  | Leadership |
|  | Modern matron |
|  | Recruitment |
|  | Conflict |
| Quality | Nursing Metrics |
|  | Supervisory Status |
|  | Outcomes |
| Leadership | Nursing |
|  | Patient outcomes |
| Empowerment theory | Nursing |

### 2.2 Background and policy context

### 2.2.1 NHS reforms

The National Health Service (NHS) employs approximately 1.7 million staff members, and in the region of 400,000 of these are nurses and midwifes (Nuffield Trust, 2017). Annual running costs for the service are in the region of £116 billion, with 70% of expenditure paying salaries, and a further £4 billion per annum spent on training the staff. The recent economic climate has plunged the NHS into a future of unprecedented financial constraint with a financial challenge of a £30 billion funding gap by 2020/21 (NHS England, 2016). To address the gap in funding, the government has set out that it will provide £8bn, but state that the remaining £22bn must be identified through efficiency savings across the NHS. This was followed by instruction from NHS Improvement (NHSI), the regulatory body responsible for overseeing foundation and NHS Trusts, that Trusts much reduce the NHS deficit and reduce their pay bill (NHSI, 2016). Alongside shrinking financial budgets, NHS services struggle to maintain financial stability. In the acute Trust setting, organisations ended the financial year 2016/17 with a deficit of £2.6 billion (Kings Fund, 2017). In order, therefore, to achieve the challenge set out by NHSI, provider organisations face growing pressure in relation to retaining safe staffing levels.

In the near seven decades since the NHS came into existence in 1948, there have been continuous reforms of the service. These reforms have been driven by political agendas many of which have been associated with efficiency savings whilst others in more recent decades have focussed on improving the quality of service delivery for patients whilst continuing to drive down costs.

The underlying philosophy of a national service providing health care for all free at the point of delivery was intended to ensure that all parts of society receive not only what it requires but also what it is entitled to in the areas of health care and social support. Successive governments claim to have endeavoured to adhere to these principles up to modern day (Department of Health, 2015).

Bevan’s far-reaching vision included better organisation of hospitals with the removal of inequity in geographical provision (House of Commons, 1946). One of the great advantages of taking the NHS forward lay with skilled clinicians working within the front line clinical setting which would be a crucial factor throughout history in the success of an evolving health service. This early model of medical dominance and clinical leadership with little accountability for how funds were allocated and spent, remained un-challenged until a number of government reforms set out to review management structures within the NHS; notable among these were the Guillebaud Committee of Enquiry (Ministry of Health, 1956), the Salmon Report (Ministry of Health & Scottish Home & Health Department, 1966), and the Briggs Report (Report of the Committee on Nursing, 1972). However, it was not until The Griffiths Report (Department of Health and Social Security, 1983) that it was clearly articulated that the managerial control of hospitals should be given to appropriately trained managers, without clinical backgrounds working closely with doctors (Ham, 2009). With these reforms came a structure of general managers and the creation of a managerial hierarchy with accountability to central government.

Salmon’s (1966), Briggs’ (1972) and Griffiths’ (1983) work had a profound effect on the ward sister role. The Salmon Report set out to modernise the career structure for nursing in the United Kingdom, introducing the role of nursing officer above the ward sister who had an authoritarian role in staffing and clinical expertise, replacing the traditional role of the matron. It also introduced the role of the ward clerk and recommended that the ward sister stepped away from non-nursing administrative duties. The Briggs (1972) report saw the movement of nurse education from the NHS to higher education, a huge change from the historical responsibility of the ward sister for the education and training of learners (Dingwall, et al., 1988). Similarly, Griffiths’ (1983) reforms saw the management of nursing shift from the senior nursing team who maintained control of their own budget to the control of general hospital management. Most significant within the changes was the shift to a ward sister role that required a greater managerial focus as opposed to the main focus being on nursing issues within the ward.

Along with the establishment of a general management system the Griffiths (1983) report also saw the beginning of a move to contract services to the private sector. The National Health Service and Community Care Act (1990) saw support services such as cleaning and catering, previously areas of hospital activity that were managed and controlled by the ward sister, contracted to external providers. Deterioration in the quality of service delivery in these areas as a result of the internal market and competitive pricing emphasised the reducing impact of the ward sister within her clinical setting (Audit Commission, 1992).

Although these reforms represented government attempts to improve the role of the ward sister enabling her to spend more time in direct patient care related activity, what they actually achieved was a step-wise disempowerment of the ward sister role as they struggled with new titles, posts and structures and uncertainty about the expectations of others above and below them in the clinical as well as managerial setting (Ball, 1998).

The introduction of an internal market with a purchaser / provider system in 1990 led to still greater conflict within the hospital setting as budget holders struggled with the conflicting demands of improving access to services, whilst reducing the number of sites available for care in order to make financial efficiencies.

Other changes continued in the late 1980s and 1990s, notably with the focus on shifting primary care to community settings. Griffiths’ reforms were met with a backlash of political and professional mis-trust and disagreement. The British Medical Journal (1996, p.1622) described the NHS as a ‘political, statistical and managerial battleground’ as the reforms were said to distance clinicians from leadership, shifting in focus from clinical care to performance management and finances.

Throughout the 1980s and 1990s the NHS continued to show strain. Le Grand, Mays and Mulligan (1999) attribute this to the behaviour of doctors, nurses and managers who became alienated rather than motivated by this new found internal market which had led to a shortage of resources, inadequate staffing, and poor facilities and performance and confusion in relation to roles and responsibilities.

Whilst the academic status of nursing saw a long-awaited advancement with the advent of Project 2000 and clearer plans for career development, unstable workforce planning between 1989 and 2007, saw no single system for NHS workforce planning in England for more than a few years before being replaced as a result of broader re-organisation or specific redesign (Buchan, 2007; RCN, 2012). The resulting gap in supply of nursing had a significant and long-lasting impact on front line nursing during the following decade and remains a challenge up to the current day. The House of Commons Health Committee has recently reported that workforce planning continues to have “suffered from short termism and has lacked a coherent, long term strategic view” (House of Commons, 2018). Whilst the NHS reforms of 2012, created Health Education England (HEE) which served as a new structure for workforce planning, this ceased in August 2017, whereby all new nursing, midwifery and allied health professional students on pre-registration undergraduate and post-graduate courses now receive their tuition funding and financial support through the standard student support system, rather than NHS bursaries and tuition funded by HEE. Whilst this has in theory opened up the market for the training of students in these fields, there will be a significant delay before the NHS feels the impact of a new approach to planning. In addition to the uncertainty the changing model has in relation to training numbers for the future, there remains no joined up approach nationally for addressing immediate demands and gaps in workforce. This remains the responsibility of individual NHS organisations and with this are varied and uncoordinated, competitive and poorly thought through approaches to recruitment and workforce provision (Addicott, et al., 2015). Coupled with this is the current and unprecedented financial challenge across the NHS and the decisions being made at local levels in relation to reductions in workforce to close financial gaps. In 2011 the RCN collected evidence from 21 NHS Trusts in England showing 54% of nearly 10000 posts identified for removal were front line clinical posts, 46% of which were nursing posts. Carter in his address to Congress in 2011 described clinical staff as the “lifeblood of the NHS” but said they were “haemorrhaging at an alarming rate”. He went on to say “cutting these front-line doctors and nurses could have a catastrophic impact on patient safety and care. Our figures expose the myth that front line staff and services are protected” (Carter, 2011). In a further analysis by the RCN in 2017, 67 per cent of nurse leaders stated that compared with two years ago, finances had become worse and three in five nurse leaders reported that insufficient financial resources exist within their organisations to provide adequate staffing levels (RCN, 2017). This on-going uncoordinated recruitment and local adjustment to workforce levels continues to complicate the stability of front line nursing.

Publication of the NHS Plan in 2000 saw a focus on Hospital Boards and their accountability for clinical outcomes including healthcare acquired infection rates (HCAI) (Department of Health, 2000). Of particular significance to nursing within this plan was a proposal for the return of the matron as the Modern Matron, who would focus on 10 key areas of practice including infection control and hospital cleaning, in the prevention of HCAI particularly Methicillin-resistant Staphylococcus aureus (MRSA) (Department of Health, 2001a; 2002). Surrounding the reintroduction of the role was the belief in the popular perception that matrons traditionally held great power and influence and as a result would drive up standards of cleanliness (Barrett, 2003).

Oughtibridge (2003) argued that inadequate consideration for the introduction of the Modern Matron role in relation to how it would function alongside modern day nursing and healthcare provision led to confusion and inconsistency in its introduction as well as its application across the NHS (RCN, 2003). Currie, Koteyko and Nerlich (2009) identified four dimensions of contemporary professional organisations that should be considered alongside the introduction of new professional roles. These include: considering the dynamics of the profession with which the new roles are most closely associated; the changing role of those within this profession and its relationship with the new role; the relationship between various professions and power differentials that impact upon the new role; and finally, the relationship between the new role and organisational management. All four of these dimensions hold specific importance for the modern matron role, in terms of changing roles and the long journey of professionalisation of nursing from the 1960s onwards. The relationships with various professions that the matron holds, including the ward sister, has also been seen to change alongside government drivers so that the role influences policy and modernises delivery of public service, and finally the relationship between the new role and organisational management.

Currie, Koteyko and Nerlich (2009) concluded that the introduction of the Modern Matron role exemplified the government’s attempts to create a hybrid of professional and managerial role function, which falls short in addressing the challenges associated with introducing new roles within a pre-existing and dynamic system of professions.

The current decade of reform centres on the Health and Social Care Act (2012) implemented in April 2013. In addition to the commitment to training already described, the theme of leadership features significantly within the reforms, along with a renewed focus on quality, regulation and inspection, with the role of front line clinical leaders once again highlighted as a critical factor in improving quality of care.

Throughout the changing face of the political landscape the ward sister role has continued to be subject to challenge and redefinition. As a result, a weakening in the wards sisters’ position of authority has been seen (RCN, 2009), together with a negative impact on recruitment to the role, with many senior nurses preferring a more defined specialist nurse route, adding to the challenge of recruiting and retaining nurse leaders for the future. It is suggested only 10% of junior staff nurses aspire to becoming a ward sister (Wise, 2007; Sherman, 2005). Between 2010 and 2013, the RCN reported a 5.98% reduction in nurses within the agenda for change nursing leadership bands 7 and 8, these being two of the nine pay bands within the pay system for all NHS staff except doctors, dentists and senior managers (RCN, 2014).

### 2.3 Role of ward sister

The pivotal role the ward sister holds has long been seen as central to the quality and delivery of patient care, described by Cole (2010) as the linchpin of healthcare. Its importance in the provision of safe, effective and person focussed care is historically noted throughout nursing literature (Rankin, et al., 2016). Fenton and Phillips (2013) suggest the role has remained unchanged since its early conception in the context of being an expert nurse, a manager of a ward, a team leader and an educator. It is argued however that the constant political influence and sequence of organisational changes within the healthcare system has directly impacted upon the ward sister role, limiting its ability to function effectively (RCN, 2015b). A number of factors contribute to the success of the ward sister role including the individual’s ability to undertake the full range of activities that exist within the role without being utilised in front line nursing numbers at the same time, in other words not being responsible for a patient caseload as well as managing the ward. A critical factor therefore is the ability to practice within a supervisory capacity. Vital to the success of the role, is organisational support and commitment to its purpose and application (RCN, 2009). My study sets out to examine the ward sister role within one NHS organisation and through the lived experience of a group of ward sisters and the context within which they operate. It also seeks to understand the evidence from the literature review which suggests that, despite the body of evidence supporting the ward sister role in relation to patient care, variations in training, understanding and practical application of the ward sister role across the NHS continue to be seen (RCN, 2009). Such variation has been shown to impact negatively on patient care as well as recruitment and retention of the ward sister role (Enterkin, Robb and McLaren, 2013). A number of recent high profile failings in care identified the common theme of the importance of the role of leadership in care delivery, and in particular the role of the ward sister as a leader (Francis, 2010; Berwick, 2013; Keogh, 2013). By researching the literature supporting the issue and combining it with the lived experience of a group of ward sisters, my research seeks to add to the body of knowledge underpinning the supervisory ward sister role, and what enables or constrains its efficacy.

The previous section set out the changing political landscape over the last 50 years along with changes to nursing policy and the impact on the role of the ward sister as each consecutive government has strived to optimise patient care across the NHS. It is argued that over this time period, the increased emphasis on managerial focus around performance, quality improvement, and decentralised decision making over time has diminished and confused the role of the ward sister (Bradshaw, 2010; Orvik, et al., 2015). The following section examines the role of the ward sister within four key areas:

* Early differentiation of the ward sister role
* The impact of supervisory time
* The ward sister’s role in quality of care
* Leadership and the ward sister

### 2.3.1 Early differentiation of the ward sister role

Following the inception of the NHS in 1948 the differentiation of the role of the ward sister from that of other nursing staff was identified and noted in the early literature. Remnants of the religious origins of nursing remain with the retention of the term ‘Ward Sister’. Goddard (1953) described three distinguishing roles of Sister being:

* The supervision of nursing care and treatment including the interpretation of medical instructions.
* The coordination of services to patients.
* The training of student nurses.

The role of the ward sister can be traced back to the work of Florence Nightingale who discussed the significance of the supervisory role of the ward sister in her Notes on Nursing (Dingwall, Rafferty and Webster, 1988). The Briggs report identified the ward sister as the key figure in a successful ward team (Report of the Committee on Nursing, 1972). Pembrey (1980) also set out the core values of the ward sister in her quote: “The ward sister remains the key nurse in negotiating the care of the patient because she [or he] is the only person in the nursing structure who actually and symbolically represents continuity of care to the patient. She [or he] is also the only nurse who has direct managerial responsibilities for both patients and nurses. It is this combination which makes the role unique and so important in nursing.” The importance of the assertions within this paragraph remain relevant within current day nursing and the importance of the role continues to be highlighted as a key to safe and effective patient care. As Francis (2013, p.80) asserts, “the ward manager’s role as leader of a unit caring for patients is universally recognised as absolutely critical”.

As debate continues across the NHS, as to whether or not the gender specific term is a subject of equality and diversity, the title ‘Ward Manager’ can be seen as an alternative description of the role. Its introduction as a title following the previously described 1980s reforms served to emphasise the important management role of the ward sister. Bradshaw (2010) argued disparity in the title 'ward sister' espoused by ward sisters and the public, and the title 'ward manager' espoused by non-nursing managers. She suggested that it is not just about a title but the values enshrined by the term and entrusted to the role, and that as a consequence of professional, educational and managerial changes, the traditional authority of the ward sister for nursing standards, ward services and ward facilities is diminished. Bolton (2003) argues these differences in understanding have led to destabilisation of the ward sisters’ own interpretations in both their personal and professional identity. The literature also suggests in attempts to secure both personal and professional identity within the senior nursing structure, ward sisters have associated with certain aspects of the role and disassociated with others for example administrative management roles associated with a ward manger title, versus a more traditional caring and clinical expertise (Weik, 1995). Despite the literature pointing to the importance of the ward sister role within the NHS structure, well intended developments may have led to poor understanding of roles and inconsistent interpretations from both the hierarchical management structures as well as the ward sisters themselves.

### 2.3.2 The impact of supervisory time

Pivotal to understanding the role of the ward sister is understanding the definition and debate in relation to the term ‘supervisory’ versus ‘supernumerary’ status. There has been debate within the literature as to which term is most relevant to the aims of the role. The term supernumerary implies extra to the establishment numbers within a clinical team, whereas supervisory encompasses the purpose for which the supernumerary time would be used. The Royal College of Nursing advocated supervisory status for the ward sister role supported by a framework for the role which would set out clear roles and responsibilities that make accountability for the quality of care from the point of care to the NHS Trust executive boardroom explicit (‘from ward to board’) (RCN, 2009; RCN, 2011). Francis also explicitly set out in his recommendations that the ward sister role should be supervisory (Francis, 2013, p.106) “ward managers should operate in a supervisory capacity, and not be office bound or expected to double up, except in emergencies as part of the nursing provision of the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team.” Despite the support for these recommendations from Sir Robert Francis little evidence exists to date of wide implementation across the NHS (RCN, 2015c).

The importance of the debate within these terms is useful in avoiding the misconception that a supernumerary ward sister is based in an office as opposed to supervising her ward, team and patient care. The RCN concluded in 2015 in their baseline survey of ward sister roles that supervisory ward leaders have the time to be present in clinical areas, and therefore be visible and accessible to patients, their family/carers, ward staff and the broader multidisciplinary team. In a supervisory capacity they are able to proactively coordinate care, finding sensible and innovative solutions to problems. In addition, as clinically knowledgeable professional role models they are able to work alongside staff, supporting, educating and managing staff. In being able to function this way they are able to develop and sustain high standards of care (RCN, 2015b). Therefore, in order to ensure that the ward sister role is understood in a supervisory capacity it is critical to have clarity in relation to the supernumerary status in order to allow her to act in a supervisory way.

The Prime Minister’s Commission (PMC) in 2010 was established to examine how nursing could take a more central role in 21st century health care services. The commission built on Lord Darzi’s 2008 report of the NHS Next Stage review (Darzi, 2008) and supported the move to supervisory status recognising the authority, confidence and feelings of safety that patients derive from the ward sister. To support and strengthen the role the PMC set out instructions to the Care Quality Commission to observe if ward sisters had supervisory status in England (Prime Minister’s Commission, 2010). In the light of the findings in the Francis Report (2013) and RCN recommendations (RCN, 2015b), the government again supported the importance of supervisory roles for nursing sisters with an endorsement of their commitment to supervisory status: “We recognise that many ward managers currently have the same caseload as other nurses on the ward, which does not always allow them time to perform the full scope of the supervisory role” (Department of Health, 2013 p71). The Department of Health later confirmed however, whilst supporting supervisory roles for ward sisters, employers should have flexibility over the way they are deployed (Catton, 2013). To date, supervisory practice and the ward sister role, is not uniform in practice across England (Seers, et al., 2015).

In 2015, the RCN commissioned Warwick University to provide a baseline survey of activity in relation to ward sisters’ supervisory roles. 234 chief nurses or directors of nursing across NHS England were invited to participate. 63 Trusts from the 234 approached responded (27%) and these included 37 acute Trusts, 10 integrated Trusts, 5 community Trusts and 8 mental health Trusts. The specific aim of the study was to understand what activities took place as part of supervisory roles for ward sisters. However, the findings provide a wider insight into the varying levels of application of supervisory status in practice. Whilst the majority of respondents were positive about implementation, five were unable to implement supervisory status due to lack of finance and high vacancy factors, and of the others the extent of implementation varied in practice ranging from one to four days per week designated supervisory time. The study reported overall that financial constraints and high vacancy factors meant achieving supervisory practice was a struggle and ward sisters were frequently drawn back into the numbers to cover gaps in front line nursing shifts.

The study also explored evidence of evaluation of the role by the individual Trusts. Of the 63 Trusts that responded, 58 had already introduced supervisory status but only 34% (n=21) reported that they were evaluating the role. Within this group of 21, key performance indicators (KPIs) were used to assess the impact of the changed status by 15 Trusts; 62% of the Trusts (n=38) were not evaluating the role, and 3% (n=2) reported not knowing if the role was being evaluated. Whilst there were some commonalities in those Trusts using key performance indicators, a wide range of ways of evaluating the role were reported including ward documentation, staff focus groups, ward accreditation process; student experience; ward quality and workforce indicators; away day discussions; nurse sensitive indicators; appraisal; staff surveys; and time in supervisory role. This wide variety of measures led to a conclusion that more research was needed to assess the impact of supervisory status. However, the study did report a strong perception that care had improved where the supervisory status had been implemented, and that it would be difficult to fulfil every day duties as a ward sister without such status. Therefore, the growing assertion emerging from the literature that the supervisory status brings about improvement in quality of care is based largely on perception and a heterogenous group of outcome measures which are largely inconsistent. It is therefore an area that requires a more consistent and objective analysis to be performed in order to support the implementation of the supervisory role wholescale.

The RCN has continued to support key changes to the ward sister role and in particular supervisory status over the last 50 years (Kitson and Antrobus, 1999). The Prime Minister’s Commission (2010) also supports the ward sister role and sets out within its 20 recommendations the importance of nursing leadership and commitment to securing the nursing pledge to deliver high quality care. Whilst the themes of the report were well received, there has been little impact in professional terms and the ward sister role has still not been standardised (RCN, 2015b). In order to examine the relationship between supervisory status and quality of care, the following section sets out to examine the ward sister’s role in quality of care and begins by defining quality in health care.

### 2.3.3 The ward sister role in quality of care

Within healthcare, there is no universally accepted definition of the term quality of care. Throughout the last decade there has been an increased focus on organisations attempting to clarify what is understood and expected in relation to the definition of quality, prompted largely by the failings in care which have manifested during this period. In reaching a definition a number of domains of care upon which quality can be assessed have been identified including safety, effectiveness, outcomes of care, patient-centred/experience, timely access to care, efficient value for money, equitable and leading to independent living and health improvement (Raleigh and Foot, 2010).

The work of Don Berwick in his report ‘Crossing the Quality Chasm’, laid the foundation for healthcare reform in the United States and is now commonly used globally. He describes six dimensions of quality in healthcare: safety, effectiveness, patient-centredness, timeliness, efficiency, and equity (Berwick, 2013). In 2008, Darzi identified three key core dimensions of quality, these being patient safety, clinical effectiveness and the experience of patients. The NHS Outcomes Framework uses Darzi’s key dimensions to define the five domains of quality upon which the NHS commissioning board is held to account as shown in Figure 2.2 (DH, 2010). It is therefore incumbent on health care leaders to consider these dimensions when considering quality improvement in health care.

Figure 2.1: The five ‘Outcome Domains’ of the NHS Outcomes Framework

|  |  |
| --- | --- |
| **Domain 1** | **Preventing people from dying prematurely** |
| **Domain 2** | **Enhancing quality of life for people with long term conditions** | **Effectiveness of care** |
| **Domain 3** | **Helping people to recover from episodes of ill health or following injury** |
| **Domain 4** | **Ensuring that people have a positive experience of care** | **Patient experience** |
| **Domain 5** | **Treating and caring for people in a safe environment and protecting from harm** | **Patient safety** |

In 2008, the then Chief Nursing Officer for England published a paper framing the nursing and midwifery contribution, driving up the quality of care (DOH, 2008a) which included the publication of quality indicators for nursing which built on these quality domains.

Throughout this study the dimensions as defined by Lord Darzi serve as a focus from which to examine the impact of the ward sister role in relation to quality of care and chapter 5 describes the nursing quality indicators linked to these themes in detail. The ward sister’s impact on leading the clinical team to deliver quality care, and the education of staff and patients, as well as supporting organisational objectives is well documented within the literature (Phillips and Byrne, 2013). Throughout the 1980s a number of research studies examined the importance of the ward sister role in planning and directing work for learner nurses as well as the importance of the supervision of learners and ward-based staff in practice by the ward sister (Ogier, 1982; Runciman, 1983; Lathlean, 1988). During the same period the Royal College of Nursing published a number of studies relating to the importance of the ward sister role to an organisation and the standard of hospital and community nursing (Pembrey, 1980; Redfern, 1981; Ogier, 1982; Stapleton, 1983).

In 2006 Hay Group, a global management-consulting firm, examined the relationship with efficiency, clinical safety and quality of care to the role of the ward sister. Their study examined 22 ward managers across seven English Acute Trusts, including teaching, foundation and general Trusts in both urban and rural areas. The ward sisters were streamed into two groups: high performing versus low performing ward sisters based on their leadership styles and the climate within their ward areas. Those who exhibited a range of leadership styles and created a positive learning environment were identified as the high performers. They examined five performance indicators over which the ward manager had influence; these included patient satisfaction, staff absenteeism, complaints, drug errors and staff turnover. The results identified that the higher performing ward sisters achieved 36% lower staff turnover, a 57% reduction in absenteeism, 40% lower drug errors with life threatening drug errors being 50% higher in the wards of the lower performing ward sisters, and a 45% overall improvement in the remaining indicators compared with the lower performing group. Whilst these results are striking, limitations of this study however include its failure to acknowledge contingency (sometimes described as situational) leadership theories which highlight that effective leadership is not just about the leader’s approach and style but should also consider other factors which affect the situation (Bernhard and Walsh, 1990; Doran, et al., 2004). An example of these factors includes the effect of span of control (the number of people supervised by a manager) on job satisfaction, patient satisfaction and turnover of staff. Whilst acknowledging the fact that leadership matters and some leadership styles are indeed better than others, their study unequivocally concluded that no leadership style can overcome span of control and that the wider the span of control the more negative the impact on quality of care. Understanding the span of control of the ward sister is an important factor to be considered within the relationship of quality indicators not just in terms of numbers but also for designated time for supervisory functions. Whilst the debate around safer staffing levels continues across the United Kingdom, staffing levels in England are not set out in law; nor does England have mandated tools that are used consistently across the NHS, resulting in wide variation of staffing levels and therefore, support for a ward sister to be able to optimize her workload and that of her team in relation to the delivery of quality care (NHS England, 2015).

Throughout the early 2000s, further studies explored the ward sister role and its relationship with quality of care. Griffiths, Renz and Rafferty (2008) identified a strong correlation between infection control practices and ward level leadership. Whilst the study acknowledges weaknesses in direct evidence of the impact of leadership and infection rates, it does provide evidence that positive leadership at ward level is a strong prerequisite to good infection control practices. Grimshaw, et al. (2004) and Francke, et al. (2008) comment on the importance of the ward sister’s role as educators and change agents and the impact they have on influencing the team around them to best adapt their setting to the clinical context and organisational challenges. Ward sisters can ensure the ongoing translation of continuous learning and reflection into everyday clinical practice and in particular helping to bridge the gap from the classroom to the front line (Coomarasamy and Khan, 2004). Further work by the RCN in identifying factors influencing high quality care included the fundamental importance of the ward sister role (Cunningham and Kitson, 2000). The RCN work looked at the role of the ward sister across England including mental health, children and adult wards. They identified that the importance of the ward sister role applied universally and that where the ward sister was supervisory in practice, patient care benefitted by improvement in quality outcomes reflected by improved patient experience, health and well-being of staff, productivity and efficiency and patient and public confidence (RCN, 2009; RCN 2011; RCN 2015).

Wong, Cummings and Ducharme (2013), undertook a systematic review of the relationship between nursing leadership and patient outcomes. This study built on the findings of their earlier review in 2007 whereby they examined 20 years of evidence between 1985 and 2005 finding seven studies examining nursing leadership and patient outcomes (Wong and Cummings, 2007). Their more recent review identified 20 studies providing evidence relating to the theme. Their definition of nurse leaders included ward sister roles who deliver front line nursing leadership and supervision of other nurses. Results concluded that there was a strong association between nursing leadership and 19 patient outcome variables including, patient satisfaction, patient mortality and safety (including falls, pressure ulcers, medication incidents, use of restraint, and hospital acquired infections), adverse incidents, complications of care, and patient healthcare utilisation. Whilst their systematic review recommended support for the assertion that nursing leadership is positively associated with patient outcomes in the areas identified, limitations of the study suggest that, on the whole, cross-sectional or correlation designs dominated the literature review along with a wide variety of practical settings and patient outcomes, making it difficult to synthesise findings. They concluded that the majority of studies confirm causal connections between nursing leadership and outcomes of patient care but propose the literature would benefit from longitudinal studies with repeated observations. Gilmartin and D’Aunno (2007) support this view suggesting studies which included changes to leadership practices, which examined the impact of such changes on the individuals, their teams and patient outcomes would strengthen the body of evidence.

In examining the literature supporting the relationship between the ward sister role and quality of care, it is important to consider the wider issues which impact on quality of care. Sawbridge and Hewison (2011) considered practical solutions identified by members of a nursing think tank which debated the issues relating to the relationship with nursing and poor care. The work was organised into three main phases: a consultation with key stakeholders at local, regional and national level; a critical review of the literature in relation to the dimensions of poor care; and thirdly, the use of focus groups involving executive nurses. Whilst the study was limited to the West Midlands and acute hospital settings, many of the findings are transferable to the wider NHS due to the similarity in organisational settings. Their study concluded that quality of care is influenced by four dominant themes which emerged from the think tank and included the physical environment in which the nurse works, education, and support available for all staff within the clinical setting and the concept of appreciation of the emotional labour endured by nurses throughout all levels of the profession. Whilst it is clear that there are a number of issues surrounding the ward sister’s role in quality of care, my study focusses primarily on the relationship associated with supervisory versus non-supervisory time for the ward sister and how this impacts upon quality of care.

### 2.3.4 Leadership and the ward sister

In order to ensure safe and effective care in the ward setting effective leadership is critical (RCN, 2016). Within this context the definition of leadership is that relating to clinical leadership in healthcare delivery based on the evidence that enabled leaders benefit patient care (Dawson, et al., 2009). To succeed in having the right leaders in place, there is a need for greater focus on leadership development for front line staff both nationally and internationally (Ham, 2011; McNamara, et al., 2011; Martin, et al., 2012).

Kennedy (2008, p.942) stated, “we recruit ward sisters from a pool of very capable clinical nurses and throw them, virtually unaided, into an entirely new role with an uneven chance of survival, let alone success”.

The increasing focus on healthcare costs and delivery of high quality care is not limited to the NHS but have a global application. Gantz, et al. (2012) identify the need for networking of innovation in nursing leadership to find a world view for best practice to face the extensive challenges facing the profession and in particular the challenges facing the ward leadership role.

The Hay Group (2006) identified significant gaps and inconsistencies in the understanding of clinical leadership in ward settings, highlighting the need for a well-defined ward sister role with formal role preparation and training and definition of how it relates to other management roles. Whilst leadership and management are described discretely in the literature, with leaders often being considered to have a visionary role and managers a more operational focus (Blegen and Severinsson, 2011). The ward sister role can be argued to encompass both clinical leadership in ensuring the translation of best practice care within the healthcare setting, as well as operational management of the delivery of a service and management of ward teams. Martin, et al. (2012) concede the importance of ensuring clarity exists within these roles and alongside other NHS management roles to ensure the ward sister is able to operate effectively.

Despite a plethora of literature calling for clinical leadership development leading to national as well as local leadership programmes, there is still no common single approved leadership role programme for ward sisters (Phillips and Byrne, 2013). Pegram, et al. (2014) undertook a comprehensive search of the literature pertaining to the development of the ward sister role. Whilst their study primarily focussed on solutions and innovations to strengthen the role, it examined education and training provided for the role nationally. Whilst their research identified a number of studies which focussed on distinct sub themes including preferred approaches to ward sister programmes, content and identified benefits, they concluded there was limited research relating to the role components, role delivery and preparation for the role of the ward sister, and that there was in fact a paucity of primary research which examined the ward sister role suggesting what limited research there was focussed on local programmes and national campaigns.

The closest programmes supporting wider leadership development in nursing are the Leading Empowered Organisation (LEO) Programme 2002-2005 and the RCN’s Nursing Leadership Programme. Little evidence of the success and value of such programmes has been published (Enterkin, Robb and Mclaren, 2013).

National campaigns in pursuit of a cultural change to support front line leadership have set out guidance for change such as Modernising Nursing Careers, Setting the Direction, High Impact Actions and Safety Express contained within the Energise for Excellence umbrella (DH, 2006; 2010; 2011). In 2013, the Chief Nursing Officer for England developed a strategy designed to set a strong direction for nursing and to improve patient care with a focus upon something that both addressed the need for leadership and direction, as well as practical solutions to improve the care nurses give (Cummings, 2013). This led to the introduction of the ‘6Cs’: care, compassion, competence, communication, courage and commitment with the aim of redefining the strategic direction for nursing. In addition, Compassion in Practice commits to ensuring that there is the right staff, with the right skills in the right place, and includes supporting leaders to be supervisory (Cummings, 2013). Whilst supportive of the supervisory status of wards sisters, it is of note that no further commitment to its implementation has followed to date.

The question remains therefore, as to why evidence of commitment to leadership programmes across the NHS falls short in stabilising and embedding a clear ward sister role from training to practice. In the absence of a wider research base, it is argued that the ward sister role has changed over time, adapting to the changing social and political context. Whilst research has been progressed in relation to changing clinical roles within nursing, there is a lack of research evidence relating to nursing leadership roles (West, et al.,2015).

A number of authors from the 80s up to the present day have reported studies in the literature which propose a positive change by ward sisters completing leadership training programmes including Dodwell and Lathlean (1987), Ranprogous (1989), Fairbairn-Platt and Foster (2008), Jasper, (2012), Enterkin, Robb and Mclaren (2013) and Phillips and Byrne (2013). Cummings, Lee and MacGregor (2008) undertook a systematic review of the literature to examine the factors that contribute to nursing leadership and the effectiveness of educational programmes in developing nurse leaders. They examined 27,717 titles/abstracts resulting in 26 manuscripts reporting on 24 studies. Twenty leadership factors were examined and categorized into four groups - behaviours and practices of leaders, characteristics of individual leaders, influences of context and practice settings and participation in educational activities. Nine studies that examined participation in leadership development programmes all reported significant positive influences on observed leadership, suggesting that leadership can be developed through specific educational programmes. Similarly, Stoddart, et al. (2014) undertook a mixed methods study of the views and experiences of ward sisters in Scotland who undertook a senior leadership programme. The programme followed the publication of Delivering Care, Enabling Health as part of the quality ambitions of the Scottish Executive Health Department (Scottish Executive Health Department, 2006) The programme known as Leading Better Care was designed to develop the leadership role of ward sisters. Whilst the response rate was low at 54%, participants reported a perceived improvement in their role following the programme. Whilst a criticism of both of the above studies is the limitations of self-reported perceptions of change, Martin, et al. (2012) add more objective evidence to this position in their study in Switzerland which examined 14 ward sisters in one hospital before and after completion of an adapted Royal College of Nursing Clinical Leadership Programme. In their study, independent observers were used to rate change over time. Evidence of improvement in practice in relation to the quality of care was demonstrated as a result of the educational programme.

Phillips and Byrne (2013) identified the link between leadership development and organisational engagement. They identified the importance of recognising that looking at the NHS as a system alone runs the risk of ignoring the impact of the people within it and their influence on change. Kanter (1993) identified the importance of empowerment of staff within organisational themes. Stacey (2002) supports this view in considering the invaluable role of individuals in creating and recreating the organisation through complete processes of interaction, hence challenging the concept of a prescriptive programme of leadership applied to participants with a greater appreciation of the influence each individual’s experience and style will have on the sustainability and success of a programme. Stoddart, et al. (2014, p. 57), highlight this issue when commenting that there was a ‘void’ in the ward sisters’ discussions pertaining to the relationship with the leadership programme and the structural / organisational relationship with their role. They identify this as a significant difference from international studies of nursing and suggest it is an area where greater focus should lie in ward sister development programmes.

Maben, et al. (2012a) acknowledge the key role leaders of teams, such as ward sisters play interpreting organisational expectations and setting out the behaviours and attitudes that are required by the team to support the delivery of goals. The importance therefore, of engaging ward sisters in the wider organisational context and decision-making processes out with a more limited functionalist approach of organisational control and performance management, is an important consideration for hospital management teams. The place however of rule-based knowledge, as represented through evidenced based practice in nursing, has its place to ensure vitally important safe practice, but such knowledge is not the highest goal of learning. The Dreyfus model of skill acquisition (Dreyfus and Dreyfus, 1986) describes five distinct stages of learning - novice, competence, proficiency, expertise, and mastery. The first three levels are where rule-based thinking and action is the most important as skill levels increase. When competence is reached, performance reaches a threshold of rationality. By the later stages, rational, logic-based action is replaced by experience, and by expert behaviour. Here, having progressed through nursing career structures, this would be the behaviour of ward sisters, whose experience is based on context and intuition. At these levels, an experienced ward sister will simply perform an act without relying on specific rules for action. So, if intelligent action, which is likely in ward leadership, consists of something other than calculated, rules-based rationality (Flyvbjerg, 2002), the Dreyfus skill acquisition model demonstrates the need to see beyond rational levels of behaviour and recognises the role played by less obvious tacit knowledge and the wider organisational relationship integral to the ward sister role.

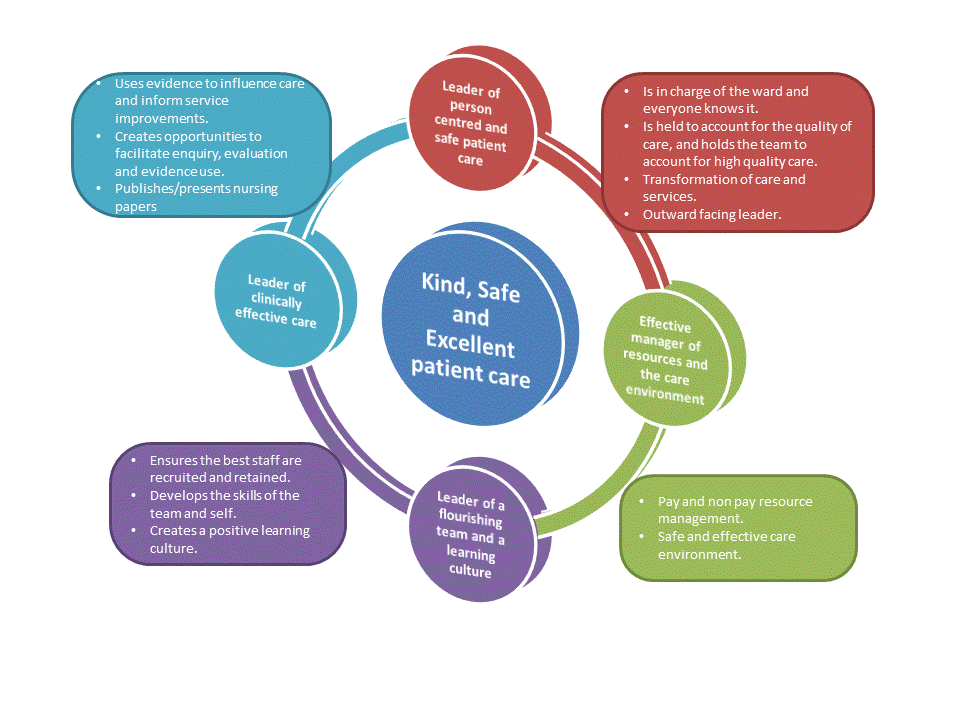
Therefore, a leadership programme for front line nursing sisters needs to encapsulate the unique experience and setting of each ward leader and provide a framework for the leader to adapt within a specific context whilst maintaining their role as leaders of change. Lawrence and Richardson (2014) describe the requirement for this level of flexibility within nursing leadership programmes to reflect the complex demands within these roles. Fairbairn-Platt and Foster (2008) recommend that further research is required to identify the links between ward sister development and impact on patient care.

Alongside the introduction of supervisory ward sisters at the researcher’s own setting, a programme of ward sister development was designed and implemented to facilitate the change from non-supervisory to supervisory status. The programme was based upon the principles set out by the Royal College of Nursing in their work which examined the role of the ward sister and charge nurse (RCN, 2009). Within their work the RCN identified a number of areas that ward sisters required more formal education and preparation in relation to undertaking their role. These areas included:

* Leading a team, team dynamics and different approaches to influencing teams
* Human resource processes, including dealing with conflict and difficult situations with staff, sickness absence and disciplinary procedures
* Management of resources, especially financial management and understanding
* Assessment of clinical risk and associated decision making
* Using audit positively
* Influencing senior managers and trust policies.

In addition, in order to address the requirements for flexibility within the complexity of nursing sisters’ roles, the need for some form of coaching and mentoring was both identified by the ward sisters and recommended within the RCN work. The programme within the research setting was therefore underpinned by a role profile for the ward sister, capturing these areas within the principles of developing leadership with creativity, authority and compassion whilst impacting at three levels: individuals, teams and the organisation. Figure 2.3 illustrates the four key elements of the role profile and the associated aspects of the ward sisters’ roles and responsibilities, synthesising the RCN recommendations.

Figure 2.2 Key elements of the ward sister role profile



In 2014, the RCN commissioned Warwick University to undertake a study of ward sisters evaluating the perceptions of ward sisters, senior nurse managers and the wider clinical teams in two NHS hospitals in England, in relation to the impact of supervisory status on expectations, experiences and perceptions (RCN, 2015b). The study included interviews with 22 ward sisters, eleven from each hospital site, before the introduction of supervisory status and then again four to six months later. In addition, interviews were undertaken with two senior nurses on each site, and two further interviews were performed with wider teams including registered nurses, allied health professionals, health care assistants and medical personnel. The findings of the report support evidence of the value of supervisory roles, suggesting that the experiences and perceptions of ward sisters and their management teams were positive in relation to the transition to supervisory status. Their findings were categorised under a central theme of the ward sister ‘being pivotal’, underpinned by four categories which included:

1. Reclaiming the role: Within this category ward sisters described that during the move to supervisory status, they had reflected on their role and took the opportunity to reclaim aspects of the role they had lost when included within the nursing numbers.
2. Forging a path: Similarly, as a result of reflecting on the changes that supervisory status brought to the ward sisters, some reported they had engaged in a process of self-awareness in their roles as leaders.
3. Leading the way: Within this category, leadership of the clinical teams, and in particular developing and educating the staff emerged as an important theme.
4. Connecting with the organisation: Within this category ward sisters reported feeling greater organisational support for their role which they welcomed.

Whilst the RCN study does not discuss empowerment theory in depth within this work, the study is congruent with empowerment as a concept in the ways that the ward sisters described feelings of greater autonomy in practice, as they described becoming empowered as leaders and being able to reclaim their role as well as having a greater sense of empowering others. They identified how, in being able to connect more widely across the organisation they felt their role was understood more widely allowing them to feel valued and supported. Limitations of the study acknowledge the multifaceted impact of the supervisory sister, and the complexity of understanding and measuring all of the benefits of the role. The study recommends greater attention is paid to examining the different aspects of the role and in particular the aspects of the role not currently addressed within key performance indicators. Examples of this include the invisible nature of large aspects of the role such as information gathering, synthesising, organising and sensing what is happening on a ward.

Developing the concept of empowerment hinted at within the RCN work, my research seeks to build on the study by unpacking the concept of empowerment to explore how perceptions of ward sisters develop after status change.  Using the conceptual framework (see figure 2.3, p.40) the study explores *what* structural changes are made in status change and *how* psychological empowerment emerges after structural empowerment (through management interventions) is facilitated.

**2.3.5 The hospital context of the ward sister role**

Important to the understanding of this case study, is the context in which the ward sisters who participated in the research were operating at the time of the study. The hospital is a 1100 bedded local district general hospital, as well as a national and regional centre for patients requiring specialist treatment in a number of specialties. During the study period the hospital was on a journey of improvement that began in September 2015, having been placed in ‘special measures’ due to its financial position and following a Care Quality Commission (CQC) inspection in which the hospital was found to be below the required standards in several areas. A number of significant challenges were therefore present during the study including the mobilisation of an improvement programme which involved all members of the hospital staff of which the ward sisters were of key importance. One key area related to the staffing levels across the organisation with a high vacancy factor against the required establishment for nursing. This led to an aggressive recruitment campaign and an increased focus on retention of the valuable workforce. Many of the ward sisters were operating their ward areas with such vacancies in their establishment and were actively involved in recruitment campaigns and retention programmes across the hospital. Moving forward with a supervisory model was undoubtedly a significant challenge against this backdrop, but one which was considered a key part of the improvement journey by the Board of Directors.

This section has considered the changing nature of the ward sister role in the context of a changing NHS, presenting considerable obstacles to achieving high quality care with ever greater financial pressures and increased clinical challenges. Having explored the historical backdrop of nursing roles and the role of the ward sister in relation to quality of care, the theme emerging from the literature of the potential for greater workplace empowerment of the ward sister, is now examined within the final section of this chapter as a theoretical orientation underpinning the difficulties faced by the ward sister in this role.

### 2.4 Theoretical orientation – Empowerment theory

In examining the literature relating to the ward sister, the current systemic problems within the healthcare system and NHS including the high demand on bed occupancy, shortage of front line nursing staff, fast and demanding expectations of patient throughput across the hospital setting, and increased challenges for ward sisters, led to the emerging themes and descriptions of disempowerment and how this impacts upon the ward sister’s ability to undertake the role. The multitude of challenges that present to ward sisters who, whilst endeavouring to manage a ward, educate and train staff, provide expert advice and guidance to patients and families whilst also being expected to provide nursing care to a group of patients, led to feelings of disillusionment, frustration and loss of control of their role along with work overload and low morale within the professional group (Fenton and Phillips, 2013; RCN 2015).

There has been considerable debate and criticism about the definition of empowerment over the past two decades (Greasley, et al., 2005; Spreitzer, 2008). In broad terms the views can be divided into two main groups: one in which empowerment is viewed as a management tool or technique (Hechanova, Alampay and Franco, 2006), and one in which empowerment is seen as a psychological state of the individual (Greasley, et al., 2005). Ahearne, Mathieu and Rapp (2005, pp.945-946) propose an integrated definition and suggest empowerment is “a practice or set of practices involving the delegation of responsibility down the hierarchy so as to give employees increased decision making authority in respect to the execution of their primary work task”.

Workplace empowerment as a management strategy has been shown to be successful in creating positive work environments in organisations (Laschinger, Finegan and Wilk, 2009). It is a construct that links strengths and competencies and proactive behaviours to social policy and social change (Rappaport, 1981; 1984). It compels us to think of competencies and strengths versus deficits and weaknesses (Perkins and Zimmerman, 1995).

The early concept of empowerment emerged in the literature in the late 1960s following the civil rights movement introducing people to the power of group initiatives. By the 1970s alongside the government’s challenges around public spending, group advocacy increased to address specific problems in the community, people became aware of the value of the mutual support available in self-help groups and the impact this could have (Ryles, 1999).

Empowerment can occur as a result of processes – actions, activities or structures introduced within an organisation (Zimmerman, 1995) - or it results from the individual impact of such processes. This is important in the definition of empowerment theory in terms of how individuals might take part in activities to become empowered or how at the organisational level empowering processes might include collaborative leadership or decision making (Perkins and Zimmerman, 1995). The consequences of empowering processes are seen when empowerment is operationalised. For example, empowered outcomes for ward sisters might include ward-specific perceptions of control and authority, whereas outcomes at the organisational level may include compliance with leadership quality standards set out by regulatory bodies such as the National Health Service Improvement, single oversight framework (NHSI, 2017).

Reviewing two decades of research, Spreitzer (2008) found two broad themes for workplace empowerment: structural empowerment (access to conditions that enable optimal role performance) and psychological empowerment (employee cognitions in response to working in empowering conditions). Taken together, structural and psychological empowerment represent a powerful approach to creating workplaces that attract and retain individuals to organisations.

Kalisch (1979) and Chandler (1986) had been among the first to describe the application of empowerment theory to nursing, which built on the seminal works of Kanter (1977; 1993) and her theory of structural power in organisations. Chandler ([1992](http://www.nursingworld.org/ojin/topic32/tpc32_1.htm#Chandler)) distinguished between power and empowerment, suggesting that empowerment is about the ability to act, whereas power is about having control and influence. Recognizing the wider interpretations of the concept of empowerment, Laschinger, et al. (2001) expanded the work of Kanter to include Spreitzer’s (1995) notion of psychological empowerment. Laschinger and Wong (2012) further suggest empowerment theory varies but generally relates to the notion of individuals having the power to accomplish their work in a meaningful way. Udod and Racine(2014) describe it as multidimensional (1) enabling an individual to act by sharing power with others in order to achieve a common goal, and (2) enabling individuals to gain control over their lives as they become aware of aspects of the organisational system and their practice that constrain their work.

### 2.4.1 Kanter’s (1977) theory of structural empowerment

Returning to the foundations of the understanding of empowerment, Kanter’s (1985) works set out a definition of power as the ability to be able to mobilise information, resources and support to get things done in an organisation. She goes on to explain that in order to make this possible, the management teams within organisations should provide employees with the “power tools” to enable them to do this (Kanter, 1985, p. 221). Kanter’s early work described two key empowerment structures, which exist within organisational settings, one being the structure of opportunity and the second being the structure of power. Specific job characteristics and interpersonal relationships that foster effective communication improve an individual’s access to empowerment structures. Kanter (1985; 1993) advocates that having access to opportunities for learning, growth, and advancement in the organisation will result in greater employee satisfaction, commitment and productivity. The ability to access these empowerment structures requires the presence of what she describes as formal and informal power systems which managers should ensure are in place. For example, meaningful roles aligned to the organisation’s goals where individuals have the flexibility to be creative and to make decisions, elicit formal power systems that enable empowerment. Informal power is derived from effective relationships and communication with colleagues and groups in and outside the organisation. Laschinger, et al. (2010) illustrate examples of such formal and informal empowering structures which promote nursing practice (Table 2.3) and in the setting of this research to the ward sister role.

Table 2.3 Informal and formal power structures (Adapted from Laschinger, et al. 2010)

|  |  |
| --- | --- |
| **Informal power** | **Formal power** |
| * Participate in special task forces or important organisational committees * Provide opportunities to network with colleagues through task forces, work groups * Build networking skills initially at the unit level through team building exercises * Broaden networking to include agency-wide and extra-organisational contacts * Develop interdisciplinary networking opportunities * Encourage collegiality | * Increase recognition of the sisters’ role as central and relevant * Develop a comprehensive job analysis of professional nursing practice * Define outcomes of nursing practice and align with organisational goals * Encourage sisters to positively view their contribution to patient care and education * Provide opportunities for ward sisters to develop and showcase their skills * Promote participative management and autonomous work units |

### 2.4.1.1 Structure of opportunity

Kanter (1985) conceptualises this first aspect of structural empowerment as the presence of the social structure in the work place that provides opportunity. This opportunity enables employees to develop their knowledge and skills to take a proactive approach towards their area of work which leads to problem solving approaches and active participants in change and innovative practice within the work setting. Within structure of opportunity Kanter considers opportunities within roles, which facilitate career advancement and development of knowledge and skills. Conversely Kanter argues, individuals who are not exposed to such opportunity, reflect this in lower levels of personal and career aspirations and are often less committed to the wider organisational goals. She also suggests lack of opportunity in this way leads individuals be cautious around new approaches and sometimes resistant to change on a local as well as organisational level. In relation to the ward sister role, having opportunity to develop in order to examine ways of solving work-based problems and consider changes to practice to optimise patient care is therefore argued as an essential component of success within the ward sister role.

### 2.4.1.2 Structure of power

Within the second empowerment structure, that of structure of power, she considers the importance of access to three key facets being:

* lines of information, including nursing knowledge and skills
* lines of support, not only in receiving feedback but in support for exercising discretion in daily work
* lines of resource, including tools to complete the job which in nursing includes having the right numbers of staff as well as time to accomplish the work required.

Kanter (1985) suggests that when staff fail to have access to such empowerment structures they experience powerlessness manifesting in a variety of work attitudes and behaviours including feeling stuck in jobs without prospects of progressing, excluded from wider organisational decision making, frustration and hopelessness (Kanter, 1979). Scott (2009) affirms the importance of such power systems in nursing, suggesting that without power, nurses are unable to influence patients and other clinical colleagues - in particular, medical staff. Page (2004) also supports the concept that powerless nurses are ineffective nurses, whilst Manojlovich and Laschinger (2002) agree that without power nurses are more susceptible to burnout and that lack of nursing power in influencing patients and affecting clinical decisions may also contribute to poorer patient outcomes (Laschinger, et al., 2010).

Kanter (1979) argues these structural factors have a greater impact on employees than personal predispositions or the effect of socialisation. This is distinct from perspectives such as Conger’s and Kanungo’s (1988) who suggest that empowerment may arise from within one’s own psyche, or the view of Gibson (1991) who suggests empowerment may be viewed as either a process or an outcome. Then there is the suggestion from Ryles (1999) that empowerment may stem from an individual, or a group attribute, for example the ward sisters becoming empowered as a professional group and approaching a problem from a united viewpoint rather than acting in isolation. A number of studies have tested Kanter’s theory of empowerment within organisational nursing settings (Laschinger, 1996; Laschinger et al., 2001, 2004; Siu, Laschinger and Vingilis, 2005; Udod and Racine, 2014). Laschinger, et al. (2001) report feelings of greater satisfaction, job satisfaction and higher levels of care quality are seen in empowering work environments. Laschinger and Finegan (2005), also link higher levels of respect and trust within empowered teams (Allen, 2001). The effects of job-related empowerment on nurses’ occupational mental health and work effectiveness were explored by Laschinger and Havens (1996) and the positive impact on levels of respect and trust within empowered teams (Allen, 2001). When critical care nurses perceived themselves to be working in an empowered environment, they demonstrated greater organisational commitment and lower job stress. This was supported by McBurney (1997) in the study of first line nursing managers in a large Canadian acute care teaching hospital who found a strong negative relationship between perceptions of work empowerment and occupational stress.

Numerous structural determinants have been associated with organisational commitment and job satisfaction, such as pay, promotional chances, distributive justice, peer/supervisory support, workload, role conflict, role ambiguity, autonomy and routinisation (Price and Mueller, 1981) and work in this field has found evidence to suggest that only distributive justice, promotional chances, and supervisory support are directly related to organisational commitment. However most structural determinants are directly related to job satisfaction – with one exception - the amount of pay employees receive (Geartner, 2000). Exploring the structural determinants of job satisfaction, these views capture the power sharing notion of empowerment (Tuuli and Rowlinson, 2007) or as in Legge (1995) the power redistribution model of empowerment where trust and collaboration develop as power is balanced across the organisation unit. Here, it is the practices and structures that improve access to information and resources or provide support all of which create an ‘empowering climate’ (Seibert, Silver and Randolph., 2004) in which employees have greater autonomy to make decisions and perform their roles. But what if all of these structures are absent from a workplace yet employees feel and act empowered (Spreitzer and Doneson, 2008)? Spreitzer explores structural and cultural antecedents of workplace empowerment and the effect these have on individuals’ behaviours and feelings of role effectiveness. She finds that providing structural empowerment in the workplace doesn’t necessarily lead to empowering outcomes (Spreitzer, 1995). The work of Maton and Salem (1995) defined empowerment as a process enabling motivated individuals, collectively participating with others, to achieve their primary personal goals. They examine these claims across a range of community groups, organisations, and settings and find four themes of organisational features in all three settings; (a) a belief system that inspires growth is based on strengths and is focused beyond the individual; (b) an opportunity role structure that is pervasive, highly accessible, and multifunctional (c) systems of support which provide a sense of community with peers; and (d) inspiring and adept leadership which is committed to the organisation as well as the individual.

Whilst these studies demonstrate how structural empowerment influences both the organisation and the employee, they are limited by the scope of the focus on just structural empowerment which describes only the conditions of the work environment and not the employee reaction to these conditions (Lashinger, et al., 2001). In other words, they did not account for psychological empowerment. These unanswered questions of structural empowerment led to the development of the theory in relation to psychological empowerment.

### 2.4.2 Psychological empowerment

Spreitzer (1995) developed this concept of psychological empowerment from the building blocks set down by Conger and Kanungo (1988) and Thomas and Velthouse (1990). Spreitzer (1995) developed Thomas and Velthouse’s (1990) original empowerment construct model which consisted of the four cognitions of impact, competence, meaningfulness and choice, by renaming the meaningfulness dimension as meaning and the choice cognition as self-determination as a more accurate description of the concept.

Spreitzer (1995) considers psychological empowerment as a response by the employees to working within a structurally empowered set of conditions and suggests that the four dimensions are linked and when considered together will measure the extent to which psychological empowerment exists. When any one of these dimensions is missing, then the experience of empowerment will be reduced.

There is a broad literature theorising psychological empowerment. Laschinger, et al. (2001) draw from this that the concept of psychological empowerment demonstrated within the above four components is the mechanism through which structural empowerment affects individual employees’ attitudes and behaviours at work. These studies suggest that there are compelling reasons to consider the importance of power within nursing roles. However limited studies to date have examined the correlation between empowerment theory in nursing and actual patient outcomes (Hatler, 2006; Donahue, et al., 2008). The analysis of the case studies included within this research will be examined within the context of this theoretical underpinning, along with the clinical outcome indicators of quality which will be reviewed as part of the analysis.

Combining both perspectives of empowerment offers an integrated approach to understanding which some suggest is necessary since an individual’s cognition of empowerment cannot easily be understood independent of managerial action (Eylon and Bamberger, 2000). Spreitzer also suggests it is important to consider both the management practices that deliver structural changes and the employee’s perception of empowerment and it is this positive perception that ensues from cognitive growth and the knock-on effect to behaviour which is integral to notions of successful empowerment more perhaps than the structural changes alone (Spreitzer, 1995).

In Spreitzer’s revised constructs, she describes psychological empowerment as having four distinct components, a] self-determination, b] competence or self-efficacy, c] meaning and d] the ability to have impact on the wider organisation. These four themes, she argued, when combined create the overall construct of psychological empowerment – in other words an employee is psychologically empowered when he or she finds meaning in her work, feels competent in her capacity to perform her job, is self-determined to achieving desired outcomes and believes she makes impact in the organisation (Spreitzer, 1995). Each of the four components are elaborated in the following sections.

##### 2.4.2.1 Self-determination (autonomy)

Self-determination includes the individual’s sense of choice in the way they are working and the actions they are asked to undertake (Hancer and George, 2003). In Spreitzer’s definition of self-determination, she refers to an individual’s sense of control and autonomy. Fourie and van Eeden (2010) support this view-point that autonomy is synonymous with the construct of self-determination. Autonomy in nursing practice is having belief in the utmost importance of the patient when making responsible discretionary decisions and having accountability for those decisions. Wade (1999) suggests this concept of autonomy is linked to job satisfaction and is intrinsic to the professional status of the role. Freedom from bureaucratic constraints provides employees with autonomy, utilising their talents and resources for best possible work performance outcomes. This is enhanced when leaders acknowledge high performance in staff to demonstrate belief in their abilities so as to foster confi­dence(Hui, 1994).Laschinger, et al. (1999) have demonstrated that perceptions of autonomy improve with feelings of empowerment and to the use of a participative work culture fostered by nurse managers. Not surprisingly, having little or no autonomy leads to poor job dissatisfaction and one of the main reasons for leaving a job (Blegen, et al., 1993). Evidencing the concept of self-determination and empowerment, studies of autonomy in school nurses – by nature, working with little direction - have revealed a high level of perceived control over their nursing practice, which facilitated feelings of empowerment and job satisfaction. Similar studies in nurse managers (Blegen, et al., 1993) found higher scores on measures of autonomy than staff nurses, again due in part to higher degrees of empowerment through accountability. In other research, contributing factors relating to higher levels of autonomy found among nursing students support a link between learner empowerment when stated as a priority in nursing education (Mailloux, 2006).

##### 2.4.2.2 Competence

The component of competence originates from work undertaken by Bandura in 1977 who studied self-efficacy in clinical psychological literature. Bandura (1977) argued that individuals who possess skills of self-efficacy, demonstrate initiating behaviours, and persist with challenges in the face of obstacles. Individuals on the other hand exhibiting low levels of self-efficacy avoid situations where they are lacking in skills and therefore deter from learning and gaining competence (Holdsworth, 2007). Thomas and Velthouse (1990) developed the term competence for this concept instead of self-efficacy as a way of more accurately reflecting the ability of an individual to perform a task skilfully when he or she tries. Menon (2001) also suggests competence denotes self-efficacy and confidence in relation to work roles. Self-efficacy is widely studied in relation to nursing within and outside of empowerment theory. For example, Lenz and Shortridge-Baggett (2002) have explored how nursing interventions can influence a patient’s motivation to improve health outcomes. And whilst there has been much research on self-efficacy in relation to nurses there is less understanding of self-efficacy in relation to front-line nurse managers including ward sisters (Van Dyk, Siedlecki and Fitzpatrick, 2016) beyond what Kalkan, Odaci and Koc (2011) have revealed in terms of linking an individual’s desire to improve their abilities to win recognition for effort. The Van Dyk, et al. (2016) study was focused on determining relationships between confidence levels and self-efficacy among nurse managers – whose job it is to develop and maintain effective work environments that enable clinical nurses to deliver high-quality care. As such their role has far-reaching implications for patients’ and staff well-being. Surveying 85 nurse managers, the study concluded that self-efficacy or competence and confidence scores correlate significantly with years in a formal leadership role - which suggests that experience matters. The authors advocate targeted education programmes to enhance self-confidence and self-efficacy in nurse managers and highlight the importance of making efforts to retain such experience within the organisation.

##### 2.4.2.3 Meaning

Individuals have a primary motive to seek meaning in their work. This involves congruence between an employee’s beliefs, values, and behaviours and the requirements of the role (Laschinger, et al., 2001). Meaningfulness has also been defined by Hackman and Oldham (1980) as the value of a work goal or purpose, judged in relation to an individual’s own ideals or standards. It is considered an important psychological state or condition at work. Laschinger, et al. (2001) found that changes in structural empowerment over time led to positive changes in psychological empowerment and increased job meaningfulness and satisfaction. Thus, strategies that foster a sense of empowerment of nurses in nursing settings are critical to organisational success.

When individuals lack meaning in their work they may become disengaged or feel alienated. For employees to feel their work is meaningful they must experience motivation and personal growth (Spreitzer, Kizilos and Nason, 1997). In an ethnographic study of the psychological conditions in a US insurance company, May, Gilson and Harter (2004) explored the determinants and mediating effects of meaningfulness, safety and availability in terms of an employees’ engagement in their work. Their results suggested all three psychological conditions exhibited significant positive relations with engagement, but meaningfulness was most significant.

Exploring the determinants of job satisfaction in hospital nurses, Manojlovich and Laschinger (2002) analysed responses from both the workplace and personal perspective in relation to Kanter’s theory of structural empowerment and Spreitzer’s theory of psychological empowerment. The results revealed that structural and psychological empowerment predicted 38% of the variance in job satisfaction – leading to their conclusions that structural and psychological empowerment can be increased with changes to the hospital environment and this can result in greater job and patient satisfaction and indeed patient outcomes. In a meta-analysis of 48 studies to identify the variables most often associated with job satisfaction, Blegen (1993) found that the variables most strongly associated with job satisfaction were stress and organisational commitment - whereas variables such as communication with peers and supervisors, autonomy and recognition were only moderately related to job satisfaction.

##### 2.4.2.4 Impact

The fourth component, that of impact, is the final element of psychological empowerment. Thomas and Velthouse (1990) define impact as a sense of being able to influence important outcomes within the organisation. Exploring the determinants of job satisfaction in nursing, Manojlovich and Laschinger (2002) found the psychological empowerment factors of autonomy and ability to have an impact on the organisation, and to be most highly correlated with overall structural empowerment. Nurses’ perceived ability to be making an impact on their organisation was significantly related to structural empowerment, and in particular, access to resources. Making an impact is linked to organisational commitment which is linked to job satisfaction all of which stem from a sense of psychological empowerment (DeCicco, Laschinger and Kerr, 2006). Feeling empowered encourages a greater involvement of the individual on the job, which increases positive impact on the organisation (Liden, Wayne and Sparrowe, 2000). Investigating impact and organisational commitment of staff in the hotel industry, Jaiswal and Dhar (2016), found that employees who felt they were making an impact on the organisation perceived themselves to be psychologically empowered. They performed better and felt greater job satisfaction and organisational commitment.

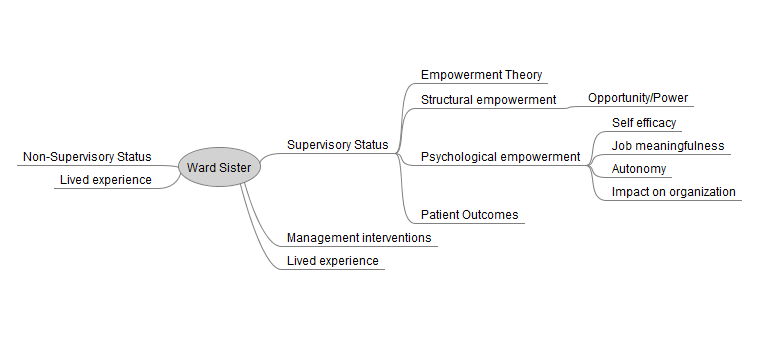
### 2.5 Chapter Summary - Towards a conceptual framework of empowerment and supervisory status in the role of ward sisters

The aim of this chapter was to introduce conceptualisations of the role of ward sisters in the context of the NHS as well as conceptualisations of empowerment as a construct comprising structural and psychological perspectives. The role of the ward sister has been explored from early definitions to contemporary analysis encompassing the concept of supervisory and non-supervisory status. In particular, the chapter discusses the ward sister role in terms of quality of care and nursing leadership. These concepts have been set against the theory of empowerment in relation to the challenges and obstacles that make it difficult for ward sisters to undertake their role.

The chapter has explored the structural empowerment theory of Kanter - from which the following conclusions may be drawn - work environments that provide access to information, resources, support, and the opportunity to learn and develop are empowering. The work of Spreitzer developed this field by defining psychological empowerment as the psychological state that employees must experience for managerial empowerment interventions to be successful, composed of self-determination, competence, meaning and ability to have impact in the organisation. Thus, changes in structural empowerment such as ensuring ward sisters have supervisory status, can lead to positive changes in psychological empowerment over time. Such outcomes can increase job satisfaction and as the sections above have discussed – this goes on to benefit staff and patient care and patient outcomes in numerous ways (Laschinger, et al., 2001).

The conceptual framework described above is presented in Figure 2.3 in order to permit the relationships amongst the concepts to be visually mapped. The figure shows how the lived experiences of the ward sisters were examined both before and after supervisory status. It then maps how the emerging empowerment themes were linked to the theoretical underpinnings of empowerment theories as identified in the literature. The framework visualises how through the lens of empowerment theory, the emerging experiences as they were lived by the ward sisters were mapped and brought together.

Figure 2.3 Conceptual framework for the study



This study uses case study methodology to capture the lived experiences of ward sisters involved in a role status change brought about by management intervention strategies and reflecting the concepts of empowerment theory. The methodology and methods are discussed in the following chapter.

There is a shortage of literature examining practice based interventions that change leadership practice in nursing, and which examine the impact of such change on individuals, teams and patient outcomes. The following broad research aim guided the study in an attempt to address some of these deficiencies: To explore factors that influence the supervisory status of ward sisters in an acute hospital Trust and examine the impact that the role has on the quality of care both perceived and actual.

This research aim is driven by the following two research questions:

* Research Question -1: What is the lived experience of ward sisters who move from non-supervisory to supervisory status?
* Research Question 2: What is the impact of supervisory role change on quality of patient care?

The research questions are addressed in the discussion chapter (Chapter 6).

Chapter 2 has set out the theoretical orientation underpinning the proposed research. It has considered the historical backdrop of nursing leadership, providing an overview of the NHS Reforms since 1948 with emphasis on nursing policy context in England, and discussed the ward sister role, and its relationship with quality of care and with leadership. Chapter 3 describes the methodological approach undertaken within the research study.

### CHAPTER 3

### Research Methodology & Research Methods

### 3.0 Introduction

This chapter presents the philosophical foundations and describes the methodology for the research. By way of introduction, Van Manen’s statement below articulates my overarching view of research.

“A rigorous human science is prepared to be *soft, soulful, subtle,* and *sensitive* in its effort to bring the range of meanings of life's phenomena to our reflective awareness (but it) is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal...full or final descriptions are unattainable” (Van Manen, 1990, p.18).

With over 35 years of nursing experience, including time as a ward sister, I knew from the start of this process that any interpretation of data would be heavily influenced by my personal views and experiences in nurse management. Therefore, if I was to work towards a deeper understanding of ward sisters’ perspectives in terms of constraints and enablements they may feel in carrying out their job I knew I would have to acknowledge and ‘work with’ my own researcher reflexivity as part of the processes. This is discussed in further detail later in the chapter. Reflecting on my pre-understanding of the experiences of the roles of non-supervisory and supervisory ward sisters was the starting point for this study, moving beyond it to a deeper understanding was the goal (Gadamer, 1989). Researching lived experience can provide a representation and understanding of human experiences, choices, and options. It can illuminate how those factors influence one's perception of knowledge (Van Manen, 1990).

Chapter 2 set out the theoretical orientation underpinning the proposed research as well as the historical backdrop of nursing leadership within the context of the ward sister role, and its relationship with quality of care.

As previously stated, the aim of this research is to explore factors that influence the

supervisory status of ward sisters in an acute hospital Trust and examine the impact that the role has on the quality of care both perceived and actual.

Under ever more demanding circumstances, ward sisters experience a number of complex situations in the care of patients. Whilst they may be able to talk about them, they are not usually able to explain the rationale around their thinking (Lindseth and Norberg, 2004). This is related to the fact that human beings live and act out of their morals, i.e. internalised norms, values and attitudes, without necessarily knowing about them (Lindseth and Norberg, 2004). It is for these reasons that simply asking questions may not elicit the full answer. In order to investigate the phenomenon in question (the experience of the ward sister), facilitating the participants to describe their experiences in depth through the description of situations in their practice setting, can lead to rich data. For this reason, case study research is an appropriate methodology to investigate the phenomenon in the context of the following research questions:

Research Question 1: What is the lived experience of ward sisters who move from non- supervisory to supervisory status?

Research Question 2: What is the impact of supervisory role change on quality of patient care?

This chapter describes the use of case study research, examining wider perspectives within the literature. Rationale for its choice and application within the context of this research study are discussed. Data collection and analysis of the quantitative data will be addressed in chapter 5. The chapter discusses the research methods used and their link to the methodology. It begins by setting out the philosophical underpinnings, theoretical view, and focus of the research as summarised in Table 3.1, and which are discussed in subsequent sections in this chapter.as summarised in box x.

Table 3.1: Summary of research approach

|  |  |  |
| --- | --- | --- |
| **Philosophy** | **Theoretical view** | **Focus of research** |
| Ontology | Nominalism | Lived experience of ward sisters |
| Epistemology | Interpretivism | Multiple realities |
| Methodology | Case study research (hermeneutic phenomenology and positivism guiding methods) | Thick description |
| Methods | Semi-structured in-depth interviews  Quantitative indicators | Lived experience + thick description |

### 3.1 Philosophical orientations of the research design

This section begins with a definition of the ontological and epistemological foundations of the research that justify the chosen methodological approach and the research methods used for the collection and analysis of the relevant data. It is important to ensure there is a link between the stages of the design to enable the research questions to be addressed (Yin, 2003). Durham, et al., (2015) describe the relationship between interpreting and classifying the researcher’s perspective and the meta-theoretical paradigm, described by Weaver and Olson (2006) as regulating the research. Such paradigms have traditionally been grouped into two contrasting categories of objective versus subjective social theories (Guba and Lincoln, 1989). The guiding propositions for this study are intrinsically related to the worldview of the researcher (myself) and my ontological beliefs about the nature of reality, and their epistemology (Yin, 2003). Grix (2004) argues that the researcher’s intentions, goals and philosophical assumptions are inextricably linked with the research they do, and therefore those who wish to execute clear, precise research and evaluate others’ research need to understand the philosophical underpinnings that inform their choice of research questions, methodology, methods and intentions.

### 3.1.1 Ontology

Ontology deals with the nature of reality and the nature of being in the world. The intention of this section is to position the research within a context that guides or informs the research direction. To fulfil the research aim, the research methods seek to uncover beliefs and lived experiences of the ward sisters and reveal the characteristics of their respective professional worlds in terms of the impact of their role.

There are three main ontological viewpoints. They can be described as relativism, representationalism, and nominalism (Denzin and Lincoln, 2011). Researchers with a worldview within the relativist paradigm advocate the notion that what is there, or the ‘facts’, are dependent on the viewpoint of the observer and there needs to be consensus to arrive at ‘truth’ (Denzin and Lincoln, 2011). Conversely those who advocate representationalism perceive facts to be real but not directly accessible. Their version of the world suggests that truth is discoverable through the verification of predictions about those facts (van Maanen, 1979).

The perspective of nominalism does not accept the notion of true or false statements that verify the existence of universal entities or theories but considers all facts to be human creations and truth depends on who is establishing it (van Maanen, 1979). This research aligns with a nominalist ontological view. In so doing the study aims to make a contribution to knowledge in the field of nursing leadership that is both socially constructed, based on the interpretations of the researcher and which is specifically situated in the time and context of the research setting.

### 3.1.2 Epistemology

Assuming a particular ontology of what is there, epistemology studies the nature of knowledge: how to know what is there in the universe (van Maanen, 1979). Epistemological perspectives, like ontologies, can be described by three main paradigms: positivism, interpretivism and constructivism. Positivism focuses on quantitative methods of investigation to find universal truths through cause and effect relationships. Conversely, research that falls into interpretivism seeks to understand phenomena through the meanings that people assign to them and asserts there are multiple realities and multiple truths. There is no one objective, universal reality, nor truth (Kaplan and Maxwell, 1994; Denzin and Lincoln, 2011).

The interpretivist paradigm is also described as an anti-positivist paradigm because it was developed as a reaction to positivism. For those researchers categorised as social constructivists, their perspective is located at the strongly interpretive end of the spectrum, where all reality is a human construction. They believe there is no reality outside of our social constructions (Denzin and Lincoln, 2011). This perspective advocates the existence of multiple truths, no objective universal truth, but contrasting and even sometimes, competing definitions of truth (Denzin and Lincoln, 2011).

This research study does not aim to prove a scientific idea or theory, but to understand the (different) viewpoints that are formed by human interactions and which reflect different constructions of social reality for ward sisters in a dynamic hospital setting. In researching the lived experiences of ward sisters, established through their personal stories, socially constructed phenomena are explored. Therefore, the study utilises an interpretivist approach, rejecting that there is a single objective truth and instead assumes that access to reality is only through social constructions such as language, consciousness and shared meanings (Berger and Luckmann, 1991).

Ernest (1994, p.25) describes how the influence of hermeneutics and what he describes as “the meaning-making cyclical process” is the basis on which the interpretivist paradigm was established. According to interpretivist theory, a phenomenon can never be objectively observed from the outside rather it must be observed from inside through the direct experience of the people. Cohen, Manion and Morrison (2007, p.19) state that the role of the scientist in the interpretivist paradigm is to, “understand, explain, and demystify social reality through the eyes of different participants”.

Critics of this paradigm focus on the non-scientific processes of verification, as well as its subjective ontological approach. In addition, the interpretivist approach is said to neglect the political and ideological influences on knowledge and social reality (Gage, 1989). It is argued however that knowledge is socially constructed rather than objectively determined (Carson, et al., 2001). The authors go on to rationalise that interpretivists avoid rigid structural frameworks such as in positivist research and adopt a more personal and flexible approach which captures meanings in human interactions. Black (2006) supports this view suggesting such personal structures capture more accurately human interactions. The interpretivist researcher approaches the research with some prior insight of the research context but assumes that this is insufficient in developing a fixed research design due to the effect of the context within which the research is undertaken and the multiple complex factors affecting the subjects (Hudson and Ozanne, 1988). Adopting this approach allows the researcher to remain open to new knowledge throughout the study and lets the research develop with the help of the subjects. The use of such an emergent and collaborative approach is consistent with the interpretivist belief that humans adapt to the challenges and social influences around them and the context in which they are functioning (Hudson and Ozanne, 1988).

The rationale therefore for adopting this perspective is to understand and interpret the ward sister role whilst considering motives, meanings, reasons and other subjective experiences which are time and context bound (Hudson and Ozanne, 1988; Neuman, 2000).

This perspective has informed the choice of methods which is discussed later in this chapter.

### 3.2 Research methodology

This section evaluates the chosen methodology and reviews the strengths and weaknesses as well as the key challenges involved in using Case Study Research (CSR). It provides a rationale for the choice of methodology, and describes the methods used.

### 3.2.1 Definitions of case study research

Case study is an approach to research that enables a deep exploration of a phenomenon within its context. The case study uses a variety of data sources that can illuminate many angles of the phenomenon under study (Baxter and Jack, 2008). Case study research is not just a data collection technique, it is a comprehensive research strategy that can provide rich, empirical descriptions of particular instances of a phenomenon, due to multiple data sources and data gathering methods (Yin, 2003).

A number of definitions of case study methodology exist within the literature; Yin (2009) and Robson (2002) both offer similar definitions referencing contemporary phenomena within real life contexts with emphasis on the chosen method and techniques to be used. Yin (2009) emphasises the importance of ensuring the case is bounded within its context in order that users of the research can determine whether or not the research findings are relevant to their particular context. Stake (1995, p.11) on the other hand, describes Case Study methodology as a more “naturalistic, holistic, and phenomenological approach” to the research rather than “quantitative, deductive and causal/comparative”. He points out that crucial to case study research are not the methods of investigation, but that the object of study is a case. Stake also advocates the relevance of context, supporting the hermeneutic approach. He suggests case study research is best applied to research topics where the units of interest to the researcher are best understood in relation to the wider range of processes going on around them.

Taylor and Martindale (2014) suggest that using case study methodology enables an in-depth exploration of the phenomenon under investigation, (in this context the ward sister role) from multiple perspectives to gain an in-depth, balanced picture of that phenomenon, sometimes referred to as a ‘thick’ description. These perspectives included the individual ward sisters, the current political context, the institution within which the individuals were operating, and the wider NHS system within which the hospital operates.

The aim was to provide an in depth understanding of the chosen topic and generate knowledge to inform nursing policy development. Stake (1995, p.11) supports these points stating “case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances”.

With regards to the definition of the term ‘case’, whilst it is not so well defined within the literature, Ragin and Becker (1992) suggest the ‘case’ may be a bounded object or a process, theoretical, empirical, or both but at a minimum it is specific to time and space. Miles and Huberman (1994) emphasise that what is in fact important is that the case is clearly defined within the research study.

Ragin and Becker (1992) propose case studies are complicated with the notion that they change over time, both in the hands of the researcher and in the hands of the researcher’s audience. It is understood that the nature of the case studies observed through this research will continue to change over time and may therefore be read in due course as intended, i.e. a study of the ward sister role or as an observation of the role at a period in time by one researcher.

### 3.2.2 Approaches to case study research

Rosenburg and Yates (2007) describe the flexibility that case study research offers as a means to investigate a complex phenomenon and its value as a tool within nursing and social science. Adopting this approach enabled a flexible approach to examining the evidence from ward sisters at both junctures (before and after the introduction of supervisory status) of the research study relating to the research questions described.

Approaches to case study methodology have been characterised by varying, and opposing perspectives by research methodologists (Yazan, 2015). Robert Yin, Sharan Merriam and Robert Stake are considered three seminal authors and founders of the methodological approaches to case study research (Creswell, 2007). Yazan’s (2015) analysis of the three different researchers’ depictions of case study methods acts as a useful aid in comparing and contrasting epistemological commitments and in designing the case study, as well as gathering, analysing and validating data. The analysis provided a helpful aid in understanding the relationships between the various epistemological orientations and that of the researcher’s own preference for this study as well as providing the opportunity to explore the use of different research techniques and strategies from each approach that best served and supported the design of this research study.

Regardless of the approach taken, it is important for researchers to provide adequate description for methodological justification (Meyer, [2001](http://www.ijqhw.net/index.php/qhw/article/view/23606/33591#CIT0048_23606)) including paradigm and theoretical perspectives influencing the study design. The balance therefore of applying a flexible approach must be made whilst not confusing it with other approaches (Rosenberg and Yates, [2007](http://www.ijqhw.net/index.php/qhw/article/view/23606/33591#CIT0058_23606)). This is essential to ensure study rigour and to enhance credibility of the field (Morse, [2011](http://www.ijqhw.net/index.php/qhw/article/view/23606/33591#CIT0050_23606)). My study was approached from an interpretivist perspective, in other words, the viewpoint that there cannot be an objective reality that exists irrespective of the meanings humans bring to it, and that the way people understand reality differs (Morrison, 2012). The use of both qualitative and quantitative methods and the opposing philosophical perspectives which may arise from this is justified on the basis that in order to stay true to the interpretivist paradigm, I have approached the collection of data in a holistic way using a mixture of approaches to reach a deeper understanding of the phenomenon. Taylor and Thomas-Gregory (2015, p.39) suggest, “This willingness to view the phenomenon from a variety of perspectives sits well within an interpretive approach and demonstrates an openness to understanding the world more fully”.

Cohen, Manion and Morrison (2003) identify some fundamental characteristics of case study methodology which provide a focus for this research.

* It is concerned with a rich and vivid description of events relevant to the case.
* It provides a chronological narrative of events relevant to the case.
* It blends description of events with analysis of them.
* It focuses on individual actors or groups of actors and seeks to understand their perception of events.
* It highlights specific events that are relevant to the case.
* The researcher is integrally involved in the case.
* An attempt is made to portray the richness of the case in writing up the report.

It is through approaching the research in this way that a thick description is offered to the reader of the experiences of ward sisters in transitioning to supervisory status and the impact this has on quality of patient care. My involvement in the research is explored later in the chapter.

### 3.2.3 Strengths and limitations of case study research

Case study research has its critics (Yin, 2009), particularly from the quantitative research field, in its apparent inadequacy towards verification and tendency to confirm the researcher’s preconceived ideas. Yin (2009) identifies three specific criticisms of case study research: (1) Lack of rigour, suggesting the case study investigator has allowed equivocal evidence or biased views to influence findings and conclusions. (2) With regard to size, he suggests that small numbers cannot be a basis for scientific generalisation. (3) Length of research studies: which he describes as containing data that is not systematically organised.

In addition, Tellis (1997) criticises the use of a single case and therefore the difficulty in reaching any generalised conclusions. Flyvbjerg (2001, p.84) argues in this specific respect that they have “no greater bias than other methods of inquiry”. In fact, the case study contains a greater bias towards falsification of preconceived notions than towards verification. He goes on to suggest that researchers who have used in depth case studies in research have reported that their preconceived assumptions were in fact wrong and that case study research led to researchers revising the hypothesis. Flyvbjerg suggests that case study can ‘close in’ on real life situations and test views directly in relation to phenomena as they unfold in practice.

Further advantages, in contrast, include the value of context and how the data is examined by the researcher within the situation in which the activity takes place (Yin, 2009). Within the context of this research, case study allows the ward sisters to be to be interviewed within their environment, contrasting for example with a more experimental approach which would deliberately isolate the phenomenon from its context and have a defined number of variables to examine (Zaidah, 2003). As well as this, the variations in the approaches to case study design previously described allow for a combination of qualitative as well as quantitative methods to be employed. Having the opportunity within this methodology to include quantitative data extracted from nursing quality indicators alongside the qualitative findings from interviews, enabled the development of thick description within the study. Finally, the detailed qualitative accounts produced from case study methodology as well as serving to describe the data within its context also allow the opportunity to describe the complexities surrounding the real-life experiences captured from the ward sisters which may not have be captured through experimental or survey research (Zaidah, 2003).

In summary, using case study methodology allows a variety of appropriate methods to investigate the phenomenon in relation to the research aim: To explore factors that influence the supervisory status of ward sisters in an acute hospital Trust and examine the impact that the role has on the quality of care both perceived and actual.

### 3.2.4 Generalisation, trustworthiness, transferability and rigour in case study research

### 3.2.4.1 Generalisation

A case study is “an in-depth study of the particular, where the researcher seeks to increase his or her understanding of the phenomenon studied” (Johansson, 2002, p.2). Case study methodology is often criticised because of the assumed difficulty with generalisations. A discussion on generalisation and transferability for case study research pulls together the characteristics of the method’s approach. The issue of generalisation, which is whether the findings from a study based on a sample can be of relevance beyond the sample and the study itself, are widely discussed in the literature (Gerrish and Lacey, 2006; Cohen, Manion and Morrison, 2003; Robson, 2002) and are an important factor in case study research (Lewis and Ritchie, 2003). Opinion is mixed in relation to the generalisability of case study research and the knowledge claims it can make. This leads to questioning of the researcher’s ability to accurately explain a complex situation and to be representative of the focal phenomenon (Easton, 2010).

Mayring (2007) describes two critical viewpoints in relation to the concept of generalisation: a constructivist and a critical rationalist position. The ‘Popperian’ positivists’ perspective stems from Popper’s challenge to the idea that it is impossible to say there are no black swans simply because we only ever (typically) see white ones. This underpins the long-established notion on generalisation, that a complete inductive proof of general sentences is not possible (Popper, 1959). From this Popper developed his programme of falsification working only with deductive inferences. His thesis promoted the idea that after falsifying all fallacies only true sentences will remain. Along these lines, Yin (2009), for example, asserts that case studies, like experiments, are generalisable to theoretical propositions and not to populations or universes. It is widely accepted by positivists that this perspective enables researchers to confidently generalise their findings from the methods used. However, this is not the case within the interpretive paradigm.

From a constructivist point of view all phenomena are time and context specific and our insight can only be a reconstruction of subjective perspectives of people in specific situations. In this respect one argument suggests that "…the only generalisation is that there is no generalisation" (Lincoln and Guba, 1985, p.110) and that such research can only reveal the unique elements of the individual phenomenon, which are particular to that context alone. Denzin (1983) supports this notion arguing that the interpretivist researcher rejects generalisation as a goal.

These two positions represent the extremes of the generalisability continuum; the positivist perspective (Popper’s angle), at one end and the strongly constructivist perspective (Lincoln and Guba’s angle) at the other. A perspective which is located between the extremes and which suits interpretive research is moderatum generalisation (Williams, 2002), where aspects of findings can be seen to have commonality with a wider set of features that are recognised elsewhere beyond the study.

Generalisation is important and necessary for scientific research, but it is important to specify what sorts of arguments or inferences are aimed at with generalisation (Yin, 2005). Promoting the critical relevance of context and particulars in case study research, Flyvbjerg (2006) advocates the benefits of in-depth single case studies suggesting that a discipline without a large number of thoroughly executed case studies is a discipline without systematic production of exemplars, and a discipline without exemplars is an ineffective one. This study argues for moderatum, for more in-depth case studies that do not aim for generalisability (as in a positivist approach) but which areaccepted as useful insights offering or illuminating something we did not know before the case study was undertaken. In this sort of research, in what is sometimes termed naturalistic generalisation, what is crucial is the use others make of the findings—chiefly, that they feed into processes of ‘naturalistic generalisation’ where readers can make their own interpretation and gain insight by reflecting on the details and descriptions presented in case studies and find descriptions that resonate with their own experience (Melrose, 2009).

Case studies are often carried out in close interaction with practitioners, dealing with real management situations. Case studies therefore represent a methodology that is ideally-suited to creating managerially-relevant knowledge (Leonard-Barton, 1990), but only if rigour is maintained (Scandura and Williams, 2000). Case study research uses a naturalistic approach to understand context-specific real world setting as it is (and subject to change as life is), and without any researcher manipulation (Patton, 2001). It is therefore necessary for the researcher to be present and involved in the process and as such “the researcher is the instrument" (Patton, 2001, p. 14).

The credibility of the research and the researcher depends on transferability and trustworthiness. Trustworthiness incorporates strategies of credibility, dependability, confirmability and transferability (Day and Bobeva, 2005). Trustworthiness of research lies at the heart of issues conventionally discussed as validity and reliability. Whilst reliability refers to the extent to which a research finding can be replicated given the same circumstances and validity refers to the extent to which a research method measures what it sets out to measure, trustworthiness is focused on highlighting the ethic for respect of truth (Lincoln and Guba, 1985).

### 3.2.4.2 Trustworthiness

The end result of the case study should be an understandable and recognisable product that presents faithful descriptions recognisable to its readers, which answers the research questions and is supported by a clear evidence and decision trail that may be followed (Silverman, 2006; Robson, 2002). In this research, two methods of data collection (semi structured interviews providing thick description alongside quantitative nursing indicators) provide two perspectives leading to a convergence of information for the reader to judge its trustworthiness (Stake, 1995). Throughout the following sections relating to trustworthiness, the qualitative data from the interviews is considered. The quality of the quantitative data is reviewed in Chapter 5.

### 3.2.4.3 Transferability

The ability for the research findings to be considered transferrable to a wider field is based on a thorough understanding of the following: (1) prior theoretical knowledge of an area, including concepts, claims, interpretations, and research tradition; (2) prior empirical results and their interpretations, including, surveys and case studies; (3) the researcher's own empirical results and their interpretations within the case study; and (4) the environment of the studied phenomenon, including its history, institutions (Lukka and Kasanen,1995). To ensure the reader can transfer findings to their own settings, the researcher has to provide the user with the information in a recognisable form. Within this research study, it is hoped that the reader will engage with ‘thick’ description of the context, the ‘story’ of the ward sisters’ experiences of the transition of the role from non-supervisory to supervisory status, and the assertions made in light of the interpretive process. The aim is to provide readers with the opportunity to determine the transferability of the findings to their own context.

### 3.2.4.4 Rigour

To ensure rigour so as to enable the research to fulfil its obligations to be of use to readers who may share this interest, and benefit from findings, which illuminate things which were not previously evident in the field, the following measures were taken (Krefting, 1991).

* Thematic Interpretations of the data were shared with the participants, who had the opportunity to discuss and clarify the interpretation and contribute new or additional perspectives on the issue under study. Whilst controversy exists within the literature with regard to this concept (described as member checking (Lincoln and Guba 1985))

supporters suggest the major criterion for external validity is in presenting the researcher’s accounts back to the research. Opposing views such as Drever (1995) argue the participants may wish to expand ideas and introduce subjective bias into the interview record. In this study all ward sisters responded supporting the thematic analysis without introducing additional themes.

* Good field notes in the form of a reflexive diary were maintained by the researcher for personal reflection and peer examination of the data.
* At the analysis stage, supervisors were used to independently code a set of data from a transcript, and to come to consensus on the emerging codes and categories. Ensuring the research was credible in reflecting the experiences and perceptions of the ward sisters who participated in the study was considered crucial to the wider acceptance of the research in the nursing arena and the transferability of the work to other organisations (Hantikainen, 2001).

Whilst the exact design of the research is based on pre and post structure changes, some literature suggests it is considered typical of the hermeneutic approach to include repeated observations or interviews in order to gain deeper insights through the informant’s and the investigator’s co-creation of substantive findings: (a) “to develop the informant’s focused life history, in other words their experience before and after supervisory status; (b) to elaborate and develop specific issues and events that appeared important during the first interview (also providing new lines of inquiry for the same and other informants); and (c) to gain informant’s reflections on the interpretations derived from the previous narratives, and any new lines of inquiry” (Crist and Tanner, 2003, p.203). Through the combination of these measures adopted throughout the study period, it is possible for the reader to assess transferability and steps taken to ensure rigour and credibility of the study.

### 3.3 Philosophical perspective of case study

As has been described earlier in the chapter, the importance of researchers recognising and understanding their philosophical orientations within the paradigm adopted for their project is emphasised (Hussey and Hussey, 1997). Creswell (2014) states that the research project must be framed within philosophical and theoretical perspectives. Case study research can be completed in a multitude of different ways; as Cavaye (1996, pp. 227-228) argues: Case study research can be carried out using a positivist or an interpretive stance, can take a deductive or an inductive approach, can use qualitative and quantitative methods, and can investigate one or multiple cases. Case study research can be a highly structured, positivist, deductive investigation of multiple cases; it can also be an unstructured, interpretive, inductive investigation of one case; lastly, it can be anything in between these two extremes in almost any combination. Leading from this, this study has adopted the philosophical orientation of the interpretive paradigm.

Stake (1995), Bassey (1999), and Cohen, Manion and Morrison (2003) support the view that case study research should be carried out within an interpretive paradigm although it has been argued that the use of multiple methods including quantitative methods, enhances the development of a ‘thick’ description of the phenomenon. Yin (2012) suggests good case study research should draw on a variety of sources, which can include both qualitative as well as quantitative sources. In doing so it is possible to check find­ings from different, as well as the same sources, allowing the development of thick description by establishing converging lines of evidence, which contributes to making the findings as robust as possible (Denzin, 1978; Kimchi, Polivka and Stevenson, 1991).

Within the context of this research in order to provide layers of understanding and the desired thick description, more than one method is used in studying the phenomena (Mitchell, 1986). This involves combining and utilising both qualitative interview analysis with nursing quality indicators in the form of metrics to provide quantitative methods in studying the single phenomenon.

Using both qualitative and quantitative methods in the same study has resulted in debate from some researchers arguing that the two paradigms differ epistemologically and ontologically (Hunt, 1991). Nursing scholars contributed to the debate in the 1980s and 1990s and to a lesser extent more recently. Those against the approach suggest that, if used, different methods could only be complementary, each supporting a distinct and independent part of a study. Hinds (1989, p.442) acknowledges that combining both qualitative and quantitative methods “increases the ability to rule out rival explanations of observed change and reduces scepticism of change-related findings”.

In using different methods in this research, the aim is to create a plausible interpretation of what was found, and from there to convincingly create a worthwhile argument from the interpretation of the experience of ward sisters. My research focussed on participants’ subjective experiences, before and after the implementation of supervisory status and an acknowledgement of the importance of context within which the subjects were operating (Parahoo, 2014). This allowed an appreciation of the subjective world of the research participants.

This research benefits from both qualitative as well as quantitative investigation within the broad interpretive framework of case study methodology. The quantitative findings have been reported within the conceptual framework of the case study research and provide an additional perspective in relation to the case.

### 3.4 Summary: Case study research for the research

Returning to the aim of this research study, in order to examine the factors which influence supervisory status for ward sisters and the impact of the role on quality of care both perceived and actual, a case study approach has been utilised. The purpose of the research is to describe, analyse and explain what happened so that the researcher and the reader can make judgments about the usefulness of the case study.

Case study research has enabled comparisons to be made between the experiences of ward sisters before and after the transition to supervisory status. Case study offers a credible, original and creative approach to this aspect of nursing research (Taylor and Thomas-Gregory, 2015).

Luck, Jackson and Usher (2006) argue case study research is under used, and that it allows the opportunity for in depth exploration of the phenomenon, within a defined and meaningful context whilst offering an understanding about real life events.

The ‘thick’ descriptions of the contexts within this research, are vital for comparisons to take place and involve the description of the particular situation for each individual ward sister where the context of practising and undertaking the full spectrum of responsibilities within the role of ward sister was different. The illumination of meaning within the contexts aims to enable the reader to make a judgment on the use of the research for his or her own purposes (Merriam, 1998).

The use of case study research in this setting aims to offer a credible, original and creative approach to the investigation of the ward sister role, itself a complex phenomenon. The method allowed me as a researcher to study the ward sister role intensively and deeply, in order to understand the facts related to both the individual ward sisters as well as the role of the ward sister within the NHS institution.

The intention is to make the results easily understood by a wide audience (nursing leaders, nurse educators, policy makers and others) so the findings of the research must speak for themselves.

The next section describes and discusses each of the research methods that have been utilised within the research. The research questions and methods are listed.

Research Question -1: What is the lived experience of ward sisters who move from non- supervisory to supervisory status?

Semi-structured Interviews at the beginning of the research study when ward sisters had minimal or no supervisory status, and again 12 months following the introduction of supervisory status.

Research Question 2: What is the impact of supervisory role change on quality of patient care?

Examination of nursing quality indicators throughout the period of the study alongside the introduction of supervisory status. In addition, the semi-structured interviews were used to explore the ward sister’s perceptions of the impact on quality conferred by supervisory status.

### 3.5 Research methods

The previous section provided rationale for the chosen research methods within the overall research design. These methods are examined in relation to data collection, and analysis.

### 3.5.1 The case: single case with embedded units

The importance of case studies being set within ‘a bounded context’ was introduced with the definition of case study research above. Case study research can become problematic if researchers attempt to answer a question that is too broad or a topic that has too many objectives for one study (Baxter and Jack, 2008). Yin (2003) and Stake (1995) have suggested that placing boundaries on a case can help the case remain manageable and in scope and use different terms to describe a variety of case studies.

Thomas (2011, p.12) considers the Latin roots of the word case: “capsa” (meaning box/containers) and “casus” (meaning event/situation) and concludes that the containment aspect of a case study with all of its features bound together in a contained way and supported by the particular situation that the study is examined in and the surrounding circumstance.

The overall case is the experience of the ward sister within an NHS hospital, which has implemented supervisory status within the context of the current political climate. The five individual ward sisters form the embedded units within the case as set out within the contextual structure of the case study (Figure 3.1).

This approach works well if the same phenomenon is to be investigated across different units belonging to the same case (Yin, 2003), for example, a hospital. This allows the researcher to explore the ward sister experience in a single hospital as a case while considering the influence of the various wards and associated attributes on the ward sisters’ behaviours and experiences. This approach can enable multiple analysis viewpoints of the data (Baxter and Jack, 2008). Further the data can be analysed within the wards separately, between the different wards or across all of the wards to give a rich picture of the hospital as a case (Baxter and Jack, 2008). The challenge is to remember to return to the global issue that the research initially sets out to address (Yin, 2003) and not to analyse only at the individual ward subunit level.

Figure 3.1 Contextual structure of the case study

Embedded sub units x 5

2 x data collections before and after supervisory role change

* The Government Context was established using secondary data from published policy documents and reports and was described in Chapter 2.
* The Hospital Context was established from documents, reports and personal perspective also described in Chapter 2. The researcher’s personal perspective and the impact that has on this study is included within the discussion chapter of the thesis recognising that this perspective plays a part in the interpretation of this research.
* Ward Sister Contexts were established using semi-structured interviews where participants were invited to tell their stories, described in Chapter 4.
* Ward Context was established from the quantitative data from established ward performance nursing quality indicators, described in Chapter 5.

### 3.5.2 Ethical issues

Ethical approval was sought for this research proposal from the local NHS Research Ethics Committee, in view of the participants being professionals recruited due to their role. Ethical approval was also provided by the university ethics panel (Appendix 2; DREP number SNM/DREP/14-009).

Ethical implications were significant in view of the relationship between the subjects being researched and the professional role of the researcher.

Ethical principles (ICN, 2012) were applied to the research. In relation to Beneficence: the research should directly benefit the individual ward sisters both within the organisation involved and by contributing to the body of evidence for nursing as a whole, in the case of this research this would include the wider NHS and how the ward sister role is employed. Non–maleficence: whilst clearly the research did not cause any physical harm attention was paid to the unintended consequences of interview style approaches and the personal issues which may have emerged. As previously described the importance of ensuring trust in the researcher as part of the research was considered. Justice in relation to fairness was another important consideration as by nature of the research ward sisters would be performing at different levels and it was therefore essential to treat all participants fairly. Veracity was an area of importance to the study, in that truthfulness of the experience described by the ward sisters was considered (Parahoo, 2014).

### 3.5.2.1 Informed consent

Parahoo (2014, p.408) describes informed consent as participants “agreeing to take part in the study based on access to all relevant and easily digestible information about what participation means, in particular, in terms of harms and benefits”. In preparation, for the changes in practice to the ward sister role a ward sister development programme was established; the programme offered the opportunity to explore the body of knowledge pertaining to the ward sister role and the impact upon patient care as presented in the literature. In order to ensure that the potential participants did not feel coerced into participating in the study, the professional lead for the ward development programme asked the sisters whether they would be willing to participate in the study.

The participant’s right to decide to withdraw at any time was explicit within the consent process with no adverse effect (Parahoo, 2014).

### 3.5.2.2 Confidentiality and anonymity

The confidentiality of information gathered from the sisters was respected. However, it was agreed with the ward sisters at the beginning of the interviews that if for example, discussion revealed an area of practice where safety to patients was compromised, this would need to be addressed in a professional manner in line with Fitzpatrick, While and Roberts’s (1996) recommendations maintaining the balance between the roles of nurse and researcher. It was agreed at the beginning of the interview that should such an issue arise the interview would be stopped and the issue addressed in line with Trust policy. Parahoo (1991) supports this principle suggesting, that one can question whether or not it is in fact unethical not to examine practice when by remaining with custom and tradition patients may be denied best possible care. In other words when there is evidence suggesting patient care could be improved it could be considered unethical not to consider making a change. All participants were comfortable with this discussion and no such issues arose.

Anonymity was assured and pseudonyms were allocated to each of the participants. Wards remained anonymous, as did the hospital in which the research took place. However, given the researcher’s role and place of work, and the limited number of ward sisters from whom the sample was drawn, it is acknowledged that there could be some challenges with anonymity. Others with ‘insider knowledge’ could potentially identify individuals or areas within the research. This issue was discussed with all the participants and they subsequently all agreed to continue to participate in the research. All identifiable references have been removed from recordings and analysis and were secured on a password protected computer in a locked office according to Data Protection laws (Data Protection Act, 1998), and the organisational data protection policy.

It is also important to understand that in addition to the broad application of these ethical principles, some are more prominent depending on the type of study. The uncertainty within findings from studies using qualitative data, means information may unfold in an unexpected or unpredictable way. Richards and Schwartz (2002) identified anxiety, distress, exploitation and misrepresentation and identification of participants in published papers as potential risks to participants. A particular imperative for the study was ensuring that there was no exploitation of the role of the researcher. Richards and Schwartz’s recommendations for strategies to avoid exploitation of the researcher were adopted and included ensuring scientific soundness, follow up meetings, confidentiality and having a reflexive stance when analysing data. The use of reflexivity is further defined below.

### 3.5.2.3 Researcher reflexivity

Charmaz (2006, pp.188-189) defines reflexivity as the researcher’s scrutiny of his or her research experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher’s interest, position and assumptions influenced inquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants and represents them in written reports.

Researcher reflexivity involves honesty and openness about how, where and by whom the data were collected and acknowledges the researcher as a participant in and of the research process (Ryan and Golden, 2006). It represents a methodical process of learning about self as researcher, which in turn, illuminates deeper, richer meanings about the research approach (Kleinsasser, 2000).

In interpretive research, interpretations may be particularly open to researcher bias or to the subjective nature of knowledge (Denzin and Lincoln, 2002). In order to achieve reflexivity within the research study, Hellawell (2007, p.483) argues that consideration of the insider – outsider continua is an essential way in what he describes as “guiding researchers into the secret garden of reflexivity”. Reed and Procter (1995) building on the early categorisations by Merton (1972) of insider and outsider doctrines, suggest a range of positions that a researcher can take on a position continuum of insider and outsider, whereby the researcher through periodic reflection can place themselves at different points in the research process. In terms of being an insider, Reed and Procter (1995) consider the researcher primarily engaged with practice and carrying out research in this area, the outsider on the other hand having no or little engagement with the practice. Hammersley (1993, p.219) argues there are no overwhelming advantages to being an insider or an outsider. Each position has advantages and disadvantages, though these will take on slightly different weights depending on the particular circumstances and purposes of the research.”

Being reflexive means being aware of the contribution the researcher makes to the construction of meanings throughout the interpretative process. The intention of reflexivity is to enhance the credibility and rigour of the research process as well as make transparent the positionality of the research (De Souza, 2004) and requires one to account for researcher involvement (Anderson, 2008) by identifying it through the process.

This study acknowledges the value-ladeness of the researcher’s experience and her perspective (over 30 years working in the NHS, as a nurse, ward sister and executive chief nurse), and recognises the contribution these experiences will have made to the selection of data for analysis.  In addition, how the participants perceived the researcher and how this may affect any knowledge claims that are made regarding the findings is recognised as a limitation to the study (Holloway and Fulbrook, 2001). Labaree (2002, p.118) suggests the challenge of ‘insiderness’ within the professions is an issue in need of further analysis and research”.

### 3.5.2.4 Power relationships

To avoid any concern regarding vulnerability of participant ward sisters in this study whilst the researcher held the position of Chief Nurse, the position did not assume line management responsibility of the ward sisters. This was delegated to divisional Heads of Nursing who remained independent from all aspects of the research study.

In addition, the use of a ‘gatekeeper’ was adopted in recruitment to the study. Holloway and Wheeler (2002) describe gate keeping as the process of allowing or denying another person access to someone or something and requires careful nurturing of the support of such colleagues. The gatekeeper role protects participants from unscrupulous researchers who diverge from ethical principles. Mander (1992) also suggests that gatekeepers may help to refine the project and address any practical obstacles to accessing participants in everyday practice. The inquiry may have involved asking questions that may be considered sensitive, embarrassing, threatening, stigmatizing, or incriminating (Dalton and Metzger, 1992). Benton and Cormack (2000) describe both organisational as well as professional gatekeepers. Within the organisation involved in the study the research and development coordinator for the Trust held the responsibility for organisational gatekeeping and the ethical approval process. In relation to professional gatekeeping, a role was identified within the senior nursing team within the Trust. The post holder led the overall senior sister development programme and acted as a professional gatekeeper to the ward sisters. An initial meeting between the gatekeeper and the ward sisters allowed the purpose of the research to be discussed and included the detailed research proposal. Letters of invitation were sent to participants and participant information sheets (Appendix 4) were provided. The research study information was reviewed by the gatekeeper, including the interview schedule (Appendix 3). This intermediary role provided a clear boundary between the researcher (myself) and the ward sisters to avoid any possibility of coercion of the ward sister. It also provided a contact for the participants should any concerns be raised during the research.

Mander (1995) emphasises the importance of the preliminary meeting to clarify and establish the gatekeeper role. At this meeting a number of important issues were discussed, including Holloway and Wheeler’s (2002) recommendations to consider the following:

* The setting in which the research interviews were undertaken for fear of ward sister becoming conscious of having her ward observed “observer effect”. For this reason, it was agreed the ward sisters would choose their place of interview and the gatekeeper would facilitate this.
* Potential for the ward sister to be embarrassed or fearful with regard to the research itself or the findings of the research. Here it was, therefore, emphasised how anonymity would be addressed within the research. The participants would also be allowed to read their transcripts and withdraw from the study at any point.

In addition to these two key areas, the significance of the researcher’s role as Chief Nurse was discussed at length and the possibility that a power relationship may affect the participant’s decision to participate, as well as potentially influencing the outcomes of the research. Malterud (2001, pp.483-494) states “a researcher’s background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions.”

Reflexivity is described within the literature as a useful approach to identifying power relations and their effects (Blodgett, Boyer and Turk, 2005). Reflexivity is described as having four levels for reflection within the process.

1. The identification of power, power relationships and effects.
2. Theory of power relations.
3. Ethical decisions in the research process and the politics and interests of those that make decisions.
4. Accountability for knowledge production (Ramazonoglu and Holland, 2002).

Schwandt (1997) endorses this approach suggesting reflexivity forms a key part of a researcher’s toolkit. The research interviews were, therefore, approached with continuous self- awareness, in particular awareness of self-bias towards the supervisory status of ward sisters. Adopting principles described by Parahoo (2014) as previously described, participants were given their transcripts as well as the coded data to confirm interpretations drawn. In addition, transcripts were given to the researcher’s two supervisors to obtain objective insight into emerging themes and to compare this to my analysis.

### 3.5.3 Sampling strategy and recruitment

Participants were recruited from a pool of 42 ward sisters who were all engaged in the introduction of supervisory status over a 12-month period. There was a phased approach to introducing the change to the ward sister role. All ward sisters moved from minimal supervisory time within existing roles, which was on average 20% of their working time, towards 100% supervisory time.

The 5 hospital wards (sub-units of the case) were considered, within which were the embedded units of analysis (the individual ward sisters). Wards varied in speciality including children, and adult acute settings. For each sub-unit (Ward), data was collected from the individual ward sister by interview and from ward-based nursing quality indicators as described below. The interview data was collected at two points. The first point was prior to the introduction of supervisory status and the second was after the introduction of supervisory status.

Ward sisters were invited by letter to participate in the study. The participants were selected by purposeful sampling as the emphasis was on obtaining an insight into the phenomenon from a variety of viewpoints from those who had direct experience of the role, in this case the ward sister (Parahoo, 2014). Purposive sampling technique, also described as judgment sampling, involves the deliberate choice of a participant due to the qualities the participant possesses. It is a non-random technique that does not need underlying theories or a set number of participants (Bernard, 2002). This approach allowed me to identify and select the 5 case study ward sisters who were willing to participate in the study as a result of their position and knowledge of the role. Important was their willingness and availability to participate within the given time frame (Creswell and Plano Clark, 2011). Within purposeful sampling, subjects are selected based on study purpose with the expectation that each participant will provide unique and rich information of value to the study (Bernard 2002).

Disadvantages do however exist with non-random selection of participants, in that it can be argued the researcher is subjective and may introduce bias in choosing the subjects of the study. In turn this may impact on the objectivity of conclusions drawn by the researcher (Etikan, Musa and Alkassim, 2016). The process for establishing the participants was managed by the use of the gatekeeper, the role of which is described in section 3.5.2.4. Specifically, in relation to the sample chosen, the gatekeeper managed all communication with the potential participants in the study. In selecting the sample, the gatekeeper used the criteria of those who were willing to participate within the described time frame and in receipt of expressions of interest to be involved. Over 25 expressions of interest were received in total.

It is also recognised that those that do agree to participate may lead to issues of bias, simply due to the fact that they agree to take part and other ‘types’ do not. When discussing issues that may expose fault or failings of any nature, Campbell, Keith and Sedikides (1999) describe self-serving bias whereby individuals offer defensive explanations that attribute success to their own disposition, and failure to external forces at play. Further bias may occur once the studies begin; participants may offer views of what the researcher wants to hear, they may be reluctant to talk about sensitive ethical issues and may even be affected by imperfect recall (Harris, 2001). Parallel to the research study, the on-going sisters’ development programme facilitated opportunities for ward sisters to raise wider issues and areas of concern. This helped to encourage the ward sisters to address specific issues in a peer group and to avoid using the individual interviews as an opportunity for this. Thomas (2011) emphasises that case study research does not seek to find a representative sample of a population but instead offers a “selection” without expectations that the wider population is represented. Therefore, whilst my selected participants were all ward sisters, the case study aimed to examine the unique individual perspectives of each.

Alongside the transition from non-supervisory to supervisory status, the ward sisters attended an in-house development programme. This programme was established to provide training and development for all ward sisters across the organisation and to support the change in role. Appendix 1 provides an outline of the contents of the development programme. The programme was designed to run over a 9-month period organised in cohorts of approximately 25 to allow all ward sisters as well as senior sisters in critical and emergency care to progress through the training alongside their individual journey towards supervisory status. In total throughout the year of the research study 93 senior sisters completed the programme in four cohorts. The 5-case study sub unit sisters were included within these numbers.

### 3.5.4 Qualitative data: semi-structured interviews

The findings from the semi-structured interviews contributed to the case study through the development of ‘thick description’ of the ward sisters’ experiences before and after introduction of supervisory status.

### 3.5.4.1 Data collection

Semi-structured interviews with ward sisters from each ward at the beginning of the study period and 12 months later (total 10 x ward sister interviews) were undertaken. This means of data collection allowed for the exploratory approach of the ward sisters’ personal stories and perceptions and enabled the probing in relation to questions as well as the ability to seek clarification of responses (Parahoo, 2014). The interview schedule was designed to incorporate broad based questions around the ward sister role and supervisory status and were designed to correlate with the research questions (Appendix 3). Interviews were recorded and transcribed before and after the introduction of supervisory status, alongside data collected from each ward area from nursing quality indicators as previously described. Table 3.2 sets out the timeline for the study period and the data collection points.

Table 3.2 Timeline for data collection

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Jan 2016 | Feb | Mar | Apr | May | Jun | July | Aug | Sept | Oct | Nov | Dec | Jan 2017 |
| Interviews |  |  |  |  |  |  |  |  |  |  |  | Interviews |
| Development Programme | | | | | | | | | | | | |
| Collection of Quality Indicators | | | | | | | | | | | | |

The interviews focussed on the research questions, including experiences in relation to supervisory and non-supervisory status, preparation and development within the ward sister role and understanding of key ward nursing quality indicators.

### 3.5.4.2 Advantages and disadvantages of interviewing

Whilst a number of interview techniques exist including face-to-face, telephone, MSN messenger, and e-mail interviews, face-to-face approaches have been the most widely used technique in the field of research that uses qualitative methods (Jamshed, 2014).

As the interviewees, i.e. the ward sisters, were the key subjects within the case study research, and in particular their views and opinions, the value of social clues including voice, intonation and body language was considered an important addition. The addition of such non-verbal as well as verbal data has the potential to enrich the meaning of the spoken words (Carr and Worth, 2001). It is also suggested that being in the same room together during the interview process, can facilitate building trust and openness and lead to rich and authentic discussion (Shuy, 2003; Polkinghorne, 2005). This was a helpful approach during the interviews whereby I was able to observe how relaxed the ward sisters were during the interviews and observe for any signs of vulnerability related to power influences previously described.

Musselwhite, McGregor and King (2006) describe benefits of face-to-face interviews, which may (1) help maintain participant involvement more successfully than phone interviews (e.g., fewer dropouts); (2) clarify the information being communicated (e.g. those with hearing difficulties or those for whom English is not their first language may encounter fewer difficulties in face-to-face interviews); (3) make messages being conveyed non-verbally available to the researcher. The importance of the relationship between the interviewer and the interviewee is well documented in the literature as it is on the strength of this relationship that reliable data is collected (Adler and Adler, 2002; Kvale, 1996). Throughout the interview process I was able to ensure through the face to face approach that I clearly understood what the ward sisters described, in particular with ward sisters whereby English was not their first language.

A number of reasons have been documented as to why individuals agree to participate in research interviews such as personal gain, interest, validation of personal experiences, and wanting to promote and help others in similar situations (Berg, 2001; Hiller and DiLuzio, 2004; Lowes and Gill, 2006). Whilst the individual reasons for participating in this research were not examined, a key factor of consideration was ensuring that the ward sisters were comfortable in their discussions and did not feel guarded. Thomas and Pollio (2002) suggest that interviewees who do not feel safe would not be forthcoming in discussing experiences. Oakley (1981) supports this view and suggests interviewees will remain engaged only if the interviewer in return is open and forthcoming.

As described earlier in the philosophical underpinnings of the study, the research methods are founded on philosophical beliefs regarding the acquisition and interpretation of data, and these beliefs affect the researcher’s interview approach toward participants. To support this open and forthcoming approach from an interpretive perspective the interviews were approached using principles of hermeneutic phenomenology. This allowed greater involvement with the subjects than perhaps the positivist approach of using the interview to test a predetermined hypothesis with a professional distance from the participants (Charmaz, 2005). In essence the interviews were approached with the aim of stimulating conversations with participants about the meaning of their experiences (Schwandt, 2000).

Other advantages of face-to-face interviews include the absence of a time delay between the questions posed and feedback, providing a more spontaneous discussion, described as synchronous communication (Opdenakker, 2006). In addition, the use of the semi-structured approach allowed the use of a broad question at the end of the interview in asking the ward sisters for any further thoughts or comments they would like to add to the interview. Wengraf (2001) describes this as a useful approach to extracting new areas of information. It also signaled an end to the interviews and allowed a natural stopping point.

Disadvantages of face-to-face interviews include the negative impact of how the interviewer can disturb the interviewee by being face to face. The use of interview protocols and piloting the interview are recommended to minimise such negative interviewer effects (Fassinger, 2005).

Other disadvantages to this approach include the high levels of concentration required by the interviewer during the interview when using a semi-structured approach as in the case of this research. Wengraf (2001, p.194) described the phrase "double attention" in that the interviewer is both “listening to the informant's responses to understand what he or she is trying to get at and, at the same time, you must be bearing in mind your needs to ensure that all your questions are liable to get answered within the fixed time at the level of depth and detail that you need".

To help alleviate double attention, tape recordings of the interviews were made during the interview with the consent of the ward sisters. This enabled a focus on the interview discussion without the need to concentrate on detailed note taking. Some notes were taken during the interviews to emphasise key points and to act as back up in the case of failure of the recordings.

Consideration was given to the timing and location of interviews: Interviews were scheduled in advance to ensure minimal impact on time for the ward sisters. All were conducted in the ward sisters’ choice of venue and at a time which suited diary commitments. No costs were incurred by ward sisters in attending interviews.

### 3.5.4.3 Skills for interviewing using principles of hermeneutic phenomenology

Principles of hermeneutic phenomenology were used as an approach to uncover the meaning of the experiences of the participants within the interviews (Streubert-Speziale and Carpenter, 2007; Benner, 1994). This philosophical approach supports case study research as a method of examining phenomena and contributing to the ‘thick’ descriptions of cases. Early description of phenomenology was reported by Edmund Husserl (Troy, Wyness and McAuliffe, 2007). Husserl aimed to explore human experience as it was lived and thereby to gain a greater understanding of the phenomenon. Martin Heidegger developed Husserl’s work further, using the concept of hermeneutics to address the question of the meaning of Being (Elliott, 2004).

Hermeneutics is about interpreting the meaning of texts, human action and institutions that can be treated as text to unearth the symbolic meaning (Prasad and Mir, 2002). The term ‘texts’ has a broad meaning and can include transcripts of interviews, organisation structures, official and unofficial documents, reports, media coverage and communications, and correspondence in the form of letters and e-mails (Ricoeur, 1981). Kinsella (2006, p.68) describes its ability to extend insight about “the fix we are in”, by exposing hidden meaning. Ricoeur (1981), asserts that hermeneutics can reveal how, for example, the powerful influences can impact on behaviour whether that be the wards, the hospital, sectoral or governmental contexts. The aim of this research is to contribute to these arguments and to "illuminate a situation so that it can be seen or appreciated" (Eisner, 1998, p.7).

Through the application of hermeneutic interpretive techniques, practical acts of living can be accessed through ‘narratives’ (interviews and observations) to reveal meaning. This methodology increases sensitivity to humans’ ways of being-in-the-world (Dreyfus, 1991), rather than providing theory for generalisation or “prediction of phenomena” (Crist and Tanner, 2003, p. 202).

Although hermeneutics originally dealt with the interpretation of theological, literary or judicial texts, today the method is used in many other disciplines including architecture, education, medicine, and sociology. More recently in social science, hermeneutics has been broadened enabling organisations and cultures, for example, to be interpreted as text analogues. Contemporary definitions define hermeneutics as dealing with the systematic approaches to clarifying the meaning of texts, and by extension the meaning of any human action, product, expression or institution that can be treated as text (Diesing, 1992). Ricoeur (1981, p. 246) describes hermeneutics as successfully unearthing the symbolic meaning of communication, the “work of thought which consists in deciphering the hidden meaning in the apparent meaning’’. Hermeneutics combines the theory and practice of interpretation that seeks to investigate the meaning of lived experience whilst enabling self-conscious reflection on the social conditions surrounding organisations, influencing talk and action (van Manen, 1990). A hermeneutic interview allows interpretive conversation wherein both partners reflectively orient themselves to the interpersonal or collective ground that brings the significance of the phenomenological question into view. The hermeneutic process of questioning the texts and responding to emerging responses lends itself to semi-structured interview questions as opposed to a more structured approach which would limit the level of inquiry during the interview process (Ajjawi and Higgs, 2007). Throughout the interview process, this technique facilitated an interactive discussion, allowing the process to move backwards and forwards between subject areas as the ward sisters described experiences and engaged in conversation.

### 3.5.4.4 Pilot study

A pilot interview was undertaken with one ward sister using the interview protocol. Baker (1994, pp.182-3) recommends pre-testing or 'trying out' of a particular research instrument, the advantages being that it may illuminate any weaknesses in the interview approach or identify if the questions are too complicated for the interviewee. De Vaus (1993) identifies a number of reasons for undertaking a pilot including the ability to test the adequacy of the research instruments and being able to identify logistical problems which might occur using proposed methods.

From the pilot, it was possible to refine the questions within the semi-structured interviews. It also enabled a trial run of interviewing in the ward sister’s chosen place, in this instance the ward sister’s office and being able to assess interruptions and distractions. It also allowed an opportunity to work with the audiotape and familiarise both myself and the interviewee with the sounds of the recorder and tapes. A simple but helpful point was noting the length of the tape’s recording ability and ensuring maximum space. The pilot interview data were not included in the overall analysis.

### 3.5.5 Qualitative data analysis

There are a number of approaches to practicing hermeneutic analyses in search of greater understanding of texts or text analogues in aspects of nursing (Crist and Tanner, 2003; Allen, 1995; Annells, 1996; Fleming, Gaidys and Robb, 2003; Koch, 1995). A number of principles underpin these methods; including the ‘hermeneutic circle’ of understanding, which can be viewed as an interpretive cycling between layers or perspectives. The process seeks This is known as thFirstlyto understand small sections of knowledge (a text/text-analogue), then to understand each one further in relation to the ‘whole’ (as understood by the researcher) of which it is part (its historical and cultural context). Understanding is achieved when there is a consistency between the whole and all its component parts and vice versa. The ‘hermeneutic horizon’ of the person seeking to interpret the text is as embedded in a specific cultural context as that of the part being interpreted. The researcher/interpreter will have their own historic-cultural context that is likely to differ to that of the text. In attempting to be critical the interpreter’s horizon will be dynamic as it circles through deeper understanding of the texts in their contexts. As the difference in horizons changes and as understanding deepens through the hermeneutic circle of interpretation, a ‘fusion of horizons’ is arrived at (Gadamer, 1975). At this stage, the integration of the horizon of the text with that of the interpreter offers a different perspective. It is this perspective that can contribute to what we know about the ward sister role, which may otherwise not have been shown using traditional forms of interpretation and analysis of questionnaires and surveys.

As regards the methods to perform hermeneutic analysis, this study followed the method approach used by Prasad and Mir (2002) who describe a four-step process:

### 3.5.5.1 Stage 1: Choosing and initial reading of the texts

The first stage began with identifying the texts and undertaking the initial read to understand the apparent meaning of the texts and to identify themes that could be used in later stages for a deeper analysis. This occurred after both the pre and post supervisory interviews. The ‘texts’ in this study were the transcribed interviews from the ward sisters. Verbatim transcription of the interviews took place as soon after the interviews as possible (Burnard, 1991). This enabled greater accuracy in the transcription, as well as early understanding of the words and themes emerging from the ward sisters. The transcripts were sent to the ward sisters so that they could determine whether the interviews had been transcribed appropriately. It also gave the participants the opportunity to make changes, add further thoughts, or choose to withdraw from the study. No changes were made, and no ward sisters chose to withdraw. Transcripts were coded at this stage with each of the pages and lines numbered to provide a means of recording the occurrence of categories and themes.

### 3.5.5.2 Stage 2: The contexts

This stage developed the context against which the texts were read again, sometimes many times to develop greater understanding through the later stages. Stage 2 built the context in which the texts were situated from a number of levels, for example, the health sector, the political, organisational, environmental and cultural context for the designated period under study.

### 3.5.5.3 Stage 3: The hermeneutic circle, closing the hermeneutic circle and fusing horizons

Once the ward sisters’ stories as told through the interviews had been read for their apparent meanings, and once the relevant contexts were established in relation to the government reforms, the regulators’ reviews, the hospital practices and cultures, I moved into the hermeneutic circle. This involved moving between texts and contexts to progressively develop deeper understanding of the stories which helped illuminate the lived experience of the ward sisters within the contexts in which they operate. The objective was to understand the parts in relation to the whole and the whole from the inner harmony of its parts (Gadamer, 1989).

From this it was possible to review all of the themes and sub-themes leading to integration.

Headings were noted for all aspects of the interviews until categories were formed (van Manen, 1990). Sub themes were identified from patterns such as conversation topics, vocabulary, recurring activities, meanings and feelings (Taylor and Bogdan, 1984). One example of this process included the early theme at the pre-supervisory interviews, relating to the relationship with the matron within hierarchical structures. In the pre-supervisory interviews, this was a common topic discussed, with the emphasis being related to the importance of the individual ward sisters’ relationship with the matron and the subsequent level of support and preparation the ward sister then had. At the post supervisory interviews, the ward sisters again described the impact the matron role had had upon their individual transition to supervisory status, and the level of success they perceived to date they had had in their new supervisory role. The historical backdrop in terms of how the matron role had been introduced brought a deeper understanding to how important this relationship was, and the matrons’ own experiences described by the ward sisters during interviews helped to further illuminate the breadth and depth of this theme.

The concept of the hermeneutic horizon relates to the idea that communication (of any nature) is embedded in a specific cultural context and the researcher seeking to interpret that communication is also embedded in his or her own historic-cultural context. The two contexts are never precisely the same (Prasad and Mir, 2002). The interpreter, therefore, will always be arguing only a certain view of the text and context in question. In this interpretive method that point is appreciated and should not be seen as an obstacle to understanding. Gadamer (1975; 1989) advises that the researcher should continue to develop the deeper understanding through cycling between texts and contexts to create a fusion of horizons which seeks to integrate the horizon of the text with that of the interpreter’s. “What results from this fusion is a fresh perspective that might not otherwise have been possible” (Prasad and Mir, 2002, p.97). Leininger (1985, p.60) supports this view in emphasising that “coherence of ideas rests with the analysist who has rigorously studied how different ideas or components fit together in a meaningful way when linked together”.

### 3.5.5.4 Stage 4: Conceptual bridge

Prasad and Mir (2002) describe the conceptual bridge as the point where new connections are made to the meanings contained within the ward sisters’ discourse. Gadamer (1989) called this a rhetorical counterpoint where the researcher’s horizons are fused. Throughout this stage relevant literature was introduced to enhance interpretations. Once categories and themes were established, the participating ward sisters were sent an overview of the identified themes with clarification and a request for comments. Lincoln and Guba (1985) suggest that using member checking in this way helps to establish validity of accounts. All ward sisters responded and indicated the themes were identifiable to them.

In summary, using the hermeneutic circle brought together the ward sisters’ stories, the researcher’s interpretations and the relevant literature findings to facilitate the overall interpretation of the phenomenon, in this case the ward sisters’ experiences, which were able to be compared before and after the introduction of supervisory status to their role.

### 3.5.6 Quantitative data: Nursing quality indicators

In the face of unprecedented financial challenge, the NHS like all public services is required to justify expenditure and demonstrate value for money whilst delivering a high quality service. It is well documented within the literature that health services should systematically measure, record, analyse and continuously strive to improve quality of care, by developing their own quality frameworks which include national as well as local quality indicators (DoH, 2008b; Griffiths, et al., 2008; Foulkes, 2011; Parlour, et al., 2015). Following increased public concern relating to quality of care, the adoption of measures in relation to nursing care has progressed throughout the NHS (Maben, et al., 2012b). There are however considerable inconsistencies and irregularities of definitions of the concept of such measures with terms such as nursing indicators and nursing metrics used interchangeably (Burston, Chaboyer and Gillespie, 2014) Within the context of this research, nursing quality indicators are defined as a group of measurements drawn froma set of national quality indicators used to measure the performance of NHS nurses (Department of Health, 2008). Table 3.3 identifies the specific quality indicators used during the research study. These indicators were developed from recommendations set out by the Royal College of Nursing based on the following parameters:

* Indicators for high risk/high cost topics, particularly pressure ulcers, failure to rescue, and patient falls
* indicators for essence of care
* patient reported outcomes, such as patient experience and perception of patient involvement, which provide measures for providing feedback on person-centred care
* indicators for systems of care (for example, continuity of care, teamwork and also staffing levels) with links to patient satisfaction

Table 3.3 Nursing quality indicators used during study

|  |
| --- |
| Harm Free Care / New Harms |
| Friends and Family Test (FFT) |
| Inpatient falls |
| Inpatient Falls with Harm |
| Medicines Administration Errors |
| Pressure Ulcers (Two Categories) |
| Vital Signs |
| Intentional Rounding Compliance |
| Discharges before 12.00 noon |
| Nutrition risk assessment completed |
| Complaints nursing care |

Detailed definitions pertaining to these indicators are set out in Chapter 5.

### 3.5.6.1 Quantitative data collection

Data is routinely gathered via the central nursing office as part of regular monthly monitoring of ward quality indicators. Individual ward sisters and matrons are responsible for ensuring the collection and submission of data overseen by a unit Head of Nursing. Data was accessed through an electronic recording system for each of the ward settings and was observed throughout the period of the study, during which time the supervisory role was being introduced. No additional specific data collection is required for the purpose of the research study as data is collected and examined monthly as part of the established quality assurance programme in the research setting. The assertion is made that performance of a ward in relation to ward nursing quality indicators is linked to the role and ability of the ward sister to practice with supervisory status.

For the purpose of this study data were analysed across the study period using non-parametric tests as described in Chapter 5.

### 3.6 Summary

The research examines the relationship between supervisory ward sister roles and their influence on the quality of patient care. Analysis of personal stories within case study methodology aims to reveal meaning and demonstrate the factors which influence adopting supervisory roles as best practice when substantial evidence exists to recommend this approach. Through hermeneutic analysis of semi-structured interviews and examination of nursing quality indicators an understanding of the lived experience of ward sisters within the context of the current reforms in heath service provision is provided.

Critical to the study has been the application of ethical principles throughout the design of the research tools and analysis of the data extracted. It was important to ensure that the researcher’s role did not influence either recruitment to, or management of the research design and interpretation. Through rigorous application of sound approaches it is hoped that this research will add to the body of knowledge in relation to the critical role the ward sister plays in influencing patient care.

This Chapter has identified the philosophical foundations of my study and describes the chosen methodology for the research. Chapter 4 sets out the qualitative findings of the research interviews.

# CHAPTER 4

# Findings - Interviews

### 4.0 Introduction

As has been identified within the methodology chapter, this study was undertaken using case study research within an interpretive paradigm (Stake, 1995; Bassey, 1999; Cohen, et al., 2003). Case study research enabled comparisons to be made between the experiences of five ward sisters before and after the transition to supervisory status.

The overall case has been described as the experience of ‘the ward sister’ within an NHS hospital, with the five individual ward sisters forming the embedded units within the case. Data were analysed within the wards separately as well as across all of the wards to give a rich picture of the hospital as a case. The interviews were completed prior to the introduction of supervisory status, and again twelve months later. Combining the qualitative interviews and quantitative data from nursing quality indicators allowed the development of a ‘thick’ description of the phenomenon. This case study research benefits from qualitative as well as quantitative investigation within the broad interpretive framework. The findings from analysis of the case study are presented in the following two chapters. This chapter describes the findings from the qualitative interviews with the ward sisters and chapter five follows with the analysis of the quantitative data.

### 4.1 Description of the embedded units within the case

The five hospital wards (sub-units of the case) considered, were composed of three acute medical ward sisters, one acute surgical ward sister and one a mixed specialty ward sister. The wards varied in size from 22 to 37 beds and 35 to 50 whole time equivalent staff comprised of a mixture of registered nurses and health care support workers for which the ward sister was the line manager.

The ward sister within this context is a registered general nurse within the Agenda for Change banding group 7 (this being the NHS national system which allocates nursing posts to set pay bands, using the NHS Job Evaluation Scheme) and is commonly called the senior sister. In general terms the post holder has previously held the position of junior sister band 6. A ward may have several junior sisters within its establishment, supporting the senior sister role.

The ward sisters’ experience ranged from 1 to 9 years as a senior sister and between 15 and 25 years’ experience as a practising registered nurse. All of the ward sisters in the study were female within the range of 35 - 45 years of age.

Table 4.1 Demographic of embedded units.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ward / ward sister** | **No. of Beds** | **No. of staff** | **Years as Sister** | **Years as RN** | **Age range** |
| Unit 1 | 22 | 38 | 15 months | 12 years | 35-40 |
| Unit 2 | 16 | 25 | 6-7 years | 14 years | 35-40 |
| Unit 3 | 30 | 35 | 8-9 years | 17 years | 35-40 |
| Unit 4 | 26 | 38 | 2 years | 11 years | 35-40 |
| Unit 5 | 37 | 36 | 3 years | 16 years | 40-45 |

At the beginning of the study the ward sisters in these areas were part of the ward establishment numbers for 80-100% of their time. This meant in practical terms, that for four out of five working days they were allocated a number of patients to care for alongside their responsibilities as the ward senior sister. On the day that they were not counted in numbers, they were undertaking a variety of managerial administrative duties. No common agreement existed in relation to the amount of time ward sisters were counted in the clinical numbers as opposed to operating in a supervisory capacity. The aim of the transition period was to move the ward sisters to a common position of 100% supervisory across all wards.

Data analysis was undertaken as described in chapter three. The interviews were conducted to address, in part, the following research questions

Research Question 1: What is the lived experience of ward sisters who move from non- supervisory to supervisory status?

Research Question 2: What is the impact of supervisory role change on quality of patient care?

The chapter begins by specifying the purpose of the semi-structured interviews, before identifying and describing the themes and categories identified from the analysis.

### 4.2 Purpose of the semi–structured interviews

The purpose of the interviews was to investigate the lived experiences of ward sisters over two time periods; the first - prior to the introduction of full supervisory status and the second - 12 months after its introduction. The intention was to gather in-depth information about the experiences of ward sisters who had been in post for a period of time and were therefore able to describe the role before and after supervisory status. The interviews allowed comparisons to be made between the ward sisters’ individual experiences before and after the introduction of supervisory status as well as comparisons of experiences across all five embedded units.

Pseudonyms have been used to ensure anonymity of the participants and wards involved. The process of developing the themes and categories was described in chapter 3.

Figure 4.1 provides extracts from a reflexive diary which was used in the research which illustrates how decisions were reached when analysing the themes. Selecting the quotes to use as examples in relation to specific themes was difficult in view of the richness of the data within the interviews. The choices were made based on: quotes that were succinct and representative of a number of the participants’ similar perspectives as well as quotes that were unique and highlighted personal experiences, and quotes which related to the aims of the research. Throughout the chapter in order to ensure confidentiality of all participants, all of the ward sister quotes are supported by a reference to a number from 1-5 and either the letter ‘B’ indicating interview comments before becoming supervisory or the letter ‘A’, indicating interview comments after moving to supervisory status.

Figure 4.1 Extracts from reflective diary

**[15/01/2016]: Reflection on first round interviews [Sister 2B)]**

Feelings of anxiety and lack of control – ill prepared for work demands – what preparation for job - issues relating to lines of communication, sensing respect issues

Getting to grips with new processes and systems – learning on the fly

Comments on the attitude of wider organisation to their concerns – how capable do they feel to challenge this?

Tired, policy of …but practice different?

Clinical/organisational expectations – compromises time to delve into the detail in meetings.

Issues with matron- positive/negative.

Constant feelings of incomplete tasks – trying to learn to let go once at home – what support networks exist to support this?

Is there a difference between wards – what’s the additional emotional pressure here?

Personal organisation/time / task management.

How much training organising admin/orienting to who and provide support in the wider organisation

Getting so used to feelings of juggling plates – it becomes a way of managing.

Support: positive/negative experiences.

**[21/12/2016] Reflection on interview**

Preparation for the role

Working with limited control of other processes outside the ward which affect processes inside the ward

Carrying the can for all sorts of issues – keeping it all moving

Time pinched at many junctures, things not being finished or rushed –

Support patchy, confused about lines of control and authority

Juggling – keeping all the balls in the air

Having to deviate from process to ensure patient care remains priority

In at the deep end from the start – no time to ramp up to speed – hit the ground running or things go badly wrong

Mentors inconsistent – self-managed process if it can be arranged

**[14/02/2017] Reflections on themes emerging**

Support, training, preparation

Ineffective multi-tasking, stressful management techniques, something always about to give

Insufficient authority/control to change or direct process, insufficient awareness of external pressures affecting the ward

Over-whelmed

Keeping patient care priority

Managing relatives’ expectation

Metrics pressures

The decisions regarding the themes were identified from aspects of the interview conversation, which were repeated across the interviews by the ward sisters. Alongside this the extracts from my reflexive diary, such as those highlighted, served as an opportunity to cross reference common issues raised by ward sisters and allowed me to link the diary notes to the emerging themes. Spider diagrams and other notes were used during this iterative process, involving reading and re reading the transcripts, to ensure wider understanding of the ‘whole’.

The themes and categories arose across all the ward sisters with similar themes emerging from before and after interviews. The quotes are cited as spoken by the interviewees.

### 4.3 Themes and categories

The themes that emerged through the analytical process were:

* Feeling (un)prepared for the role
* Moving from disempowerment to empowerment
* Perceptions and relationships
* Relationship of supervisory role and quality of care.

Within three of the themes, the following categories were identified:

1. Feeling (un)prepared for the role

* Variation in training and role of the in-house programme
* Finding own way

2. Moving from disempowerment to empowerment

* Loss of control of the ward
* Competing demands
* Becoming empowered

3. Perceptions and relationships

* Confusion about what the role meant
* Navigating the hierarchical structures including support from Matron
* Patient and family relationships

4. Relationship between supervisory role and quality of care

Although each of these is discussed separately, links between the themes and categories are discussed.

### 4.3.1 Feeling (un)prepared for the change in role

The ward sisters had a range of years of experience. Whilst three were experienced ward sisters and had been ward sisters in other organisations, two had taken up their first ward sister post in the research setting. Without exception, each sister described a lack of formal preparation and understanding of their first ward sister position prior to taking up the post. As a result, all of the ward sisters expressed varying levels of uncertainty as to what the new proposed changes would mean to their day to day roles and to what extent they would be prepared for the proposed changes.

This issue was common to the two ward sisters who had become ward sisters within the case study setting as well as the three ward sisters who had become ward sisters in other organisations prior to working within the current setting. The significance of this discussion at the first phase interviews highlighted the extent to which the ward sisters described their need for support in embarking upon a change to their role.

In identifying from the pre-supervisory interviews, the lack of a common baseline for ward sister training, the conclusion was drawn that there needed to be clarification of what the expectations of the ward sister role were in more general terms, as well as the meaning of transitioning from operating in a non-supervisory to supervisory way. Within this theme it was clear that ward sisters had been ill prepared for their first position as ward sister, which exacerbated their feelings of uncertainty about how they would adapt to a change in their current role.

### 4.3.1.1 Variation of training and role of the in-house programme

Exploring the detail of the preparation for their existing ward sister roles, all five participants described a different approach to their preparation. None had undergone any formal training or a prescribed programme. Four of the five ward sisters had relied on the preparation set out by the divisional matron on a bespoke basis. Every participant talked about the lack of a consistently defined period of preparation for the role, ranging from a few days to two weeks in a supervisory capacity working closely with a matron. It was possible to extract from the five ward sister units that this was true of all three NHS hospitals which had been responsible for the appointment of the ward sisters. At the pre-supervisory interview, in relation to their first experience as a ward sister, one participant said,

*“Nothing prepared me for the role, there was no formal handover from the previous ward sister. The actual ward sister role was an alien concept, there was no formal training for me.”*

(Sister 5B)

Another recalled,

*“When I moved there I had two weeks supernumerary time when I was taking handover from the previous ward sister. It was brilliant having this time to get to know the ward and understand what was going on but there wasn’t any formal training as such.*”

(Sister 4B)

In contrast during the post-supervisory status interviews, the participants had completed the in-house ward sisters’ development programme, which ran alongside the introduction of supervisory status. All of the participants found the development programme had helped them to prepare for the change in role and to understand not only the concept of supervisory status in their role but also the wider expectations of the ward sister role which was an area they felt they had not had the opportunity to explore before this time. During the post-supervisory interviews there was an emerging issue in relation to how interesting it had been to hear how colleagues were undertaking the roles in different ways at the beginning of the programme and how each ward sister had adapted her styles and techniques to fulfil the role. The ward sisters described how they had valued comparing and contrasting approaches to the various demands of the job and hearing different experiences. In relation to the transition to supervisory status the ward sisters described again the value of learning the challenges that colleagues were facing as they tried to move into the new way of working and how the programme allowed them to share frustrations and gain support in tackling common issues. A common view at the post-supervisory interviews was the feeling of camaraderie and a new network of support from a peer group.

*“When we started having the ward sister programme it was a fantastic thing, not just a ward thing but as a therapy as well for the sisters like ‘I am not on my own, somebody has the same problems’ so it made you look at the future in a more positive way.”*

(Sister 4A)

*“I had been doing the job for years and I still found it really helpful. I really liked that. I think it’s good to get a better idea of what is going on in the hospital, I think we are all very insular prior to the supervisory programme and I definitely think I have a better perspective on my role and of the whole Trust now.”*

(Sister 4B)

*“When on the training days you actually see what the others have gone through and at some point, when you are losing the will to live and there is a lot of pressure on the supervisory time, knowing you are not alone. Being a band 7 is a lonely job on the programme you realise you are not alone and you are having similar experiences to the other band 7s in trying to change the way you work.”*

(Sister 3A)

In general terms, the pre-supervisory interviews highlighted a gap in training and provision for the ward sister role within the case study ward sisters experience, (affirming the evidence found in the literature review). Whilst the need for a ward sister training programme had been identified prior to the development of the research study, it was surprising how significant the need for such training was. This included not only the need to understand what it would mean to work in a new supervisory capacity but in addition, the ward sisters emphasised during the interviews the lack of any formal preparation for their original ward sister role. Areas they described as gaps included, understanding of organisational strategy, financial and operational challenges on the wider organisation, professional developments relating to their specialty and the need for the organisation to have a greater understanding of their role as ward sisters. The pre-supervisory interviews highlighted the importance of addressing these gaps with the ward sisters during the transition period, in order to gain their support and cooperation in moving forward with the change in role. Throughout the post-supervisory interviews there was a clear picture of greater understanding as a result of the programme being specifically tailored to support the process as well as providing a mechanism for peer support amongst the ward sister community as they transitioned into the supervisory model.

### 4.3.1.2 Finding own way

Following on from this category during the pre-supervisory interviews the discussions focussed more on how the ward sisters had managed to move forward in their roles on the basis of having had limited support into their initial ward sister roles. All of the participants described how they had worked things out as they went along. In particular they talked about identifying problems as they emerged and working out for themselves what needed to be done and just getting on with it.

*“I have often been asked how I do my job and my honest answer is I don’t know how I do it but it must just be a natural thing because I haven’t learnt management. I have read some books and listened to some talks about managing small teams but I think I just led – I don’t know I just do it.”*

(Sister 2B)

*“I did feel I was picked up and dropped and left to find my way around and I think I am the type of person who just worked it out or asked people what I needed to do.”*

(Sister 3B)

There was a common attitude observed in the case study participants of self-reliance and ability to problem solve in the moment.

*“I just went in each day and wondered what would happen today and worked out what I needed to do as it went along, whether that was with relatives or staff, or complexities with patients”.*

(Sister 5B)

A significant point was the observation of the change from the band 6 junior sister role to a band 7 senior sister role. All of the ward sisters described an overwhelming change from one role to the next and all commented on not having enough time to adjust to the change in expectations. Exploring this within the pre-supervisory interviews the ward sisters described the promotional movement from band to band within nursing being based on increasing clinical skills and knowledge of their particular area of patient care, becoming more and more expert in their field. What they described as missing was the knowledge and skills in the wider roles and responsibilities of the ward sister in an organised way. The ward sisters described being promoted to junior sister roles as a consequence of being seen as more knowledgeable and experienced in patient management and care and having the responsibility of overseeing band 5 staff nurses and health care support workers. In contrast, when they were promoted to the senior sister role, in addition to their previous responsibilities, there was a new area of nursing management for which they had little understanding. In practice, this led to them feeling skilled and confident clinically which was in sharp contrast to feelings of ignorance in relation to the sudden change in expectations of their wider roles. To manage this a common approach was described by the ward sisters, which involved fathoming their way through whatever new problem faced them day-by-day.

*“Expectations are that you change your uniform and you become a different person, but you are exactly the same as you were a week ago.”*

(Sister 4B)

*“I was setting up a new ward from scratch, I had been a junior sister so it was as though I should have known what to do, but I didn’t! It was quite daunting.”*

(Sister 3B)

*“My experience of being a band 7 in the last year has been just a really big transition from a band 6 to a band 7, and really just trying to get to grips with what the role is, what is expected of me and trying to learn where I have to go for different pieces of information.”*

(Sister 1B)

All of the ward sisters in the post-supervisory interviews were asked to reflect on the transition from their junior to senior ward sister roles compared to their transition from non-supervisory to supervisory senior sister roles. A common description was how with the former in the absence of any formal training, they took comfort in their clinical expertise and immersed themselves in patient care and being a great clinical resource as the ward sister. Several of the sisters described that whilst they did not know any better and they had not been shown what it was they were meant to do as senior ward sisters they had carried on caring for patients and followed requests for management duties by their matrons as and when instructed.

*“I felt really confident looking after my patients, the scariest thing was all the other aspects of the role, dealing with staff and doctors and managers.”*

(Sister 3B)

Reflecting on the preparation for moving to a supervisory role several points emerged. Some of the ward sisters reflected on how resistant they had been to the change in role considering that such a change would take them away from their comfortable and confident expert practitioner role and force them into a less enjoyable managerial role. Others described how valuable the programme had been in firstly giving them the opportunity to understand what the expectations of the role were for the first time, and the opportunities that were offered in developing themselves, their teams and their specialty. Others felt frustrated that the programme had set out the ideal role of the ward sister, had opened up the opportunity to fulfil the role in a wider and more productive way when given supervisory status, but throughout the year the ability to remain supervisory had fluctuated which had been very frustrating.

*“It was interesting to see how we were all ward sisters but we were all doing the job in different ways, it felt uncomfortable at first like, who was doing the role the best, but in time it was great to see we were all trying to achieve the same things but juggling lots of things makes us work in different ways.”*

(Sister 3A)

*“I have really enjoyed the supervisory sister training programme, it helped me understand what the ward sister was really all about, not just knowing the specialty really well. It’s so frustrating though as I had several months of being supervisory and really got going with it, now I’m back in the numbers a lot, it’s very hard.”*

(Sister 5A)

Another ward sister expressed frustration at the unreliability of the supervisory status.

*“I understand we have to consider patient safety first, and have nurses on the ground, but it is so frustrating when you know you could be doing other things that will benefit the ward and the wider patients but you have been pulled back into the numbers and can’t get to it.”*

(Sister 2A)

The general theme of figuring out the ward sister role as they went along was very evident in all participant interviews prior to the move to supervisory status, which led to varying expectations of what a new change in their role may mean in practice. It was clear that the previous experience of becoming a ward sister would have a huge impact on a new change to the role. The ward sisters had invested a great deal of their own time and commitment getting to a level of understanding of their existing role, and the concept of a new change was obviously a daunting proposition. The post-supervisory interviews however revealed an overall position of using the programme to re-establish themselves as a body of ward sisters and share the approach to the new way of working collectively.

### 4.3.2 Moving from disempowerment to empowerment

At the pre-supervisory interviews, despite the challenges described on taking up their posts and the lack of a formalised training programme, all of the ward sisters came across as comfortable in their current roles in terms of the routine and practice they had established within their clinical settings. All participants however described feelings of disempowerment. This presented itself in day-to-day challenges, managing chaotic situations, not having the time in their daily roles to attend critical discussions and to be involved in decision making, yet held to account when things were not progressing within the ward area by their matrons and heads of nursing. There was a general view that their voices were often not heard as the ward sister, as they would not always to be present at the key discussions or situations when they could most influence. All participants described poor work life balance from not being able to contain the role within working hours and constant challenges from many angles. During the post-supervisory interviews there was a strong articulation of how this had changed when the sister was able to function in a supervisory capacity. Clear examples of becoming empowered in both their clinical and managerial roles as well as within their personal developmentand work life balancewere described by the ward sisters as set out in the following sub categories.

### 4.3.2.1 Loss of control of the ward

During the pre-supervisory interviews, all of the ward sisters described their daily roles as extremely demanding whilst they were expected to balance the management of a clinical area and team alongside a caseload of patients. Some of the participants had an office day scheduled periodically but others had no supervisory time at all. All of the ward sisters described the impossible position of achieving control on their wards without extending their working days way above their scheduled hours of work.

*“I would be trying to sort out staffing issues on the day, longer term vacancies, everyone would be coming to me, I would be washing a patient and I found it really difficult because it is really rude half way through washing the patient to say sorry I need to take a phone call or go to help someone who needed me. I couldn’t go very long before I would be asked to help with this or that. It was really hard. I felt I was just getting through my patients as quickly as possible so that I could help everyone else and sort things out. I felt I wasn’t being a ward sister and I wasn’t being a nurse just doing half a job on both sides. It was really tough.”*

(Sister 5A)

*“I would fire fight through every shift, that’s how it was back then. I wasn’t able to identify problems in advance because I couldn’t see what was going on on the whole ward; it was a case of picking up problems after they had happened.”*

(Sister 4A)

*“A really important part of my ward management is making sure the ward is flowing patients but I would have seven patients of my own to look after, I couldn’t get on top of the outliers or get to the ward rounds, it was chaos and everyone would be ringing me or coming to the ward and asking why my patients weren’t moving.”*

(Sister 4A)

Some of the ward sisters described the lack of respect they felt from medical staff on the ward as a result of the sisters not being seen to be in control.

*“When the consultants come to my ward, they don’t see the ward as my ward, they don’t see me as the leader, I’m too busy.”*

(Sister 2B)

All of the sisters described staying late every shift to catch up.

*“I tend to stay here until 10 or 11pm most nights trying to get through those emails much to my family’s discontent. I have young children who are very unhappy when I don’t get home in time.”*

(Sister 3B)

*“Most days I work an extra two hours just catching up at the end of the day, paperwork, incidents, off duty, difficult phone calls, or sometimes I try and get in an hour earlier than I am due to.”*

(Sister 4B)

*“Everybody wants a bit of you, it’s like you are not in control of any of it, juggling lots of balls and there are lots of balls to get to grips with.”*

(Sister 1B)

During the post-supervisory interviews, the ward sisters described a sea change in their approach to the management of their ward. All described once they had understood how the supervisory role could work and had the opportunity to explore their working patterns that there was an overwhelmingly positive response to their level of control of their clinical settings. The ward sisters described how supervisory status gave them the opportunity to consider what it was that defined them as the ward sister as opposed to a registered nurse caring for a group of patients. The ward sisters appeared to have reclaimed the ability to decide how best to manage their wards, as opposed to the position of getting the work done as part of the everyday nursing numbers.

*“It feels like it really is my ward now, not the doctors’ or the matron’s, they come to me now and ask me, not tell me what is happening.”*

(Sister 3A)

*“I think now I am in a position where I can see there is a problem coming up and I can nip it in the bud before it starts which is an absolutely lovely position to be in.”*

(Sister 5A)

*“You don’t really realise how you have been managing until you have some time to think about what you are doing, then you see how crazy it was. It’s much more manageable when you are supervisory.”*

(Sister 4A)

All of the ward sisters expressed frustration when they were pulled back into numbers having identified the new position of power they found themselves in when allowed to be supervisory in practice.

*“The disappointing thing is when you have to be pulled back into the numbers because of staffing, you know what you aren’t doing and how easy things can get on top of you again.”*

(Sister 2A)

### 4.3.2.2 Competing demands

It was clear in all pre-supervisory interviews that there were constant competing demands upon the ward sisters. The sisters described typical aspects of their days before the introduction of supervisory status.

“*Your brain has to be in 1001 places at the same time. You have to be there for your staff but you have your own patients to look after. You know you have to manage your team and deal with problems but you are being asked to attend meetings to work on initiatives such as patient flow or discharge work but if you leave the ward things slow down more. If you do go to a meeting you worry about the ward and how stretched they will be without you. There are too many demands on your time.”*

(Sister 1B)

*“When you are in the numbers, the role is overwhelming because you still have to do everything else, you have your own patients, staff want you, relatives want you, other colleagues want you, you just want to hide under the desk because everyone wants you.”*

(Sister 2B)

In the post-supervisory interviews, the ward sisters continued to describe competing demands, and in three of the five case studies the ward sisters described an initial increase in demands as a result of lack of clarity in relation to their supervisory time.

*“I had to keep explaining what being supervisory meant; it didn’t mean I now had loads of free time”*

(Sister 2A)

*“Several times managers would say to me, you’re extra to the numbers now, you can do this. It was challenging explaining I wasn’t free. I was working with new staff or planning things for the ward team or my patients.”*

(Sister 4A)

They did however describe how over time, as they were allowed to embrace the new role, they were able to gain better support in managing the daily challenges in a better way.

*“As I got more into the new routine I was able to show improvements in how flow was going on my ward. People could see I was in control so they stopped hassling me so much.”*

(Sister 2A)

*“It is still difficult at times, everyone thinks being supervisory means you can drop everything at any time and do something else. It’s not fully understood yet what our role is.”*

(Sister 4A)

*“It is still really upsetting that as soon as the numbers are low, the first thing the matrons look at is who is supervisory and you are back in the numbers. It’s such a shame as when we aren’t in the numbers things work so much better but it’s the balance of who is there to do the patient care.”*

(Sister 3A)

Within this theme it was clear that the issue of competing demands remains a significant challenge to the ward sisters. Prior to their change in supervisory status they balanced one set of challenges mainly looking after their own caseload alongside supporting their team. Post-supervisory status they appeared to be facing additional requests for wider managerial roles as a result of a perception that they were now in possession of more time.

### 4.3.2.3 Becoming empowered

All participants used the term empowerment in their post-supervisory interviews. This was a stark contrast from the comments before the senior sister development programme and the introduction of supervisory status. Whilst all of the sisters had not yet achieved full 100% supervisory status they were very clearly articulating a change in their understanding of the ward sister role and how this was affected by any period of supervisory time. This was by far the most animated part of the interview process. A number of examples were identified within the interviews of how the ward sisters felt more empowered in their role.

*“I had been working in isolation before the programme with no cross fertilisation with other ward sisters. I’ve had things in the pipeline for years that I have wanted to do but wasn’t sure how to move them forward. I’m doing that now with networking with other sisters.”*

(Sister 1A)

*“I feel we are more appreciated and more listened to and we do have a say and we can help with wider things to do with how the hospital is doing, not just our ward.”*

(Sister 3A)

*“I feel empowered to have the conversations I need with my matron or my consultants so that I can have my say.”*

(Sister 4A)

*“Now that I have been exposed and discussing things and being more into what is happening outside my own ward, if I don’t agree with something I may end up doing it anyway because I have been told but I will make my point now, I am more confident.”*

(Sister 5A)

In terms of their personal development one sister talked about changes she had been able to make to practice on her ward.

*“I’ve made hundreds of changes here; One of the most important to me has been safety huddles, they are brilliant, I have been able to link some of our safety initiatives to the cost savings on our ward as well as the quality side, I’ve really enjoyed understanding how we can measure our improvements in money as well as for our patients.”*

(Sister 2A)

“*I’ve really enjoyed getting to the 8.27, it’s the one chance we get every week to talk to the CEO and the Exec team, sometimes I bring one of my band 6’s then we go back and tell the team what’s going on, I feel so much more connected, we hear about quality stuff and the money, and what the regulators are saying, it’s interesting”*.

(Sister2A)

A striking finding described by all ward sisters in the post-supervisory interviews, was how they had in turn been able to empower their own staff and described with examples the impact this had had on their roles. In particular they discussed how they had been able to invest time in the junior sister band 6 roles, and how they had identified greater opportunities for developing them in order that they would be able to take on wider responsibilities to support the senior ward sister.

*“I now meet with my band 6s every two months. We couldn’t do this before. I also have 1-1s with them. I now expect them to do the same with the band 5s that they are responsible for. This is how I role model down to the team. I think it has had a massive impact on their sense of being valued within our team.”*

(Sister 1A)

*“I am getting the band 6s involved in wider roles. I’m getting them trained up so that they can do my job. They are starting to understand what it is all about and help me with the wide range of responsibilities.”*

(Sister 4A)

One ward sister described how she had put into action the concept of flexing her role. By this she meant she was at times giving her ‘supervisory time’ to her junior sisters and she would cover their caseload to allow the junior sister the opportunity and time to undertake activities and gain experience which would prepare the junior sister for the responsibilities of the senior sister role.

*“So, I say to my band 6s you’re in charge and I am going to do your care. We have a ward meeting every other week now and take time to step back and review our work, what’s been good, what’s been bad”*

(Sister 4A)

Another example of delegation to staff is seen in the changes the ward sister had made to discharge processes within the ward. A particular focus for all ward sisters during the study period was in ensuring adequate preparation took place to facilitate timely discharge of patients from the inpatient setting to their ongoing care destination. All of the ward sisters described challenges in achieving this during the pre-supervisory period, and little opportunity to educate their staff to ensure this was as efficient a process as possible. This changed after the introduction of the supervisory status.

*"I was able to teach them so they could do it themselves. That was my first thing I put back to them with the supervisory senior sister role, training them individually through the complex processes of discharge planning, rather than me trying to oversee the discharge planning for all the patients, which is fine, apart from the fact I might die one day or have a day off!”*

(Sister 5A)

*“Having time to ensure the discharge planning processes were beginning early enough in the patient’s hospital stay and that staff all knew what forms needed completion, and processes initiated made a huge impact on our discharge performance indicators. It was also so much better for our patients and their relatives.”*

(Sister 4A)

*“I really love that I don’t feel guilty about leaving my ward anymore. I know it’s in safer hands. My staff know what they are doing. I have a good overview of my staff and the patients. I can step outside and get involved in things and not worry. For a ward sister this is incredible reassurance. Sometimes now the staff are ahead of me and say ‘we’ve got it covered’. They make me feel like they don’t need me now!”*

(Sister 3A)

Several of the ward sisters described feeling empowered as a body of ward sisters. Examples were shared during the post-supervisory interviews of how they had worked together outside of their ward area, within a wider group of ward sisters to set up working groups to support specific initiatives. They described how they had stayed in touch with ward sisters from other areas in order to share ideas and support each other. Two of the ward sisters talked about having been in the hospital for many years and never having met ward sisters in nearby wards up until this time.

*“The best thing for me has been being able to come together with other band 7s and having those conversations from a practical point of view. It is very hard to do when the wards are so spread out and we all work very divisionally so I think it’s great to get people from different divisions in with different ideas, it’s really nice.”*

(Sister 4A)

*“I’m mentoring a new band 7. I wouldn’t have done this before the programme. I feel I’ve got much greater understanding of other sisters’ areas now.”*

(Sister 5A)

*“I’ve been helping another sister with a staff development programme for our overseas nurses. I didn’t realise how much work she was trying to do. It’s great to help each other.”*

(Sister 3A)

All but one of the participants talked about having begun to think about their own development now and taking on new things in their ward areas. One sister had started a postgraduate programme, one talked about her vision for the ward. The sister who had not focussed on her own development during the period, described her priority being her junior sisters who she felt needed her time and support in order to develop their skills which would in time allow her to focus further on her own development.

### 4.3.3 Perceptions and relationships

Almost all participants described the impact of wider multidisciplinary roles on their role as ward sister. Of particular note was the variation of understanding across nursing colleagues, medical teams and operational managers. Some ward sisters described feeling well placed within some parts of the multidisciplinary team, whilst others described a lack of understanding of the supervisory role and a variety of perceptions as to what the ward sister role involved. This led to frustrations for the ward sister and was a constant source of discussion within their peer group.

### 4.3.3.1 Confusion with the role

Prior to the introduction of supervisory status, the ward sisters described a large degree of variation in their existing ward sister roles from ward to ward. Some experienced almost no time outside rostered clinical hours, which meant the vast majority of their time was spent on direct patient care. None of the ward sisters were able to regularly attend multidisciplinary ward rounds or leave the ward for wider operational management meetings. All of the ward sisters spent additional hours at the end of their shifts trying to catch up on paperwork and administrative duties. Across the organisation this had become the normal expectation of the ward sister role. Following the decision to move to a supervisory model and introduction of the ward sister development programme there was a level of confusion in relation to what being supervisory would mean, both within the ward sister group themselves, within the wider nursing teams and across the multidisciplinary and management teams.

Despite the acknowledgement from all ward sisters about the difficulty in fulfilling their role when included within clinical numbers, a number of the ward sisters described feeling confusion and concern as to what the expectations of their role would now be and what the proposed changes would look like in clinical practice.

*“It’s all a bit muddly at the moment. We’ve started the supervisory thing but we aren’t supervisory most shifts so it’s complicated. My staff are a bit confused because I was explaining what supervisory would be like but then I’m needed in the numbers. It’s taking time to help my staff understand what supervisory means. I was upset when a member of staff made reference to me putting an apron on one day saying I ‘should do it more often’. It took time to explain what I was doing within the new role. I’ve had a few remarks from staff who perceived I wasn’t doing anything because it wasn’t direct patient care.”*

(Sister 5B)

Several of the ward sisters described how concerned initially they felt about losing their clinical credibility with their team. As a result of confusion about what the new role would be, a number of the sisters expressed fears that they would be forced to be office based and not have contact with patients.

*“I’m worried that introducing supervisory status will mean I’m in the office all day. I find it difficult when I’m in the office, the numbers won’t allow me not to have a group of patients, I won’t be in my comfort zone.”*

(Sister 2B)

Several of the ward sisters described within this confusion, personal challenges of stepping away from being one of the team to the leader of the team. They described feeling concerned that moving to supervisory status would pull them away from the clinical team and forge a distance in their relationships.

*“I still want to feel part of the team, and not another manager who doesn’t know how it feels on the front line.”* (Sister 3B)

*“My team trust me, they know they can come to me for help. I don’t want to be seen as locked away in the office, not interested in nursing care.”*

(Sister 4B)

In pursuing this question at the post-supervisory interviews with the ward sisters further comment included:

“*There were a lot of us that didn’t want to do it at the beginning. It was about the clinical bit. It was about wanting to deliver care to patients. I think it has taken us all a long while to get our heads around the fact that actually although we might not be delivering it, we are making sure they get better care and they generally do. Taking the step back was quite hard*.”

(Sister 4A)

Illustrating how role confusion manifested itself amongst the team, one sister said:

*“A downside for me is people saying I’m less visible as I was always on the ward and then late at night I’d stay behind and do my other work. The staff didn’t really know what I was doing. Now I am in and out of the ward, sometimes in my office sometimes teaching, sometimes with a family - it’s better but it’s different. The staff are getting used to it and I think they are enjoying it more as I am available to them”*

(Sister 2A)

*“If you had asked me two years ago if I would want to be supervisory absolutely not, I didn’t understand at all what it would have meant as a ward sister. Now I think I have learnt how important it is that you build your team around you as a ward sister, to get the best of them and to make the role work.*”

(Sister 5A)

In all of the post-supervisory status interviews without exception the ward sisters described improvement in the confusion around the role and a move towards a new norm but that this remained a frequent area of challenge in their day-to-day practice when in a supervisory capacity. In the clinical setting, all ward sisters described being asked to step into clinical numbers when the ward was short, or to send some of their staff to other wards that were short which then led to the ward sister losing her supervisory status. This level of operational challenge remains a significant concern for all ward sisters.

*“It feels demeaning when you are told you aren’t short staffed because you are supervisory to the numbers. It defeats the whole aim to plug the gaps.”*

(Sister 5A)

*“My matron is fully supportive of my supervisory status now, which is great and feels much better in everyday working but sometimes when other areas are short she will say, ‘I’m so sorry I know this is not good but I need to move your staff around’. It’s so demoralising when you know the ward will be less efficient when you are not supervisory.”*

(Sister 4A)

In addition, a number of the wards sisters described how at times in senior leadership meetings, senior managers referred to perceived new ‘extra capacity’ the supervisory ward sister would have to be able to pick up operational challenges, as a result of still not fully understanding their role.

*“I was at a new meeting all about blockages to patient flow. The manager said can the ward sisters collect this data, they are supervisory. I spoke out and said, ‘this isn’t the best use of our time, we need an administrator for this’. You have to keep constantly telling people we have a huge workload as it is, and the time lets us do it properly.”*

(Sister 1A)

It was apparent during the post-supervisory interviews, that the ward sisters had had significant challenges explaining their new status in the early period and that this continued albeit less frequently as the year progressed. It was interesting to note that as the year moved on, there was still an expectation that the ward sister could drop the supervisory status when staffing levels were short despite the increasing awareness of the greater levels of ward efficiency when the ward sister was in her supervisory capacity. The ward sisters made reference to this in describing how they believed the nursing quality indicators improved during their periods of supervisory status and how when they were pulled into clinical numbers less focus was possible on quality indicators.

### 4.3.3.2 Navigating the hierarchical structures, including support from matron

Within the nursing structure of the hospital setting, the ward sister role sits under the auspices of a matron, who in turn sits within a divisional structure overseen by a Divisional Head of Nursing. The matron role was re-introduced into the NHS in 2001 in an attempt to address failing standards across the health service (Department of Health, 2001a). The remit of the Matron is to provide leadership to professional and direct care staff within a group of wards, whereby each ward has a designated ward sister, in order to secure and assure high standards of clinical care, including administrative and support services.In addition, the matron is expected to have a visible and authoritative presence in ward settings for staff, patients and families. A criticism of the matron role within the literature reflects the lack of clarity in relation to how the role interlinked with the role of the ward sister, who’s central role to quality of care on the ward are well acknowledged (Pegram et al., 2014). Each of the ward sisters participating in the research study report to a matron who in turn oversees approximately five ward and ward sisters.

A significant influence described in both the pre-and post-interviews was the role the matron played. All of the participants emphasised the importance of support from the matron role within the preparation for their first ward sister position. Whilst this varied from experience to experience all described the pivotal role the matron has in preparing and supporting the ward sister in the early period of transition. For some ward sisters, there had been a structured period of time working alongside the matron, while for others this had been more informal; but in common to both positions was the guiding hand of the matron as they approached the challenges of the ward sister role.

*“My matron at the time was fantastic and I couldn’t have done the job without her help.”*

(Sister 2B)

*“I had a number of different matrons when I first took up my post as there were changes going on. They all had quite different ideas about how things should be done but it was really important to have a good relationship with them.”*

(Sister 4B)

*“My matron was brilliant; she held my hand through the first few months. I wouldn’t have survived without her. To begin with I was going to her about absolutely everything and checking everything I was doing via her. That was the thing that was propping me up really as there was a lot to sort on the ward. We have come out the other side now.”*

(Sister 5B)

Significant therefore in the pre-supervisory interviews was the question of how the matrons would be involved in the transition from non-supervisory to supervisory ward sisters, and how supportive they would be to the change in role. In all of the interviews, the relationship with the matron role and that of the ward sister was emphasised along with the importance of this relationship as a key enabler to the success of the change in practice. Whilst matrons were not interviewed formally as part of this research project, ensuring the matrons were on board with the proposed plans for the ward sisters to become supervisory in their roles was an important aspect of consideration throughout the period of transition. As a result, a number of conversations were held with the matrons as part of normal working practice during the study period to prepare them for the change in their wards sisters’ roles and to seek their support and engagement. Whilst it was generally well received and supported the change in role did lead to concerns both from the ward sisters and from the matrons in relation to the impact of the changes on each other’s roles and responsibilities. One ward sister described how she had a good relationship with her matron who had shared her concerns about the changes to the role:

“*She said I don’t know what you do on your supervisory days, I don’t know where your job ends and mine now begins.”*

(Sister 4B)

*“It was very difficult at times, they didn’t have a great understanding of what the change in our role would mean. I think they felt threatened by us because I think they thought we would take over their job and they would no longer be needed. I felt quite a lot of resistance generally from the matrons.”*

(Sister 5A)

*“I was worried that I might spoil the relationship I had with my matron. She had been really supportive when I got my post, but I could tell she didn’t get the supervisory role. She hadn’t been a supervisory ward sister; she kept referring to it as a new idea. I felt anxious about talking to her about it.”*

(Sister 4A)

A number of the ward sisters described the hierarchical structure in which they worked within nursing which made it difficult at times to speak up and be heard in person at senior levels as there was an expectation they had to work through the matron level first. Others described the increase in delegated tasks from the matron as it was felt the ward sister now had free time.

*“They said now you are supervisory you can take on more things. Throwing stuff at us. It’s got better as the year has gone on. We have been able to talk about what the supervisory time is needed for. It’s getting much better but still difficult at times.”*

(Sister 3A)

*“We discuss our ward budgets, what she is responsible for and what I should be doing, it was hard at first prizing some of it off her but we are much more joined on this now, it makes sense it’s my staff who are using the resources I need to be able to control them more directly”.*

(Sister 5A)

All of the ward sisters suggested that the matrons should be included in the on-going nursing development programmes to ensure they were able to focus on their own matron role which they felt would help address some of the problems ward sisters had faced during the transition period. They came across as anxious that if the matron was not part of the process the journey would remain challenging for the new role.

*“I think our role has changed incredibly, and I am sure theirs now has as well, but I don’t think they are moving along like we are.”*

(Sister 2A)

Considered also within this hierarchy were medical colleagues. At the pre-supervisory interviews, there was a general ambivalence to the relationship with medical staff described by the ward sisters with the exception of one ward sister. The majority described doctors coming and going from their wards. As the ward sister was frequently committed to a patient group they were rarely free to engage with consultants or their juniors and ‘caught up’ afterwards with any instructions or messages within case notes or with the nurse assigned to the patient. This served as a source of frustration to all the ward sisters as they recognised the need to be pivotal in decision-making discussions, which they were often excluded from.

*“I have hundreds of consultants down here. They all think they are the big boss, coming and going. I want to tell them it is my ward, I don’t think they respect this and I don’t know how to change this.”*

(Sister 2B)

*“I want to be on the ward rounds, influencing decisions, but I have only one day when I am not in the numbers so I can’t do it.”*

(Sister 3B)

One sister had a well-established relationship with a key consultant for the ward and managed to ensure regular ward rounds occurred with herself or one of her staff, albeit she described being constantly interrupted and disturbed prior to supervisory status.

In the post-supervisory interviews there was an obvious shift in this position, and a number of the sisters expressed a huge change in the relationships they had with consultant and junior medical staff in their ward areas.

*“The ward doctors are really getting it. They come in and ask me now ‘are you clinical today or are you here’, and they mean supervisory to accompany them or talk through stuff. The consultants are less engaged but they are noticing us on their ward rounds more and referring to us.”*

(Sister 1A)

*“Because you are more visible you are less scary and you feel less scared because you are seeing people more often. A simple example: I have been a nurse in this area for 10 years. In my supervisory role I now attend the (specialty) Friday morning meeting with the whole multidisciplinary team. We discuss the patients. I’ve been able to go now every Friday for months. They see me in a different capacity, our communication is so much better. I used to be scared to go into busy big meetings and I’d think please don’t ask me a question in front of my operational manager, you want the earth to open. Because I’ve kept going, meeting the same people, you build your confidence. I know how to fight certain things. I speak up and make my point to the consultants with my rationale and I’m not scared to do so.”*

(Sister 2A)

*“I think the consultants appreciate the fact that they know I am around pretty much through the working week, so when there is an issue they don’t faff around on the ward wondering who to speak to, they just come and see me, and there is quite a big difference to the working relationships I think as well between the nurses and the doctors. It just generally feels more comfortable. I think it’s safer.”*

(Sister 4A)

It is clear from the analysis of the interviews that the nursing hierarchical structures play a significant part in the implementation and success of changes to nursing models. The ward sisters all articulated the pivotal relationship with the matron and how this influenced the ward sisters’ ability to adopt the new change and to communicate across the wider nursing structure. It was unusual for the ward sisters to talk directly to their unit heads of nursing or any of the senior managerial team within a division and described an expectation that they would go to their matron first. Included within this hierarchy were medical colleagues, and it was evident that there was a marked change in the interface of these relationships as the ward sister role changed.

### 4.3.3.3 Patient and family relationships

During the pre-supervisory interviews, the ward sisters talked about difficulties in finding time in their working days not only to talk to all of the patients on their ward but to meet with families to discuss patient treatment plans and discharge planning arrangements. All of the ward sisters described staying late to meet with families or relying on other members of the team to convey messages. The ward sisters described often only knowing their own patients for whom they had primary responsibility and relying on their team to update on other patients in their ward at handover meetings. This meant when relatives or senior managers called and asked to speak with the ward sisters about a patient they would frequently know very little and have to search documentation or call on the nurse assigned to the patient on that specific shift. The ward sisters described feeling constantly rushed and unable to spend time and detail on each patient in particular if they needed to engage with other care providers outside of their ward about a patient’s forward plan.

*“Before we became supervisory it was really difficult to fit time in to talk to patients or their families, it had to be late after visiting usually when the ward was quieter but you were always worried about leaving the ward and not having very much time.”*

(Sister 4B)

*“It is embarrassing when someone calls and asks about Mrs Smith and you’re the ward sister and you have to say ‘I’ll find out and call you back’, or sometimes there is a manager wanting to know a very specific question if it is a concern that has been raised for example, it’s impossible to know all the patients.”*

(Sister 2B)

*“Sometimes when a complaint comes through you wish the family had spoken to you at the time, but you can see why they wouldn’t have done so, as you would always be rushing around or not easily available*.”

(Sister 3B)

In the post-supervisory interviews, all of the ward sisters described a change in the way they worked with patients and families. When able to work in a supervisory capacity the ward sisters described restructuring their days to ensure patients’ and family’s discussions were central.

*“Before we went supervisory I think I said I would be here until 10 or 11pm most nights trying to get through e-mails, attend to any problems, pick up any concerns from patients and families - that kind of thing. It’s much better now, tenfold. I do still have to stay late some days but nothing like it was. I try and come in a little bit earlier now and then set out my day and it’s much better. Everybody’s work life balance is a bit better on the ward and I feel more structured with the patients.”*

(Sister 4A)

*“I plan my days now when I know I am supervisory. I have a balance. I fit in the ward rounds and any key meetings about patients with staff or families. I plan time to catch up on incidents and paperwork and I make sure I have time on the ward talking to staff and helping them, talking to all the patients on my ward, doing some teaching. The staff really like it. I tell them what I will be doing and when I am about etc.”*

(Sister 3A)

*“My patients like me coming around and chatting. The nurses were a bit unsure at first like I was checking up on them but they are more used to it now. The patients make a joke, ‘here comes the boss’ that kind of thing. I think they feel more confident in us as a team.”*

(Sister 4A)

Two of the ward sisters felt this change had had a significant impact on complaints in the ward. Whilst this was not supported in a significant change in nursing quality indicators over the time period, a greater understanding of which is provided in the discussion chapter, the ward sisters felt they had been able to address issues in a timelier way, which in turn prevented problems from becoming insurmountable for patients. This was also true of their interactions with family members. The ward sisters felt that the families became more positive in discussions as they got to know who the sister was and that she was available to talk through their concerns.

*“I can nip problems in the bud. I pop in and out of different areas and chat to families and see if there is anything I can do. It works really well patients and families like it very much and it helps the staff who are busy.”*

(Sister 2A)

*“I am certain my complaints are less over the last 6 months. I’ve been able to sort things out with patients when they are still with us; for example, lots of our complaints are about communication and discharge planning. I’m able to meet with the patient and their family and make sure they know what treatment plans are about and engage the families in the discharge process.”*

(Sister 5A)

*“You would suddenly realise when trying to discharge a patient under pressure that no one had updated the nursing home or altered the discharge package, sometimes they would be going out the ward literally and you’d be trying to ring people, it is so much better when I have time to talk and plan, the discharge goes smoothly everyone is happier”*

(Sister 3A)

*“Sometimes the families are still not happy with what you are telling them such as the patient has to be discharged to another place of care, but they are able to understand, you are able to explain we have to keep moving patients to the right place so that we can keep bringing in new patients. That’s hard for families. It comes easier if the sister sits down with the doctor and explains.”*

(Sister 4A)

The critical role of the ward sister in both patient and family relationships was a key focus of discussion in both interview periods. In particular being able to communicate in a timely way with patients and their families in relation to all aspects of the hospital admission and plans for discharge. It was very clear to see the struggles the ward sister has when not supervisory and the marked change when she is able to find designated time to undertake this pivotal part of an individual’s treatment pathway.

### 4.3.4 Relationship between supervisory role and quality of care

Whilst the quantitative component of this study examines the relationship between the ward sister’s ability to practice in a supervisory capacity alongside a pre-determined set of nursing quality indicators, and is examined in detail within chapter 5, the role of nursing quality indicators was discussed at both interview junctures.

During the pre-supervisory interviews, the ward sisters described the process of completing the required nursing quality indicators monthly by selecting a group of patients and completing the relevant returns within the quality assurance framework. Sometimes the ward sisters described completing this themselves and at other times delegating this to which ever nurse had capacity to collect the patient data. The ward sisters in general saw this as a task to be completed monthly without any significant ownership or discussion with the wider nursing teams. None of the ward sisters felt concerned about any key aspects of their nursing quality indicators and were unable to identify specific examples of where the indicators were routinely discussed in detail with the ward teams. The response in the pre-supervisory interviews, largely focussed on ensuring ‘they’ were completed for matron.

As can be seen in chapter 5, there was little evidence of change within the nursing quality indicators over the data monitoring period; however, the post-supervisory interviews indicated that the ward sisters perceived a positive change to nursing quality indicators as a result of the ward sister having supervisory time to oversee, monitor and act upon quality indicators. Some ward sisters described specific examples of improvement in areas:

*“Our ward documentation has changed massively in the last 12 months in care planning and pressure ulcer monitoring. From the previous template we had, we found bits missing when it came to daily documentation. We had a massive drive on that. We had an away day to tackle the problem.”*

(Sister 5A)

“*You notice the change quite significantly if you are not supervisory. I had two weeks leave and my supervisory time was not covered. When I got back there were a number of metrics that had slipped - it was obvious. I’m not saying nobody was doing it, but it is one of the things that gets missed when the sister is not there overseeing, highlighting etc.”*

(Sister 1A)

*“We had a difficult time with patient complaints. I was not supervisory at the time. It was around the time we had a change in the electronic patient record again. Once we settled and I was 100% supervisory we got on top of the complaints again.”*

(Sister 6A)

All of the ward sisters went on to describe a marked change in ownership of the indicators as a team and how they were a much more meaningful part of the ward processes. They described being able to increase understanding within their staff of what the indicators were for, how they were collecting and reporting data and how it impacted on practice and improvements to patient care.

*“The band 6 nurses now have greater ownership of the nursing metrics. They will follow up an individual area if there has been a problem, like a focus for a teaching session that kind of thing.”*

(Sister 1A)

*“Even with a small increase in supervisory time you see a greater focus on the metrics*.”

(Sister 3A)

*“All of the band 6 nurses are involved in making sure everyone understands what our metrics are saying, what we do with them. It isn’t just me gathering all the data and then feeding it back. It’s much more owned by the team now.”*

(Sister 4A)

A further area described by the sisters was a feeling of being trusted in their area from matrons and the senior nursing team as a result of greater ownership of the nursing quality indicators.

*“I had a period where I was 100% supervisory. For the period we were better staffed and it worked beautifully. It was really nice. I had a good handle on what was going on, my quality indicators were all good. Both of my matrons felt there was nothing to worry about on my ward which was really nice and reassuring.”*

(Sister 4A)

One ward sister summed up the impact she felt supervisory status had on patient care, her ward performance, and how through greater opportunities to invest in and develop her staff she was seeing greater retention of the team.

*“Look at the numbers on my ward back then and now, the nursing metrics, how we are implementing initiatives, how well we are doing. We have got a few vacancies but my band 5 nurses are now staying a bit longer. We can offer study days. The mandatory compliance is better and empowering the nurses coming behind us is better, so for me you can utterly be the voice for your ward being supervisory and protecting and empowering at the same time is the only way.”* (Sister 5A)

Significant within this theme was a perceived marked change in nursing quality indicators relating to pre-and post-implementation of supervisory status by the ward sisters. This related to both a change in awareness and value amongst staff as well as perceived actual improvements within the range of nursing quality indicators.

### 4.4 Summary

Chapter four has provided an overview of the findings from the interviews, these demonstrated that there were many similarities, and some differences, between the ward sisters’ experiences pre-and post the introduction of supervisory status. Similarities were identified in the lack of preparation for the transition of a staff nurses or junior sister into the senior sister role, and how as a result of this each of the ward sisters had worked out their own unique approaches to managing the role on a day to day basis. This meant that for all of the ward sisters in the case study, the implementation of a change to their role in the form of supervisory status was met with a degree of apprehension as to how this would work in practice.

Prior to the introduction of supervisory status, all of the ward sisters described similar experiences relating to competing demands, loss of control and feelings of disempowerment in their work. Throughout the post supervisory interviews, the ward sisters described similar feelings of becoming empowered and how this had benefited their ward teams, patients and relatives as well as their own personal development. Differences existed within unique relationships with medical staff and senior nursing staff and aspects of the ward sisters’ interpretation of the role which illuminated the wider aspects of introducing such a change in practice model for a professional group.

Alongside the analysis of the qualitative data, chapter 5 will provide analysis of the quantitative data pertaining to nursing quality indicators over the study period.

The four themes – Feeling (un)prepared for the role, moving from disempowerment to empowerment, perceptions and relationships and relationship of supervisory role and quality of care have been described. Throughout the process of data analysis, the themes and categories were developed in the ways described in chapter 3. The literature was utilised as a way of reflecting on the findings and considering the relevance of previous research on the context of the role of the ward sister before and after the introduction of supervisory status.

The quantitative findings in chapter 5 will now be considered, alongside the qualitative aspects of this area from the interviews.

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# CHAPTER 5

# Quantitative Findings

### 5.0 Introduction

Chapter 3 introduced the national quality indicators that can be used to measure the performance of NHS wards (Department of Health, 2008). It went on to explain that the RCN set priorities for the development of these indicators which focussed on a number of key areas of care delivery. It also examined how these areas may be used as surrogates for quality, as set out in the NHS outcomes framework allowing a comparison to be made between the care delivered to patients in a wide variety of settings.

### 5.1 Nursing quality indicators

Within such a broad background, for the purposes of this research, the thirteen nursing quality indicators set out below, that were in use within the researcher’s hospital setting at the time of the research study were measured over time for the duration of the research period.

Table 5.1 Summary of Nursing Quality Indicators.

|  |
| --- |
| Harm Free Care / New Harms |
| Friends and Family Test (FFT) |
| Inpatient falls |
| Inpatient Falls with Harm |
| Medicines Administration Errors |
| Pressure Ulcers (Two Categories) |
| Vital Signs |
| Intentional Rounding Compliance |
| Discharges before 12.00 noon |
| Nutrition risk assessment completed |
| Complaints nursing care |

A supporting explanation of what each indicator involves and how this is collected by the nursing teams is set out below. The first three indicators (harm free care, new harms and the Friends and Family Test) are submitted externally to the organisation as part of a national data set of quality indicators. The remaining ten are reported internally only within the organisation.

### 5.1.1 Harm free care / new harms

This quality indicator was introduced into the NHS in 2012. The indicator has two components: an old harm and a new harm. An ‘old’ harm is defined as being a harm that was present when the patient was admitted to the ward or developed within 72 hours of admission. A ‘new’ harm is defined as being a harm that developed 72 hours or more after the patient was admitted.

The quality indicator is described as a snapshot measure of four common patient harms within each of the two categories of the quality indicator and includes falls, pressure ulcers, urinary tract infections and venous thromboembolism (VTE). It is a snapshot of all patients being treated in NHS care on a predetermined day during each calendar month. This information is gathered using a survey tool known as the NHS Safety Thermometer (DH, 2012). Information gathered is submitted to the NHS Information Centre directly from the Safety Thermometer Tool; data is then analysed and aggregated to give whole organisation, regional and national data. The data provided allows the organisation to understand its areas of strength and weakness in relation to these indicators. This can be examined at individual ward level as an aggregate score and can be used in benchmarking the organisational performance in comparison to other NHS hospitals.

Nursing staff collect data from two key sources: one by physically examining each patient and the other from the patients’ medical and nursing records.

### 5.1.2 Friends and family test (FFT)

The Friends and Family Test (FFT) was introduced into the NHS in 2013, and forms part of patient experience data that is collected for all NHS funded services in England. When a patient is due for discharge from the ward area, a member of the ward team invites the patient to complete a survey question asking the patient if they would recommend the services they have used and offers a range of responses. When combined with additional follow-up questions, the FFT provides an opportunity to identify both good and poor patient experience. The data is reported to an NHS England managed data collection system known as UNIFY2. Feedback gathered through the FFT is reported back to the individual ward area, enabling local action on areas for improvement. It is also published monthly on both NHS England and NHS Choices websites as public documents.

The national safety thermometer and the FFT look at aggregate scores across monthly data sets in the ward areas; in addition to this, the remaining ten indicators are a more detailed local analysis of quality indicators within each ward setting. At the time of the study, five patients per week were selected by the ward sister and the medical and nursing records were used to gather information to inform the quality indicator.

### 5.1.3 Inpatient falls / Inpatient falls with harm

Public Health England define a fall as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard (PHE, 2017). This nursing quality indicator captures the number of falls the patient has experienced in two categories, one being a fall without harm and the second any fall which has led to harm. Harm is defined from a standard set of definitions set out by the national reporting and learning sets (Department of Health, 2001b). Falls are recorded and reported via the organisational safety learning reporting system and are collated centrally.

### 5.1.4 Medicines administration errors

In relation to medication administration errors, the specific area examined is the number of errors reported on the organisational adverse incident monitoring system (QSIS). Medication administration errors can occur at a number of points, and include the prescribing, dispensing and administering phases of the process. When an adverse event occurs, the individual practitioner would complete a safety incident report, which would be noted in the patient record. For the purpose of the quality indicator measurement this would be identified in the review of the patient’s notes.

### 5.1.5 Pressure ulcers (two categories)

The definition of a pressure ulcer is localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. This quality indicator examines the presence of either Grade one pressure ulcer defined as **‘**Intact skin with non-blanchable redness of a localised area usually over a bony prominence’; or Grade two, defined by ‘partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough’. Data relating to this indicator would be extracted from the nursing records.

### 5.1.6 Vital signs

This indicator examines the clinical records for evidence of the national early warning score (NEWS) which is calculated from clinical observations of the patient. Presence of the NEWS score provides evidence of the ability to identify early warning of deterioration in the clinical condition of the patients.

### 5.1.7 Intentional rounding compliance

Intentional rounding was formalised in the UK in 2011, in the Prime Minister’s Recommendations for Care following the increased reporting of failings in care across the NHS. It builds on the American model of care rounds and involves nursing staff undertaking and recording proactive rounding to assess four key areas of patient care, known as the four Ps and including:

* Positioning: Making sure the patient is comfortable and assessing the risk of pressure ulcers.
* Personal needs: Scheduling patient trips to the bathroom to avoid risk of falls.
* Pain: Asking patients to describe their pain level on a scale of 0 – 10.
* Placement: Making sure patients can reach items they may require.

For the purpose of the quality indicator assessment, a recording of at least one of the components within each category on ten occasions in a calendar day comprises an inpatient day with intentional nurse rounding.

#### 5.1.8 Discharges before 12.00 noon

The critical aspect of delays in the discharge of hospital patients leads to considerable backlog and impact of flow within the hospital setting, in particular overcrowding and delays within emergency departments, and cancellation of elective procedures due to lack of available inpatient beds. This quality indicator serves to identify the percentage of patients successfully discharged in an appropriate timely way before midday. Each ward area has an individualised number of discharges which should occur before midday and this is calculated within the quality indicator.

### 5.1.9 Nutrition risk assessment completed

Similar to the assessment of pressure ulcer risk to patients. This indicator examines the percentage of patients who have been in hospital for more than 24hrs who have a completed nutritional assessment recorded and a nutrition score documented. This assessment involves recording the patient’s weight and any loss, body mass index, appetite and ability to eat and drink, state of hydration and other stress factors which may impact on nutritional status.

### 5.1.10 Complaints about nursing care

Patient complaints serve as a source of valuable patient information; for the purpose of this quality indicator the complaints are those received centrally via the hospital patient advisory liaison service. These are reported to the ward area on a monthly basis.

The remainder of this chapter presents the findings of the nursing quality indicators observed during the study period. Data were accessed through an electronic recording system for each of the ward settings and was analysed by observing ward performance in relation to each indicator for each month of the study period alongside the supervisory status of the ward sister.

Data analysis was undertaken employing the analysis of covariance (ANCOVA) statistical method. This allowed a comparison of the relations between each individual quality indicator and supervisory time, as well as the differences between ward and month*.* The nursing quality indicators were utilised to address the second research question:

* What is the impact of this change on quality of care?

### 5.2 Data collection

Data is routinely gathered from all wards of the researcher’s hospital via the central nursing office as part of the regular monthly monitoring of ward quality indicators performed within the organisation. Individual ward sisters and matrons are responsible for ensuring the collection and submission of data overseen by a unit head of nursing. Data from the case study wards were selected for analysis and accessed through an electronic recording system for each of the ward settings. Ward performance was analysed before supervisory status was in place, and throughout the year that supervisory status was introduced.

Organisational logistics meant that it was not possible to introduce supervisory status across all ward areas on the first day of the study period since in order to have achieved this, it would have been necessary for all ward areas to have a nursing team running at full establishment levels, enabling the ward sister to act in a fully supernumerary, and therefore supervisory capacity. At the beginning of the study, all wards in the organisation including those in the study were carrying varying levels of vacancies and throughout the period of study, on-going recruitment permitted the ward sisters to move towards a supernumerary position in varying degrees as described in Chapter 3. The five wards where in depth case-studies were performed with the ward sister, encountered these same issues. Two additional sets of data were included in the quantitative analysis, which represented the ward used for the pilot case study, and a reserve ward for use if one of the case-study ward sisters was unable to complete the second interview for any reason. No additional specific data analysis was required for the purpose of the research study as the data is collected and analysed monthly as part of the established quality assurance programme in the researcher’s organisational setting.

### 5.3 Supervisory time

Each ward sister’s supervisory time was collected via the electronic rostering system in place in all ward areas. The information collected defined the amount of time ward sisters spent in a supervisory capacity across the period of data collection. As described in chapter 3, each ward sister at the beginning of the study had limited supervisory time with the majority of clinical hours spent on direct patient care. In the first instance, it is presented for each ward sister across the study period (Figures 5.1 - 5.7). As can be seen there is considerable variation in the amount of time that each sister was able to spend in a full supernumerary and supervisory capacity. On-going staff recruitment and retention issues affected the staffing establishment levels on each of the study wards during the study period and as a result none of the ward sisters were able to consistently spend 100% of their time in a supervisory capacity which meant the ward sisters were frequently required to deliver direct clinical care.

For each of the following graphs, the amount of time spent in a supervisory capacity is expressed as a percentage of the sister’s full time working hours. The ward sister spent additional time as overtime working which drove the supervisory time over 100% on a number of occasions throughout the period.

Figure 5.1: Time spent in a supervisory capacity by ward sister, Unit 1.

This graph shows the amount of time that the ward sister on Unit 1 was able to spend in a supervisory capacity throughout the study period. It demonstrates the variation in supervisory capacity across the study period caused by fluctuations in staff levels on Unit 1 such that the sister was required to provide direct clinical care rather than remaining in a supervisory role. The 4 months from February 2016 to May 2016 were particularly poor with 60% or less of the sister’s time in a supervisory role. There was a sharp rise in supervisory capacity in June 2016 with an uplift in staffing levels but throughout the rest of the study period it was not possible to maintain this level of supervisory time, with significant fluctuations month on month, and overall a gentle trend downwards was observed over the rest of the study period, with three months falling to the level seen before introduction of the supervisory role.

Figure 5.2: Time spent in a supervisory capacity by ward sister, Unit 2.

This graph shows the amount of time that the ward sister on Unit 2 was able to spend in a supervisory capacity throughout the study period. The first 5 months from January 2016 to May 2016 were particularly favourable with an increase from 50% of the sister’s time spent in a supervisory capacity rising to a maximum of around 85% of her time. However, she was unable to spend all of her time (100%) in a supervisory role at any stage during the study, and indeed there was a sharp drop from June to August in her capacity to be supervisory. Although there was some recovery in September to around 70% of her time supervisory, there was a steady decline thereafter falling to a lower level than at the start of the study period by March 2017.

Figure 5.3: Time spent in a supervisory capacity by ward sister, Unit 3.

This graph shows the amount of time that the ward sister on Unit 3 was able to spend in a supervisory capacity throughout the study period. Following introduction of the role in January 2016 the sister was able to spend all of her time (100%) in a supervisory role in February 2016. This fell dramatically in March 2016 due to staffing levels falling but rallied and for the time from April 2016 to January 2017 the sister was able to spend consistently between 60% and 80% of her time in a supervisory role. Staff sickness in February caused this to fall again before recovering to 80% again in March 2017.

Figure 5.4: Time spent in a supervisory capacity by ward sister, Unit 4.

This graph shows the amount of time that the ward sister on Unit 4 was able to spend in a supervisory capacity throughout the study period. During the first half of the study from January 2016 to July 2016 there was little improvement in the time that the ward sister was able to spend in a supervisory role due to the challenges of staffing levels in the organisation. However, during the second half of the study period there was some consolidation of the position and it was possible for the sister to spend progressively more time in a supervisory role increasing from around 60% in July/August to 90% or more of her time supervisory in November 2016, January 2017 and march 2017. There was only one month (January 2017) when it was possible for the sister to spend all of her time in a supervisory role.

Figure 5.5: Time spent in a supervisory capacity by ward sister, Unit 5.

This graph shows the amount of time that the ward sister on Unit 5 was able to spend in a supervisory capacity throughout the study period. The situation was particularly poor for the first three months of the study period levels falling to less than 40% of the sister’s time in a supervisory role. Subsequently there was some improvement and throughout May 2016 to September 2016 and again November 2016 to January 2017 the sister was able to be supervisory for around 70% or more of her time. However, at no stage was she able to spend 100% of her time in a supervisory role. With the return of winter staffing pressures in February 2017 she had to return to a more direct clinical care role with supervisory status occupying less than 40% of her working time.

Figure 5.6: Time spent in a supervisory capacity by ward sister, Unit 6.

This graph shows the amount of time that the ward sister on Unit 6 was able to spend in a supervisory capacity throughout the study period. It is somewhat different from the previous units in that there was an increase in the supervisory time after the introduction of the programme with a consistently sustained improvement in the amount of supervisory time throughout most of the study period. The only fall was seen in January and February 2017 with a return to in excess of 80% of the sister’s time being supervisory in March 2017. Despite the consistent increase in supervisory time it was not possible for the sister to spend all of her time in this role at any stage through the study period.

Figure 5.7: Time spent in a supervisory capacity by ward sister, Unit 7.

This graph shows the amount of time that the ward sister on Unit 7 was able to spend in a supervisory capacity throughout the study period. After the introduction of the supervisory role in January 2016 there was some increase in the supervisory time by this sister. However, she started at a high level with around 80% of her time supervisory at the beginning of the programme and was able to spend nearly all of her time in a supervisory capacity for 5 months of the study period. However, there was a sharp fall from August 2016, and in one month (October 2016) it was not possible for her to spend any time in a supervisory capacity.

Although it is possible to observe the individual circumstances relating to ward performance against ward sister’s supervisory time, in order to observe the hospital as a single case study as defined in the research methodology, the data were aggregated and presented as a mean time for the supervisory status for all sisters over the period of the study against each of the variables recorded. The supervisory time for the seven ward sisters is shown combined in Figure 5.9.

Figure 5.8: Time spent in a supervisory capacity by each ward sister, with a linear average trend line drawn in red: this reflects a small increase in average supervisory hours over the study period.

A linear average trend line (red) demonstrates the change in mean supervisory time across the units from the start of the study period. There is little change in the mean aggregated supervisory time across the study period which rises from 63% of the sisters’ time in a supervisory role at the introduction of the programme, to 68% of the sisters’ time at the close of the study period. It is disappointing that despite commitment from the organisation to the ward sister’s supervisory role local staffing condition meant that it was not possible to realise the full anticipated benefits following the introduction of the programme, this is a theme that is referred to by the sisters in their interviews and is discussed in detail in Chapter 6.

### 5.4 Quality indicators

For the purposes of the statistical analysis the indicators may be divided into two different sorts of variable: Five indicators may be regarded as categorical variables, that is that they have values that describe a quality or characteristic of a data unit, like 'what type' or 'which category'. Categorical variables fall into mutually exclusive (in one category or in another) and exhaustive (include all possible options) categories. Therefore, categorical variables are qualitative variables and tend to be represented by a non-numeric value for the purposes of the statistical test. The indicators that may be viewed in this way are: Patient falls with harm, medicine administration errors, pressure ulcers grade ≥1 (hospital acquired), pressure ulcers grade ≥2 (avoidable), and complaints (nursing care). For these variables aggregated mean values for each event are analysed.

The remaining indicators are simple, or non-categorical variables; that is, they have values that describe a measurable quantity as a number, like 'how many' or 'how much'. Therefore, numeric variables are quantitative variables. For these indicators, a positive recording is represented as a percentage of the total care delivered within one month. Since for most of the non-categorical variables the data is not normally distributed, they are presented as median values with Inter Quartile Range (IQR). The median value represents the centre data point in a range, whereas the mean does not. If the mean value had been presented this would have likely led to a bias in the outcome measurement.

For each of the identified key quality indicators the data collected described the number of events per month across the ward areas for the categorical variables, or the percentage of events achieved against the maximum potential for the non-categorical variables.

A comparison is then made between the aggregated mean time the ward sister spends in a supervisory capacity and the aggregated mean value for each variable month by month (Figures 5.9 – 5.21).

In order to permit statistical analysis of the data collected the one-way ANCOVA (Analysis of Co-Variance) method was chosen. This analyses the mean difference between time points (months) on an indicator (such as harm free care) adjusted for the amount of time spent in a supervisory capacity. This makes the assumption that the data generated for each ward are independent from February 2016 to February 2017. Analysis was performed using IBM SPSS Statistics software, version 2015 (SPSS).

### 5.5 Results

Results are presented as descriptive tables together with a statistical analysis of the data performed using the one-way ANCOVA method. A summary table of the descriptive statistics across the study period is presented in Appendix 5.

### 5.5.1 Descriptive tables

Figures 5.9 – 5.21 show comparisons between aggregated mean supervisory time (%) for the sisters and each of the13 variables by their aggregated mean values from Feb 2016 to Feb 2017:

**Figure 5.9:** Mean proportion of harm free care (blue bars) compared to the mean supervisory time for the ward sisters (red bars). (Note that each error bar in the figure is constructed using 1 standard error from the mean).



Figure 5.9 shows a comparison between harm free care (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. Both are expressed as a proportion of the total (i.e. on the *y-*axis 1.0 represents *all* care harm free or *all* of the sister’s time spent in a supervisory role). The amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period and in months 9, 11 and 13 of the study period high levels of staff vacancy resulted in a fall in mean supervisory time for the ward sisters. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity. The level of harm free care is high across the entire study period and the quantitative analysis fails to demonstrate any direct correlation between the amount of supervisory time and harm free care delivered on the study wards.

**Figure 5.10:** Mean number ofnew harms occurring each month (blue bars) compared to the mean supervisory time for the ward sisters (red bars).



Figure 5.10 shows a comparison between new patient harm (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. Both are expressed as a proportion of the total (i.e. on the *y-*axis 1.0 represents *all* care resulted in harm, or *all* of the sister’s time is spent in a supervisory role). As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of new harm is low across the entire study period and the quantitative analysis fails to demonstrate any direct correlation between the amount of supervisory time and the level of new harm on the study wards.

**Figure 5.11:** Mean number of inpatient falls (incidents reported) (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.11 shows a comparison between the mean number of patient falls month by month (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: i.e. on the *y-*axis the number of falls is shown between 0 and 6, while1.0 represents *all* of the sister’s time is spent in a supervisory role. As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of new inpatient falls is low across the entire study period and the quantitative analysis fails to demonstrate any consistent direct correlation between the amount of supervisory time and the level of falls on the study wards.

**Figure 5.12:** Mean number of inpatient falls (with harm) per month (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.12 shows a comparison between the mean number of patient falls resulting in new harm month by month (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. As with the previous figure the two factors share a common axis: i.e. on the *y-*axis the number of falls resulting in new harm is shown between 0 and 2, while 1.0 represents *all* of the sister’s time is spent in a supervisory role. As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of in patient falls resulting in new harm is low across the entire study period and the quantitative analysis fails to demonstrate any consistent direct correlation between the amount of supervisory time and the level of falls on the study wards.

**Figure 5.13:** Mean number of medicines administration errors per month (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.13 shows a comparison between the mean number of medication errors month by month (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: i.e. on the *y-*axis the number of medication errors is shown between 0 and 3.5, while 1.0 represents *all* of the sister’s time spent in a supervisory role. As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The number of medication errors does not demonstrate any consistent direct correlation with the amount of supervisory time.

**Figure 5.14:** Mean number of pressure ulcers (grade =>1) (hospital acquired) per month (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.14 shows a comparison between the mean number of pressure ulcers (Grade ≥1) occurring each month (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: i.e. on the *y-*axis the mean number of pressure ulcers occurring across the wards is shown between 0 and 1.0, the amount of the sister’s time spent in a supervisory role is shown between 0 and 1.0 where 1.0 represents *all* of the sister’s time in a supervisory capacity. As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of pressure ulcers is relatively consistent across the entire study period and the quantitative analysis fails to demonstrate any direct correlation with the amount of supervisory time.

**Figure 5.15:** Mean number of pressure ulcers pressure ulcers (grade =>2) (avoidable) per month (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.15 shows a comparison between the mean number of pressure ulcers (Grade ≥2) occurring each month (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: i.e. on the *y-*axis the mean number of pressure ulcers occurring across the wards is shown between 0 and 1.0, the amount of the sister’s time spent in a supervisory role is shown between 0 and 1.0 where 1.0 represents *all* of the sister’s time in a supervisory capacity. As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The absolute number of new pressure ulcers ≥2 is very small across the entire study period and the quantitative analysis did not demonstrate any direct correlation with the amount of supervisory time.

**Figure 5.16:** Mean proportion of vital signs observations completed per month displayed as a percentage of the total possible number of scheduled observations (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.16 shows a comparison between the mean number of vital signs observations completed each month as a percentage of the total possible number of vital signs observations (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: Both are expressed as a proportion of the total (i.e. on the *y-*axis 1.0 represents *all* vital signs observations completed, or *all* of the sister’s time is spent in a supervisory role). As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of observations completed is consistently high across the entire study period and the quantitative analysis fails to demonstrate any direct correlation with the amount of ward sister supervisory time.

**Figure 5.17:** Mean proportion of Intentional rounding completed monthly displayed as a percentage of the total possible number of scheduled rounds (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.17 shows a comparison between the proportion of intentional rounds completed each month as a percentage of the total possible (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: Both are expressed as a proportion of the total (i.e. on the *y-*axis 1.0 represents *all* potential intentional rounds completed, or *all* of the sister’s time is spent in a supervisory role). As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of intentional rounding is consistently high across the entire study period and the quantitative analysis fails to demonstrate any direct correlation with the amount of ward sister supervisory time.

**Figure 5.18:** Mean proportion of discharges completed before 12:00 noon displayed as a percentage of total possible number of discharges completed before 12:00 noon (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.18 shows a comparison between the mean number of discharges completed before 12 noon each month as a percentage of the total possible number of discharges before 12 noon (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: Both are expressed as a proportion of the total (i.e. on the *y-*axis 1.0 represents *all* potential discharges, or *all* of the sister’s time is spent in a supervisory role). As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of discharges completed is low across the study period and the quantitative analysis fails to demonstrate any direct correlation with the amount of ward sister supervisory time.

**Figure 5.19:** Mean proportion of nutrition risk assessments completed displayed as a percentage of total possible number of nutrition risk assessments (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.19 shows a comparison between the mean number of nutritional risk assessments completed within 24 hours each month as a percentage of the total possible number of risk assessments (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: Both are expressed as a proportion of the total (i.e. on the *y-*axis 1.0 represents *all* possible nutritional risk assessments, or *all* of the sister’s time is spent in a supervisory role). As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of nutritional risk assessments completed is relatively consistent across the entire study period and the quantitative analysis fails to demonstrate any direct correlation with the amount of ward sister supervisory time.

**Figure 5.20:** Mean number of complaints (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.20 shows a comparison between the mean number of complaints occurring each month (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: i.e. on the *y-*axis the mean absolute number of complaints is shown between 0 and 1.0, and the proportion of the sister’s time spent in a supervisory role is shown between 0 and 1.0 where 1.0 represents *all* of the sister’s time in a supervisory capacity. As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The level of complaints fluctuates across the study period and is a relatively small absolute number; the quantitative analysis fails to demonstrate any direct correlation with the amount of supervisory time.

**Figure 5.21:** Mean proportion of positive friends and family test responses displayed as a percentage of total possible number of positive responses (blue bars) compared to the mean amount of supervisory time for the ward sisters (red bars).



Figure 5.21 shows the results for the friends and family test. It compares the proportion of positive recommendations from all questionnaires returned each month (blue bars) and the mean time ward sisters spent in a supervisory role (red bars) over the study period. They share a common axis: i.e. on the *y-*axis the proportion of positive recommendations is shown between 0 and 1.0, and the amount of the sister’s time spent in a supervisory role is shown between 0 and 1.0 where 1.0 represents either *all* recommendations positive or, *all* of the sister’s time in a supervisory capacity. As before the amount of time spent in a supervisory role varies due to the number of staff vacancies on each ward over the period. Supervisory time is expressed as a mean for the wards studied and at no stage during the study period were all ward sisters able to spend 100% of their time in a supervisory capacity as described elsewhere in this chapter. The proportion of positive recommendations is very high across the study period and the quantitative analysis fails to demonstrate any direct correlation with the amount of supervisory time.

### 5.5.2 The ANCOVA analysis

The ANCOVA (Analysis of Co Variance) method is used to observe if the different months (assuming that they are unrelated) had different effects on the indicators adjusted by supervisory time (%) with two examples shown below. This method allows the relations between each variable and supervisory time to be analysed and identifies the differences between the wards and month. The number of wards contributing data is seven and therefore in terms of analysis only small, and it is for this reason that descriptive statistics have been used. The results showed that there was no significant difference in the harm free care indicator between the 13 months when adjusted for supervisory time (%) (p>0.05). A similar result was found for the inpatient falls indicator.

The results of the Tests of Between-Subject Effects were performed for harm free care and inpatient falls and are shown in the following tables with a comment on outcome:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | |
| Table 5.2: Dependent variable: harm free care | | | | | | |
| Source | Type III Sum of Squares | df | Mean Square | F | Sig. |
| Corrected Model | .023a | 13 | .002 | .773 | .685 |
| Intercept | 3.857 | 1 | 3.857 | 1712.056 | .000 |
| Months | .023 | 12 | .002 | .833 | .617 |
| Supervisory time for sister/ charge-nurse | 8.184E-005 | 1 | 8.184E-005 | .036 | .849 |
| Error | .137 | 61 | .002 |  |  |
| Total | 69.585 | 75 |  |  |  |
| Corrected Total | .160 | 74 |  |  |  |
| 1. R Squared = .141 (Adjusted R Squared = -.042)   The above table shows that there was no overall statistically significant difference in harm free care between the time points (13 months) adjusted for supervisory time (p=0.617). It has been assumed that the observed data are independent. | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Table 5.3: Dependent variable: inpatient falls (incidents reported) | | | | | | |
| Source | Type III Sum of Squares | df | Mean Square | F | Sig. |
| Corrected Model | 95.058a | 13 | 7.312 | .786 | .673 |
| Intercept | 28.528 | 1 | 28.528 | 3.066 | .084 |
| Month\_code | 76.755 | 12 | 6.396 | .687 | .759 |
| Supervisory time for sister charge nurse | 13.519 | 1 | 13.519 | 1.453 | .232 |
| Error | 716.481 | 77 | 9.305 |  |  |
| Total | 1854.000 | 91 |  |  |  |
| Corrected Total | 811.538 | 90 |  |  |  |
| a. R Squared = .117 (Adjusted R Squared = -.032) b. Computed using alpha = .05 | | | | | | |
|  | | | | | | |

The above table shows that there was no overall statistically significant difference in inpatient falls (incidents reported) between the time points (months) adjusted for supervisory time (p=0.759). Again, it is assumed that the observed data are independent.

However, in examining the relationships between supervisory time (%) and each indicator at each month, it shows that for individual indicators there are some positive and some negative correlations with supervisory time on an individual month’s basis albeit at low statistical significance.

The strength and direction of the linear relationships between pairs of variables was tested using Spearman’s coefficient, since the variables (in this case supervisory time and each nursing indicator for each month) are not normally distributed.

For the majority of indicators there was no significant correlation between the amount of supervisory time and the outcome measured. Appendix 6 presents the full findings. However, 5 indicators showed some correlation in at least one month of the study period and these are summarised in the following tables: In each table ‘r’ is the correlation coefficient and this value can vary between -1.0 and +1.0. A negative result shows a negative correlation and a positive result a positive correlation. Although the P value does not achieve great significance it is at a level that allows rejection of the null hypothesis with α set at 0.05. When using the Spearman rank method, the correlation coefficient can be interpreted to show the association between the two variables tested. The strength of the association may be interpreted by the size of the correlation coefficient according to the following table:

**Table 5.4:** Spearman coefficient strength of association

|  |  |  |
| --- | --- | --- |
|  | Coefficient, *r* | |
| Strength of Association | Positive | Negative |
| Weak | .1 to .3 | -0.1 to -0.3 |
| Medium | .3 to .5 | -0.3 to -0.5 |
| Strong | .5 to 1.0 | -0.5 to -1.0 |

**Table 5.5:** Significant correlations for harm free care:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Supervisory time | | |
|  | March 2016 | April 2016 | November 2016 |
| Harm Free Care | r= -0.82,  **p=0.046** | r= -0.89,  **p=0.045** | r= 0.85,  **p=0.03** |

For harm free care in March and April 2016 (Month code 2 and 3 in the statistical analysis) there is a negative correlation between harm free care and supervisory time – that is there was less harm free care for the amount of supervisory time, and in November 2016 the opposite was true, with a greater proportion of harm free care associated with a greater proportion of supervisory time. The r value for each association is high and therefore the association is strong.

**Table 5.6:** Significant correlations for medicine administration errors.

|  |  |  |
| --- | --- | --- |
|  | Supervisory time | |
|  | April 2016 | Jan 2017 |
| Medicines administration errors | r= 0.87,  **p=0.01** | r= -0.92,  **p=0.004** |

Medicine administration errors had two significant correlations across the study period: In April 2016 (month code 3) the r value was high and positive demonstrating a positive correlation between the amount of supervisory time and reduced medicine administration errors across the wards, while in January 2017 the correlation was negative, that is the administration errors increased despite there being more supervisory time available.

**Table 5.7:** Significant correlations for discharges before 12 noon.

|  |  |  |
| --- | --- | --- |
|  | Supervisory time | |
|  | April 2016 | September 2016 |
| Discharges before 12:00 noon | r= 0.74,  **p=0.058** | r= 0.82,  **p=0.02** |

In April and September 2016 (month code 3 and 8) the r value is high and positive confirming that in these two months increased supervisory time is associated with an increased level of discharges achieved before noon.

**Table 5.8:** Significant correlations for nutrition risk assessment completed.

|  |  |  |
| --- | --- | --- |
|  | Supervisory time | |
|  | May 2016 | December 2016 |
| Nutrition risk assessment completed | r= -0.79,  **p=0.035** | r= 0.74,    **p=0.057** |

In May 2016 and December 2016 there was a significant association between the amount of nutrition risk assessments completed and the amount of ward sister supervisory time. The values were again at a level that suggests a strong association with a negative correlation in May and a positive correlation in December. i.e. more nutrition risk assessments were completed in December when there was greater supervisory time available, and fewer were completed when there was less supervisory time.

**Table 5.9:** Significant correlations for patient experience recommender

|  |  |
| --- | --- |
|  | Supervisory time |
|  | February 2016 |
| Patient Experience recommender | r= -0.79,  **p=0.035** |

There was only one month when the patient experience recommender showed any association with supervisory time. In February 2016, there was a single strong negative correlation.

### 5.6 Validity and Reliability of quantitative findings

Data collected across the study period after the introduction of the supervisory ward sister programme confirmed that there was some increase in the amount of supervisory time available to the sisters in the study wards. However overall the increase in supervisory time was not as great as had been hoped at the start of the programme due to continued difficulties maintaining staffing levels within the organisation.

Analysis of the quality indicators and direct comparison with the amount of supervisory time available failed to show any consistent significant correlation. Five indicators demonstrated some correlations at a low level of statistical significance in more than one month, but four of these presented conflicting outcomes with one month showing improved outcomes with increased supervisory time and another showing poorer outcomes with increased supervisory time. Additionally, the months that showed an association between supervisory time and outcome in one indicator did not necessarily show any association for the other indicators. Only one indicator (discharges before 12 noon) showed a positive correlation between the amount of supervisory time available, and improved outcome in two months of the study period

It is difficult to understand the reason for these conflicting results although several possible mechanisms are apparent. With increased supervisory time, it possible that the ward sister was able to improve reporting practices in her area, and thus avoid false under-reporting. This would produce a poorer outcome in the overall interpretation of some of the indicators. It is also possible that when the ward sister is involved in some areas of direct care (e.g. medicines administration) that her greater experience would lead to lower levels of errors, and that when she is in a supervisory capacity with tasks delegated to less experienced members of the team that the errors might increase.

Critical to understanding this inconsistency in findings, is understanding the validity, defined as the extent to which the indicators were accurately measured, and the reliability relating to the consistency of the nursing quality indicators (Lobiondo-Wood and Haber 2013)

The contrast in the reported perceived improvements in nursing quality indicators, reported by the ward sisters in the qualitative findings, compared with the quantitative findings described above, led to interrogation of the long-standing data collection methods within the ward setting and problems were identified in the data collection methods in place. Inconsistency in data collection was identified as well as in the level of level of expertise in the person collecting the data. For example, in some areas the data were collected by a senior member of the ward sister’s team, in others data were collected by health care support worker staff or administrative staff. Anderson and Lindgren (2008) emphasised the importance of both empirical data as well as the content validity being undertaken by experts who have undergone greater levels of training in relation to the importance of accurate data recording processes. Similarly, Maben et al (2012a) whilst recognising the advanced progress made in the use of nursing quality indicators and accountability systems such as clinical dashboards within hospital settings, identified a difficulty in achieving consistency and accurate data collection methods and recommend the development of more consistent infrastructures that will enable accurate data collection, analysis and timely reporting in order to provide accountability, transparency and service improvement.

Issues with the data quality of the nursing indicators were identified at the analysis stage of the research study, and whilst providing a marked contrast to the participant perceptions of improved quality, served as an important outcome to the study due to the significant relevance and clinical value of such widely used indicators across the NHS. This is discussed in further detail in the discussion chapter.

### 5.7 Summary in relation to the integrated findings

The relationship between the role of the ward sister and nursing quality indicators, was discussed within the review of nursing literature and the assumption was made that increased supervisory time would have a positive impact upon quality indicators across the inpatient hospital setting.

Analysis of the qualitative findings found this to be the case with all ward sisters reporting a perceived improvement in nursing quality indicators and ward performance. In addition to the perceived quality improvements, the ward sisters reported increased knowledge and awareness of the indicators across the clinical team and greater ownership of the importance and relevance of the indicators to patient care.

In sharp contrast to the qualitative findings the quantitative analysis failed to demonstrate any consistent significant correlation in relation to supervisory time throughout the study period and performance in relation to each individual nursing quality indicator. A few sporadic months demonstrated correlation between supervisory time and events reaching a low level of statistical significance but this does not represent clear evidence of the benefit of increased supervisory time. Indeed, in the ANCOVA analysis in some individual months there was a negative correlation between events and the available supervisory time.

As a result of these findings, a detailed examination of the way data was being collected in my organisation, and a coinciding transition to real-time data collection in the organisation, led to identification of flaws within the data collection method at the time of the study. These findings are discussed in Chapter 6. The limitations of the quantitative findings are discussed alongside the broader limitations of the study in Chapter 7.

The next chapter develops the discussion in relation to the key themes identified within this study, through the lens of empowerment theory and provides ‘thick description’ in relation to the effect of supervisory status on the ward sister role and its impact on patient outcomes.

**CHAPTER 6**

# Discussion

### 6.0 Introduction

Chapters 4 gave accounts of the findings that emerged from the descriptions of the experiences given by ward sisters following the introduction of supervisory status into their existing ward sister role as they also undertook a developmental programme. Chapter 5, set out the findings from the quantitative analysis of nursing quality indicators observed over the study period. Comparisons were made between the five participating ward sisters to inform the overall case within one NHS hospital. In addition to the findings of the research the literature review assisted in the development of the argument that is set out here in the discussion. In particular - a synthesis of the literature review led to a theoretical underpinning for the research in the context of empowerment theory.

According to Gadamer, “understanding is an event, a happening, in which both interpreter, text and text analogue, mutually determine one another. It is what happens during the research act” (Gadamer, 1989, p.319). Within the hermeneutic approach to understanding, data sources are the ward sisters’ stories merged with my interpretations and journal entries and combined with the extant literature in this area. These combined sources serve to achieve a ‘fusion of horizons’ – the crux of hermeneutic interpretation.

The discussion develops thick descriptions of these combined data sources and incorporates the four themes identified in the analysis of the ward sister interview, these being: Feeling (un) prepared for the role; moving from disempowerment to empowerment; perceptions and relationships; and, relationship of supervisory status on quality of care. Throughout the discussion the lens of empowerment theory is used as an underpinning theoretical orientation.

The focus of the research emerged from gaps identified in the extant literature on the relationship between the ward sister role and quality of patient care and the call for more studies of structural interventions that change leadership practices in this role (Gilmartin and D’Aunno, 2007). Examining the impact of such changes on the individuals, in terms of empowerment and the impact this may have on their role, their teams and quality of patient care, was an area recommended by the RCN research evaluating the ward sister supervisory role (RCN, 2015a).

The chapter is divided into two main sections, which respectively address the research questions:

Research Question 1: What is the lived experience of ward sisters who move from non- supervisory to supervisory status?

Research Question 2: What is the impact of supervisory role change on quality of patient care?

To understand the effects of supervisory status change to a ward sisters’ perceptions of their role, I begin by examining the empowerment themes which emerged from the interviews under the two broad headings of Structural Empowerment and Psychological Empowerment.

The literature evidence demonstrates that nurse empowerment is linked to positive individual as well as organisational outcomes. These include job satisfaction (Manojlovich & Laschinger, 2002), reduced burnout (Laschinger, et al., 2003), increased intention to stay longer in the job (Nedd, 2006), and improved patient outcomes (Laschinger, et al., 2010). In contrast disempowerment creates frustration and feelings of failure in nurses, despite remaining accountable for patient care (Laschinger and Havens, 1996).

Manojlovich (2007), in examining the question of why nurses remain disempowered despite the empirical evidence of the value and impact it has, considered the historical aspects of social, cultural, and educational influences on power. Suggesting the early position of nursing both socially and culturally as a female dominated domestic role alongside the ongoing challenge and tendency of other professions to exert control over entry levels into nursing practice and the content of nursing education has influenced the position of power in nursing (Rafael, 1996).

The findings from the ward sister interviews affirm that structural empowerment and structural power play a significant role in developing psychological empowerment (Spreitzer, 1995). The following sections of chapter 6, set out to discuss the themes from these findings within the context of the theoretical underpinning described above to assist in deepening the understanding of the empowerment of the ward sister role after the structural interventions of the supervisory status change and development programme. The discussion is framed within the research questions of the study. By way of introduction to this relationship, Figure 6.1 describes the relationship between the findings (summary of main findings’ themes and sub-themes in blue box) and the theory.

Figure 6.1 Summary of main findings’ themes and sub-themes and theory.

**Feeling unprepared for the role.** Development Programme, Supervisory Status Change.

**Disempowerment to empowerment**

Loss of control, competing demands, becoming empowered

**Perceptions and relationships**

Confusion, navigating hierarchy

relationships.

**Supervisory role and quality**

**6.1 Research Question One:** **What is the lived experience of ward sisters who move from non- supervisory to supervisory status?**

### 6.1.1 Structural empowerment

Kanter (1985, p.221), suggests the role of management is to provide employees with the “power tools” that empower them to make best use of their skills in a meaningful way. Recalling the salient aspects of empowerment theory described in Chapter 2, Kanter (1985) suggests structural empowerment is achieved via two structures – the structure of opportunity and the structure of power. The presence of social structure in the work place that provides empowerment through opportunity enables employees to develop their knowledge and skills to take a proactive approach towards their area of work. This leads to problem solving approaches where employees are active participants in change and innovative practice within the work setting. Establishing empowerment through the structure of power, necessitates lines of information, lines of support and lines of resources. In this study, opportunity and power structures came in the shape of the supervisory status change and the development programme, which was introduced alongside the change in the practice model.

The impact of the structural opportunity and power were well supported by the findings from the qualitative interviews. The interviews opened with a conversation in relation to how the individual sister had been prepared for their current role of ward sister. The purpose of introducing this line of discussion within the first phase of interviews was to gain an understanding of what training the ward sisters had had in becoming a ward sister and in what way this may influence their views in becoming a supervisory ward sister.

At the start of the research, all sisters described the variation in their training and preparation for their role. They described how they had ‘worked things out’ as they went along. The interviews revealed how the ward sisters had described finding their own way and highlighted the extent of the variation in training that had been experienced. None of the ward sisters interviewed had been provided with the opportunity to develop their knowledge and skills within the non-supervisory ward sister role and relied heavily on support from other colleagues, mainly their unit matron.

Within the standards set for nurse education (NMC, 2010) are four domains, which include the areas of leadership, management and team working. Whilst translation of the standards varies across provider settings, within the context of this study setting, this is achieved when the third-year student undertakes a two-part placement. In part one, they are introduced to the concept of managing a group of patients (eight weeks in duration - thirty hours/week) by the end of which they are expected to be able to manage a group of four patients, actively engaging in care planning and the formal ‘hand over’ of patients. Achieving part two of the placement requires the student to achieve a minimum grading of four (internalisation) from Steinaker and Bell’s (1979) fine grading taxonomy, across all cluster skills in order to pass the placement. Whilst this prepares the registered nurse for independent practice the focus is largely on clinical and academic development with limited exposure to management theory and practice in the broader sense. The ‘step change’ the ward sisters described as necessary to progress from staff nurse to ward sister was significant and could be explained partly by the absence of experience in the training model for the registered general nurse at the time that they did their training.

The knowledge of the more in-depth understanding of how to run a ward therefore has traditionally been achieved as part of the career progression of a staff nurse gaining experience as they go along. Kennedy (2008) affirms that the responsibility and understanding of what it takes to run a ward has been increasingly lost to a focus on clinical and academic competencies, rendering the newly appointed ward sister unprepared for the role. This was supported in the descriptions from some of the ward sisters of stepping into the new role of ward sister with no clear idea of what the role involved and how they would undertake it. This learning on the job and apprenticeship type experience often leads to unplanned and haphazard preparation for the ward sister role (Ball, 1998) and falls short of a clearly planned pathway for the ward sister to follow.

### 6.1.1.1 Structural opportunity

The preparation of the necessary conditions that would provide sisters with the chance to gain the required knowledge and skills (Kanter, 1985) for the proposed transition to supervisory status created the ‘opportunity’ to develop a training programme. The introduction of this new ‘structure’ enabled the ward sisters to develop their knowledge and skills and to take a proactive approach towards their duties leading to problem solving approaches. It also helped them to feel like active participants in change and innovative practice within their ward settings – as per Kanter’s theoretical propositions. This aspect is explored further in the next sections.

### 6.1.1.2 Structural intervention – the training programme

The literature review highlighted that there exists a paucity of research in relation to role components, role delivery and preparation for the role of the ward sister nationally, and what evidence exists is focussed on local programmes and national campaigns (Pegram, et al., 2014). Thus, in the absence of any set standard for such a programme a bespoke ward sister development programme was developed as has been discussed. Following a review of the supporting literature and adopting Lawrence and Richardson’s (2014) recommendation of flexibility within nursing leadership programmes to reflect the complex demands within these roles, the programme was designed in conjunction with senior nursing colleagues and using my previous experience in nurse education. This took place around the same time that the ideas for this research project were being formulated.

Whilst the findings of my research did not directly inform the design of the development programme, the views of the case study sisters expressed during the interviews supported the bespoke approach to the programme, which was designed to flex to the needs identified by the wider group of ward sisters during the programme through their on-going evaluation. For example, during the pre-supervisory status interviews participants described the lack of opportunity to have their voice heard in the wider organisational setting. One sister described the frustration felt:

“*when you have ideas about ways to move forward the problems we are having, for example in discharge planning or infection control but I can’t get to the meetings, I can’t leave the ward.”*

(Sister 2B).

In contrast the post supervisory interviews highlighted examples of the greater sense of engagement in discussions the ward sisters felt:

*“It was helpful that we were able to request certain topics on the programme, it was really helpful being able to talk to senior people we didn’t normally get a chance to speak to. It was good to tell them what we were involved in, that they may not have known about as there is always a layer between us and the senior management.”*

(Sister 4A)

The contrast from the lonely isolated positions the ward sisters described during their pre-supervisory interviews compared to the greater sense of belonging and presence as a group of ward sisters was palpable in the post supervisory interviews. This mirrored the wider feedback from the ward sister group as they progressed through the development programme. The post supervisory interviews described in detail examples of how the general discussion sessions which were introduced on the programme, driven by topical issues the wards sisters came to the sessions with, had facilitated access to Board level engagement in issues of key importance to them by ensuring the Chief Executive and other members of the executive team were invited to join the sessions.

Within the comments made by ward sisters during the post supervisory interviews, references were frequently made to the development programme in relation to how they had gained a voice as ward sisters. They also felt that this had empowered them to move forward within their supervisory time in an organised way. It gave them the forum to challenge the expectations of the role set against other organisational challenges and helped them to find ways as a group to agree how to move forward. The ward sisters also described how whenever they identified gaps in knowledge and experience within their transforming role, they would feed suggestions into the programme ensuring it was individualised to provide the opportunity for solving practical work-based issues. Jasper et al., (2010) support this approach to achieving empowering and transformative effect on participants.

Adopting a collaborative approach to the development programme, with executive commitment to changing how ward sisters are prepared to work within a supervisory capacity provided a unique experience for the ward sisters involved. Embedding this support and development for all ward sisters going forward requires a continued cultural shift both within the researcher’s organisation and the wider NHS.

### 6.1.1.3 Structure of power

Moving from a practice based ward sister model of non-supervisory to supervisory status, provided ward sisters with a structure of power that enabled access to new lines of information, support and resources. Building on the structural changes introduced by the development programme, ward sisters were able to access the necessary knowledge to undertake their job tasks in a more meaningful way (Kanter, 1985). This was evidenced in the responses which referred to feelings of clarity, for example having time to seek out relevant information in a first-hand way as opposed to hearing information via a number of second hand sources often much later than they would have wished. There were many examples of this in the ward sisters’ roles spanning different aspects of their work. An example in relation to technical aspects of their role was their ability to access information relating to the new electronic patient record (EPR) in a real-time way, by being able to contact the EPR team and make the opportunity to meet and discuss ward based key issues. They were also able to have the opportunity to attend wider organisational leadership forums, such as the regular Tuesday morning information meeting run by the Chief Executive and executive team in order to access information relating to the wider organisation. Access to lines of information continued to be enhanced once the role became supervisory as the work model enabled opportunities for ward sisters to access specialist training, study leave and a wide range of meetings off the ward. The latter in particular further enhanced knowledge of the wider organisation, countering previous notions of confusion when sisters felt held back by hierarchy due to limited knowledge of the bigger picture.

As well as access to information, Kanter suggests structural power is also enabled through lines of resources. In the supervisory role, ward sisters were given new access to a range of resources which had hitherto been unavailable causing feelings of frustration. The findings suggest that when leaders introduce organisational structures that enable ward sisters to access appropriate managerial levels of information, a greater sense of clarity and understanding of what it is a ward sister is expected to know is promoted, particularly in terms of organisational goals and processes, thereby creating greater work engagement (Wong and Laschinger, 2012).

The findings highlighted that having time - as a resource - made a fundamental difference in terms of feeling able to perform and complete job activities commensurate with the role. Time is critical to managing workload, which is the relationship between work demands and available time and resources (Maslach and Leiter, 1997). Since unmanaged workload is related to higher levels of emotional exhaustion (Wong and Laschinger, 2012) it is not surprising that the study revealed ward sisters perceived that there were benefits associated with having more time in their supervisory status. In the Phase 1 interviews the sisters reported having insufficient supervisory time to complete all of the components of the ward sister role, with the majority of their time spent on direct clinical care of a group of patients. The findings demonstrated the effects of the change in supervisory time over the study period for each of the five ward sisters. Whilst this position shifted in a positive way over the year for some of the participants, it is also evident that the position varied month by month for the ward sisters as a direct result of staffing levels on the ward. For example, in month three, March 2016, all five ward sisters within the study were exposed to less than 35% supervisory status which coincided with an increased vacancy position in all wards, necessitating that the ward sisters manage a patient cohort in this period.

The results show how crucial time is to structural empowerment. Ward sisters perceived time to be critical to their ability to fulfil the requirements of the role effectively – and all spoke of how easily this was compromised when the ward was short-staffed and they were pulled back into the patient care numbers. All ward sisters described a detrimental impact on their ability to fulfill the role without the resource of supervisory time.

Combined with supervisory status the structural changes facilitated through the training programme provided sisters with a greater understanding of how they could access or use other resources relevant to their day to day roles. An example included spending time on the development programme with the chief finance officer and increasing their knowledge of both the wider NHS funding challenges and how this related to their individual ward budgets and the internal organisational cost improvement programmes. During the pre-supervisory interviews, almost all the ward sisters described being out of the loop in terms of managing and understanding their ward finances, that this was largely managed by the matron or head of nursing and they had little time or opportunity to be involved in this area of management. These findings correlate with those of the Royal College of Nursing in a 2013 UK-wide survey among ward sisters which found that only 50% of respondents had budget-holder responsibilities (RCN, 2016). In the interviews with the ward sisters during the post-supervisory period, several were frustrated as having a new-found understanding of the importance of recognising their budgets as their roadmaps for ensuring quality and cost-effective services are provided to patients. Without their supervisory time, they were less likely to be able to significantly influence budgetary decisions. In particular they emphasised the importance of understanding staffing and supply costs as they are at the forefront of patient care which enables them to have a clear understanding of what is needed to provide care and services. The challenge ward sisters face in order to be cost-effective with their ward resources requires understanding and ownership of their operating budget and its major components. (Finkler, 2001). A number of the ward sisters described improved conversations with their senior nursing colleagues and operational managers in having greater involvement in the ward budget and moving towards greater autonomy in this respect. However, for others, the feeling of frustration in not being allowed to fulfil this aspect of their role reinforced feelings of role confusion and blurring of role boundaries.

In addition to local control, all of the ward sisters expressed the desire to have greater understanding of the wider financial control of the hospital. This was of particular interest as the hospital at the time of the research study was operating within the National Health Service Improvement (NHSI) ‘Special Measures’ regime. The ward sisters were aware of this level of central government control but felt distanced from the opportunity to influence change directly in their sphere of work. During the post-supervisory period interviews, two of the ward sisters described how they had engaged their ward teams in specific service improvement programmes having gained a much greater understanding of the financial challenges the organisation was experiencing from the supervisory programme. In talking about one such change the ward sister described having led work in pathway redesign for a group of surgical patients. She elaborated on how she had organised a ward study day, exploring the pathway and evidence base for care of the specific group of patients in collaboration with the consultant responsible for the specialty. Work had commenced within her area of practice to reduce length of stay post procedure for the specific patient group, which would support best practice and patient experience whilst contributing to the wider financial efficiency model.

Several of the ward sisters described improvements in their discharge planning performance indicators as a result of empowerment brought about by the increased supervisory time, which in turn gave them more time to spend with patients and their families. Whilst this was not strongly evidenced in the quantitative analysis of this study, the ward sisters articulated examples of improved relationships with patients, their families and community services, in particular extended conversations with local care home providers. Baillie, et al. (2014) affirmed the importance of the nurses’ position in the transition of patients between hospital and community settings, but their study also showed that ward staff who lack control in relation to care transitions, feel disempowered and are therefore less effective in engaging the patients and their families in the transition process. Access therefore to time as described within Kanter’s lines of resource serving as a means to structurally empowering ward sisters to improve their patients’ quality of discharge and relationship with system partners involved in the transition of patient care.

An area of further importance for the ward sisters in terms of resources was having time to ensure rotas for the staffing of their areas were planned well in advance, not only for the safe staffing of their wards but for the important aspect of timely rostering for staff to plan outside of work. During the pre-supervisory period the ward sisters described their inability to sign off rotas as complete in a timely way, and frequently staying beyond their normal working hours in order to complete this work. In addition to this, the fact that the ward sisters were not able to address this area of their responsibility had led to another example of the matron being responsible for the sign off process, sometimes without the ward sister input. In the RCN study in 2013, 35% of ward sisters were not in a position to sign off rotas, impacting upon how the ward sister was able to supervise and develop members of her team, and have control on the developing team dynamic within the ward setting (RCN, 2016). When able to practice in their supervisory capacity, the ward sisters described how much more empowered they felt, sorting their own rotas, and feeling more in touch with their staff both in managing their ward needs and in supporting their teams everyday life outside of work.

Also suggested by Kanter’s model and evidenced in the findings was the positive difference to feelings of empowerment made by improved lines of support. Support and feedback from colleagues such as matron, operational management and medical staff which was both constructive and acknowledged ward sisters’ capabilities and discretion in doing their jobs was a feature of the post-supervisory interviews. In contrast to this at the pre-supervisory interviews, the findings demonstrated the hierarchical structure within the clinical setting. This was largely dominated by the role of the matron but also included the roles of operational managers and relationships with medical staff. Examples included in chapter 4 highlighted how as the ward sister became more knowledgeable in relation to the wider aspects of her role and was able to fulfill the role when given supervisory time. This in turn affected the relationships with clinical colleagues in particular the matron and medical teams. In all cases relationships improved with medical colleagues as the consultants and junior medical teams became more aware of the ward sister, and familiar with the more dominant presence she began to hold on the ward. Without exception, all ward sisters described this as a positive journey with their medical teams. In relation to the nursing hierarchy, this was a less smooth journey. Significant in the analysis of the pre-and post-supervisory interviews was the relationship with the matron role.

MacLellan, Levett-Jones and Higgins (2014) suggest that the transition from one role to another is multidirectional and multifaceted, and that it can be a confusing and disruptive experience. Lee, Jennings and Bailey (2007), in examining the transition from staff nurse to nurse practitioner roles, described the confusion experienced by nurse practitioners and suggest how the changes a new nurse practitioner needs to make both on an individual as well as professional basis, often depends on how others view the role and on recognition or lack of recognition of clinical competence. Behaviours and attitudes of medical colleagues and the impact on nursing care and consequently patient outcomes is well documented in the literature, and the importance of this relationship is seen to be a key factor in ensuring patients receive the right care at the right time and move through the clinical setting in a timely manner (Rosenstein and O’Daniel, 2005; Rosenstein and Naylor, 2012). The importance of how the ward sister role was received by matrons and other colleagues was prominent during both junctures of the ward sisters’ interviews. The majority of ward sisters described their enthusiastic approach to becoming a ward sister and described the pivotal role matrons played when they first took up their positions as ward sisters. In contrast, however as the role moved to a new model of supervisory status, the ward sisters described a less supportive and understanding approach from the matron and lack of understanding from medical colleagues and operational teams. This in turn led to the ward sisters describing a feeling of isolation and change from the role they had become relatively established in to a new uncertain supervisory role. Benner (2001) describes how these negative experiences can lead to an initial decline in competency and to a loss of confidence in their knowledge and clinical abilities until a new period of settlement into the new role is achieved. This combined with the general lack of clarity in what defines a competent ward sister could explain the level of confusion the ward sister felt around their change in role. (Hutchinson, et al., 2010).

During the second interviews, it was obvious that a level of settling had occurred with all of the case study sisters, albeit some continued to describe levels of confusion at times with their role but on the whole a new sense of competence was apparent. Nagelsmith (1995, p.247) states “with increased levels of competence comes a corresponding increasing sense of self-worth and empowerment”. Crafter and Maunder (2012) suggest that the experiences described by the ward sisters in struggling with confidence and competence within their change in role are in fact an essential experience. Few would disagree that most nurses enter the profession with the sole purpose of caring for others, yet it appears that there is too often a lack of compassion toward each other (Hutchinson, et al., 2010). The findings of this study suggest that critical to the success of a change in role structure and function is the organisational context in which the role is set and the importance of support and engagement in those contributing to this context (Bamford, Wong and Laschinger, 2013).

Kanter’s work went on to illuminate how access to the empowerment structures discussed above is facilitated through systems which are both formal – derived from the job itself, and informal – derived from relations at different organisational levels and describes the importance of senior management ensuring these power systems are in place. Table 6.2 provides examples of nurse empowering management behaviors emerging from my findings in relation to informal and formal power systems aligned to Kanter’s theory. The table is derived from Laschinger, et al. (2010).

Table 6.1. Illustrative data examples of nurse empowering management behaviours emerging from my findings in relation to informal and formal power

|  |  |
| --- | --- |
| **Power component of Kanter’s Theory** | **Ward Sister management behaviours** |
| **Informal power**   * Effective relationships and communication | * *Clarity around ward sister and matron roles, removal of role ambiguity.* * *Regular one to one meetings with matron and head of nursing* |
| **Formal power**   * Meaningful goals aligned to the organisational goals, with flexibility to contribute | * *Ward and personal objectives aligned with organisational goals.* * *Opportunity through availability of time to attend meetings outside of the ward which impact on ward development.* * *Access to personal development*   *opportunities* |

Having examined the emerging themes from the ward sisters’ interviews within Kanter’s theoretical concept of structural empowerment under the domains of structure of opportunity and structure of power, the discussion now shifts to examining the themes through Spreitzer’s concept of psychological empowerment.

### 6.1.2 Psychological empowerment

Spreitzer’s concepts of psychological empowerment including, a] self-determination, b] competence or self-efficacy, c] meaning and d] the ability to have impact on the wider organisation, were found to change profoundly in the post-supervisory status. Psychological empowerment as an addition to Kanter’s model (1985) as a product of structural empowerment provides an understanding of the intervening mechanisms between structural work conditions on the ward and important organisational outcomes. Successful implementations of Kanter’s empowerment theory can achieve several beneficial outcomes including reductions to job strain and improved work satisfaction and performance in current restructured healthcare settings (Laschinger, et al., 2001).

The outcomes of my study support the proposition that empowerment has an impact on the perceptions of ward sisters and their ability to fulfil their ward role. More specifically, the findings evidenced that structural empowerment in the workplace resulted in higher levels of psychological empowerment (Laschinger, et al., 2001; Wong and Laschinger, 2012; Spreitzer, 1995). The findings revealed that each of the ward sisters perceived greater feelings of empowerment through the role change which had been facilitated by managerial structural interventions. These issues are now discussed within the context of Spreitzer’s four components of psychological empowerment.

### 6.1.2.1 Self-determination (autonomy)

Empowered ward sisters have the freedom and accountability to make responsible discretionary decisions for patient care (Wade, 1999). When leaders facilitate self-determination or autonomy in managers and freedom from bureaucratic constraints they allow for the best utilisation of employee talents and resources. This increased feeling of autonomy leads to a positive impact on performance (Hui, 1994) and it is suggested on patient outcomes (Wong and Laschinger, 2012). The findings of my study support the notion that employees feel greater levels of autonomy following structural empowerment such as the status change but interestingly, also highlight the double standards experienced by non-supervisory ward sisters. During the pre-supervisory interviews when ward sisters were counted within the nursing numbers and therefore without supervisory time, they felt immersed in patient care. As such they felt able to take responsibility for patient care based on their own decision making and expertise in practice, feeling a much greater sense of self determination. However, during the pre-supervisory interviews these feelings of autonomy did not stretch beyond the level of direct patient care. Describing feelings of a lack of overarching control of the ward, the sisters felt less able to influence wider decisions relating to the way their ward and subsequent patient services could be delivered. This aspect of self-determination felt obscured by the lack of time to address wider aspects of the ward sister role and the dominating role of their matron. It was evident in the pre-supervisory interviews that some of the ward sisters were afraid of losing the ability to hold on to their self-determination for fear of, in some cases, the unknown as to what working in a supervisory capacity would mean. These findings are consistent with expectations of staff who are not empowered since confidence is derived from empowerment (Laschinger, et al., 2001). The confidence issue appeared to be around the confusion of the sisters’ roles with the matron as described earlier and a fear that they would have less autonomy in relation to patient care - the area in which they felt most comfortable in practice.

At the post-supervisory interviews, it was evident that having had time to understand the wider expectations of a ward sister within a supervisory role, the concept of self-determination had widened for the ward sisters. Not only did they understand that they would be able to continue in their expert practice role and remain competent, but in addition they would have wider autonomy in the managerial aspects of the role that had been in many areas overseen by other members of the hierarchical structure. This issue generated the actual language of empowerment in ward sister responses. Some described it as having been on a journey of disempowerment to empowerment.

*“I was very sceptical at the beginning that I would lose my clinical leadership role and be forced into office work. I was quite confused by it all, looking back. I get it now, I’m still the ‘go to’ person for my staff, but I decide what way I do things, how the patients are going to be cared for but also how the ward is going to run.”*

(Sister 4A)

### 6.1.2.2 Competence

When considering the ward sisters and the cognition of competence, Ryan and Deci (2001) described the relationship with feeling competent and confident in relation to goals linked with enhanced intrinsic motivation and well-being. As the ward sisters progressed through the development programme, their post-supervisory status interviews identified a number of areas whereby the ward sisters described increased competence within their day to day practice. Their examples included feeling more confident in speaking out with the multidisciplinary team or moving forward initiatives within their ward settings such as safety huddles or specialty study sessions. The relationship with competence and confidence however does require further examination. As far back as 1984, Benner stated that a competent nurse has “feelings of mastery and the ability to cope with and manage the many contingencies of clinical nursing” (Benner, 1984, p.27). Marshburn, Engelke and Swanson (2009) suggest confidence results from competence. However, not all nurses who possess confidence are competent. Smith (2012) in reviewing the literature relating to nurse competence, identified little development over the years in establishing a definition that is flexible enough to meet the needs of the changing roles of nurses as they move from student nurse training through to senior nursing roles. She suggests that the variation in perspectives of how competence can be considered in nursing provides an opportunity for nurses to create such a definition using attributes identified within the literature. These include ability to integrate knowledge into practice, experience in an area, critical thinking skills as well as proficiency in skills of caring, communication, understanding the environment, motivation, and professionalism. The ward sisters described their positions of expert clinical practice at the point of transitioning from the role of staff nurse to ward sister and their level of competence in nursing practice in relation to patient care. Competence however, in relation to the ward sister role itself, was less well articulated and understood by the ward sisters in their pre-supervisory status, with all of the ward sisters reflecting on how they had picked the role up as they went along and describing a loss of confidence compared to how they had felt prior to the transition in their role.

In contrast to the evidence in the literature pertaining to nursing competence and its impact on patient level outcomes, the relationship between competence within nursing management roles themselves is less evident in the literature (Van Dyk, Siedlecki and Fitzpatrick, 2016). In examining the early work of Bandura around self-efficacy the forerunner to the development of competence as a cognition, Bandura describes self-efficacy as "the belief in one’s capabilities to organise and execute the courses of action required to manage prospective situations" (Bandura, 1995, p.2). He suggests self-efficacy represents an individual’s understanding of his or her ability to succeed in a given situation. Bandura described these beliefs as determinants of how people think, behave, and feel. The findings at the pre-supervisory interviews were consistent with these theoretical indications as ward sisters described their individual feelings of self-efficacy in terms of patients, relaying their personally felt frustrations of not always having sufficient time to influence patient behaviours and subsequent quality outcomes within their wards. Zulkosky (2009) confirms this view suggesting self-efficacy influences how people think, feel, motivate themselves, and act. She suggests that self-efficacy is concerned about the perception or judgment of being able to accomplish a specific goal and cannot be sensed globally.

It has been proposed that to gain a sense of competence, a person can complete a skill successfully, observe someone else doing a task successfully, acquire positive feedback about completing a task, or rely on physiological cues (Zulkosky, 2009). In clinical practice this is well understood by the ward sisters. However, ward sisters suggested that their perceptions of low levels of competence in the wider duties of the ward sister role result from frequent interruptions during their shift preventing them from completing tasks and receiving the positive feedback that this would have generated. The ward sisters also felt their self-efficacy diminished in not being able to provide similar task completion feedback to her nurses. The importance of promoting competence amongst one’s staff as described in the work of Van Dyk, Siedlecki and Fitzpatrick, (2016), was a subject that arose in the post-supervisory interviews. Here ward sisters reported the considerable impact supervisory status had made to their ability to invest in staff from both clinical as well as managerial development. As a result of this the ward sisters offered examples of how they believed their actions had empowered their teams to take on greater responsibility and ownership of the quality of care within their ward settings.

Alanova, et al. (2011) examined the relationship with supervisory leadership roles and the impact this had on competence within a group of staff nurses in a large Portuguese hospital. Data analysis revealed a full mediation model in which transformational leadership explained extra-role performance through self-efficacy and work engagement. A direct relationship between transformational leadership and work engagement was also found. From this study, she concluded that nurses in a position of supervision who use a transformational leadership style, were able to enhance ‘extra-role’ performance in nurses and this increases hospital efficacy. Alanova, et al. (2011) concluded this was as a result of establishing a sense of self-efficacy within the individual staff nurses, which in turn amplified their level of engagement within the clinical setting. Whilst my research did not explore the leadership styles of the individual case study ward sisters, the findings were consistent with Alanova’s insofar as competence in the role was an important concept discussed by the ward sisters in the sense that having supervisory status allowed them to run the ward with a much greater sense of control. They compared their role with and without supervisory status and identified significant benefits to being able to self-determine how their ward would run in comparison to juggling many duties in an uncontrolled way. The greater potential for perceiving themselves to be more effective corresponds to the notion that goals which are selected through self-determination are well-internalised and autonomous (Ryan, Huta and Deci, 2008). This was evident when ward sisters described having shifted in their feeling of competence in the ward sister role itself and how they used this to influence how they managed their ward and their team as well as how they influenced the relationship with their hierarchical nursing structure. Ergeneli (2007) argues this feeling of competence is the strongest control mechanism for empowerment.

### 6.1.2.3 Meaning

Within Spreitzer’s concept of meaning, she refers to a personal connection to work (Mishra and Spreitzer, 1998) suggesting those who are empowered feel that their work is important to them and they care about what they are doing (Quinn and Spreitzer, 1997). Meaning has been considered the ‘engine’ of empowerment – energising individuals in their work especially when their values are reflected in the work they do (Quinn and Spreitzer, 1997). The findings in my research highlighted both the presence and lack of meaningfulness between the two roles. In the first interviews - when ward sisters described overwhelming feelings of loss of control and competing demands - the findings suggest they were not connected to their work and in feeling overwhelmed by the demands felt despondent and worn down. This was evident in the way some of the ward sisters described the perceptions amongst junior nurses of the ward sister role. They talked about the lack of interest in their teams in moving to sisters’ posts as they were perceived as difficult roles that required long hours and constant juggling and being neither a nurse or a nurse manager. One sister talked about how she was persuaded to take on the role as the post had been unsuccessfully filled after several attempts. None of the ward sisters talked enthusiastically about the future of the role in terms of succession planning and portrayed concern for how the role would survive under the existing challenges.

By stark contrast, in the post-supervisory interviews the ward sisters talked about being able to feel what they were doing was meaningful in the sense of being valued. They described many examples of this in being able to spend more time supporting staff and patients and being able to get out from their ward environment to contribute to the wider hospital agenda. Some of the ward sisters suggested there was greater interest from their junior sisters to seek promotion as senior ward sisters in other parts of the organisation as they believed there was a change in the perception of the role in the wider organisation. One ward sister talked about the appreciation amongst all of the ward sisters in her peer group for the renewed focus in their role at senior level in the organisation.

Changes in structural empowerment over time lead to positive changes in psychological empowerment, and if employees are to feel their work is meaningful they must be exposed to motivation and the opportunity for personal growth (Spreitzer, Kizilos and Nason 1997; Quinn and Spreitzer, 1997; Laschinger, et al., 2001). Without exception, all ward sisters described in their post-supervisory interviews, how the changes that occurred in their role because of the development programme and the increased amount of supervisory time had made them feel more motivated to succeed. They also described how they had felt valued having been supported through the supervisory programme and that there had been palpable investment in the ward sister role by the executive team. Clear examples of this were articulated by the ward sisters, as they described feeling greater enthusiasm to develop both themselves and their teams as well as the specific area of expertise in which they practiced. Examples included the sequence of training days one ward sister was now regularly running, and others included examples of personal development such as the ward sister who enrolled on a Master’s programme.

The concept of meaningfulness was evident in the greater sense of value that the ward sisters described and they now felt in terms of their contributions to their ward settings. Olivier and Rothmann (2007) suggest in restoring the meaning in work, an employee’s motivation and attachment to work is fostered, leading to greater engagement. The findings in my study reveal that being able to fulfill their role in a meaningful way is considered fundamental to all of the participating ward sisters which further enables them to derive a greater sense of meaning from their role.

### 6.1.2.4 Impact

The final component of Spreitzer, Kizilos and Nason’s (1997) psychological empowerment framework relates to impact on the organisation. The theory suggests that impact should be positively related to other aspects of psychological empowerment – in other words, feeling one’s job is more meaningful and that one has greater autonomy to be more effective is likely to be perceived as making a positive contribution to the organisation. If individuals believe they can have an impact on the ward and more generally across the wider hospital in which they are embedded, they can influence organisational outcomes and then they will be more likely to have an impact on this through their work – and likewise be considered more effective at their job (Ashforth, 1989).

Within the sub theme of confusion around the role, the ward sisters described a number of different ways in which they perceived they were viewed. These included being a hands-on nurse and looking after patients most of the time as well as being responsible for providing information related to the ward when approached by senior nursing colleagues, operational managers and medical staff. None of the ward sisters considered their role to be viewed as pivotal in the decisions around how the organisation as a whole was operating. It was unusual for any of the ward sisters to leave the ward to attend meetings relevant to the wider organisation and if they did it was often in their own time and in some cases on their days off. This reinforced the ward sisters’ feeling of lack of autonomy out with their clinical roles, and sense of meaningless in relation to the overall organisational strategy and objectives. Several of the ward sisters expressed a sense of excitement relating to the opportunity supervisory status would bring in seeking to engage the ward sister more widely within the organisation. Two of the ward sisters were less convinced and expressed concern that the new status would expose them to a less favorable way of working than they currently perceived they had and indeed were worried that the importance of their clinically focused role would be undermined by an expectation that they would be moving further away from patient care. Similar findings to this were seen in the RCN review of ward sister roles whereby some ward sisters reported concerns that being more visible and engaged in the organisation would undermine the value and importance of their clinical leadership roles (RCN, 2015a).

During the post-supervisory interviews, the ward sisters described how the introduction of supervisory status had initially led to further confusion around their roles with colleagues, in particular matrons and the operational management team seeing them as having more available time than they had had before and therefore found themselves being asked to undertake a number of new tasks that they felt were outside of their newly defined role profile. Examples included attending meetings on behalf of senior staff in their absence, undertaking large amounts of data collection for operational activities and completing administrative duties. All of the ward sisters said they had found this transition difficult and meaningless and felt the change of structure to their role would have benefitted from further preparation of the wider multidisciplinary team. As the year progressed however, all of the ward sisters described a much greater understanding of their role as they were able to grow in terms of their own understanding of the role and a growth in confidence levels to engage and have conversations with their colleagues as to the expectations of their supervisory role.

In addition to this perceived improvement the ward sisters were able to offer clear examples of how they were taking greater control in the way that they worked and attending meetings that were relevant and meaningful to their practice. They also offered a number of examples of wider organisational groups they were now members of and felt their expertise was being recognised as a meaningful contribution to shaping the direction of services within the organisation. Moving to a position whereby they felt they had greater involvement outside of their individual ward areas they described feeling more able to contribute to the wider organisational challenges Examples included the impact of discharge planning and length of stay within some specialties as a direct result of the ward sister in her supervisory role having the ability, freedom and time to contribution to the multidisciplinary forum.

A key objective of the pre- and post-supervisory interviews was to examine the ward sisters’ perceptions of supervisory status in relation to the nursing quality indicators. The quantitative findings indicated there was no significant change in the nursing quality indicators observed during the study period. Yet, the ward sisters described a significant change in perceptions towards metrics which related specifically to the periods when they were able to work in a supervisory capacity and perceived a positive impact on quality outcomes for patients within their ward areas as well as for the wider organisation. In the final part of the discussion I focus on this aspect of the findings within the context of research question two.

### 6.1.3 Research Question 1 – Summary

In this section I set out to discuss the findings in relation to the first research question **- *What is the lived experience of ward sisters who move from non-supervisory to supervisory status?***

I have described the management interventions which created structural empowerment to the five wards as the role of the five ward sisters was changed from non-supervisory to supervisory status during the study. First, the role change facilitated establishing and improving lines of information, implementing and making accessible various sources of support, and providing or enabling access to a range of resources - most importantly the resource of time. These components enabled the ward sisters to access the tools they needed to begin to transition from a ward sister role which was predominantly dominated by front line nursing care and a chaotic approach to tackling the wider demands of the role in a haphazard and often meaningless way, towards a role which allowed the ward sister to take control of her ward, her duties and most importantly her own time. I also described the structural intervention of the training programme which provided sisters with the more practical opportunities to explore the role within a peer group and how they described having had the opportunity to request input in the areas of most need and relevance in a flexible and responsive way. The findings revealed the consequences of these changes as structural empowerment which was developed within the ward setting and the ward sister’s role.

When the participants were re-interviewed after structural empowerment was developed in the ward settings, the findings of the study illuminated increasing perceptions of psychological empowerment. The literature suggested meaning occurs when there is congruence between a nurse’s beliefs, values and behaviours, and job requirements. Competence is about feeling they have the necessary competencies to perform their work well and self-determination captures the ability to be able to do the job with a sense of control. Impact refers to the individual believing they have a part in influencing the way the organisation functions (Mishra and Spreitzer, 1998). Probing and listening to the lived experiences of the participants in this study after their status change to supervisory ward sisters, revealed increasing feelings of autonomy, competence, job meaningfulness and impact on the wider organisation as perceptions of empowerment developed through the course of the study. These dimensions have all been conceptualised in the literature as components of the process of psychological empowerment. Manojlovich (2007) describes such cognitions as psychological conditions that lead to employee engagement, which according to Spreitzer (1995), help people to feel more in control. From a workplace practice perspective, it is worth noting that some dimensions reinforce each other (Spreitzer, Kizilos and Nason, 1997). For example, supervisory ward sisters who feel greater levels of autonomy in their roles reinforces a sense of greater job meaningfulness, whilst others consider that some components are antecedent to, and some operate as outcomes of empowerment (Liden and Tewksbury, 1995). In my study, each participant described feelings consistent with psychological empowerment after supervisory status change. However, a particular dimension, that of making an impact on the organisation, developed as an *outcome* of empowerment which resulted in the perception that in her new role, the ward sister made a more positive impact in terms of patient outcomes. This was of significant interest. The surprising discovery in this study was that in reality, this claim was not backed up with the empirical data. This finding is explored as the discussion turns to address the second research question.

### 6.2 Research Question Two: What is the impact of supervisory role change on quality of patient care?

Earlier chapters have introduced the background to the nursing quality indicators utilised within the study period, identifying that these indicators stem from a nationally recognised framework common across the NHS inpatient setting. The information obtained from such indicators serves to provide assurance on quality and safety to the hospital Board. Data provided is used at all levels of the organisation to collect, review and utilise the information to improve practice where necessary. Jiang, et al. (2009) identified the importance of high level scrutiny of quality indicators within board practices highlighting six key areas of best practice. These are:

(1) having a board quality committee

(2) establishing strategic goals for quality improvement

(3) being involved in setting the quality agenda for the hospital

(4) including a specific item on quality in board meetings

(5) using a dashboard with national benchmarks that includes indicators for clinical quality, patient safety, and patient satisfaction

(6) linking senior executives' performance evaluation to quality and patient safety

Ensuring there is opportunity for clinical managers to be able to provide essential information coupled with a rigorous process of feedback in relation to such quality indicators is also acknowledged as a critical step in quality improvement. Without such systems in place and strong Board leadership, there is a danger of clinical staff adopting a more passive approach to quality indicators, both in terms of the data collection and the dissemination of findings (Harris, 2000).

At the beginning of the research study, and considering the literature, it could have been anticipated that the impact of increased supervisory time for ward sisters would show as a positive impact on these nursing quality indicators, but in fact they stayed the same according to the quantitative statistical analysis. However, whilst no statistical significance was found in relation to the mean supervisory time of the ward sisters and the mean position of each of the individual quality indicators, the ward sisters (as was shown in chapter 4) suggested with examples that there had been improvements in quality. The ward sisters were able to provide examples of increased knowledge and understanding in their wider nursing team in relation to the importance of nursing quality indicators as a result of their supervisory status. This factor was not captured in the data collection method but was of significant qualitative value to the knowledge and application of the quality indicators in clinical practice. This appeared to support Harris’s (2000) observation whereby the ward sisters at the pre-supervisory interviews, described a more passive process of collecting the data for the quality indicators but had little opportunity to understand where the indicators were discussed or any involvement in the translation of findings into wider organisational practice as a result. In the post-supervisory interviews, where the ward sisters had had time and opportunity to discuss the findings with senior management and their clinical teams, focused efforts in improvements in aspects of care were described.

Examining the contrast between the positive improvements in quality indicators described by the ward sisters in the qualitative findings with the lack of statistical difference observed in the quantitative findings, it was concluded there was potentially a data collection bias effect. At the time of the study, data collection pertaining to the nursing quality indicators, was overseen by the ward sister. With the exception of the three externally reported quality indicators (friends and family, and the two aspects of the patient safety thermometer) with their national data collecting process, the data set for the ten internal quality indicators, was extracted from the documentation relating to a random selection of five patients per week within their ward setting. Thirty-nine questions were used against each set of patient documentation, which were recorded and then sent to the central auditing team. The responsibility for collecting this data was shared between the ward sister and the band 6 (Junior sister). The data were analysed by the central monitoring team, providing a retrospective analysis of each ward across the hospital month by month as part of the wider Trust wide quality dashboard.

Within the organisational setting of the research study, a new electronic patient record (EPR) system had been introduced across the organisation in 2014. The system is an all-encompassing integrated patient record system and towards the end of the research study period, was coming on line to provide real time patient information. Initially the new real-time system was introduced in parallel to the established paper-based nursing quality indicator system whilst the criteria informing the real-time data were developed and finalised. Early results showed a marked difference in the real-time versus paper-based samples in terms of the overall position on nursing quality indicators. Whilst there were many variables which were considered during the transition period, it was clear the real-time data were able to provide a more accurate and quality assured system. The data required for the indicators is pulled directly from the EPR in a standardised way across all areas of the Trust. In April 2016, the paper based versions were discontinued and the full migration to EPR method was completed. The new EPR system excludes the three externally reported indicators, which remain unchanged in terms of the data collection methods. The automatic collection of real-time data provides greater consistency and removes one possible source of bias for future analyses.

Whilst it was not possible to examine the five case study metrics within the real-time data collection during the study period, subsequent analysis of the areas of both the wards involved in the case studies as well as wider examples across the clinical settings, has begun to show a correlation between ward sister supervisory time and ward performance in relation to the local nursing quality indicators (internal communication). The recommendations of the study include the need to repeat the research study of nursing quality indicators using the real-time data collected in a uniform manner through the EPR to determine if there is a correlation between supervisory time and quality.

Regardless of the difference in quantitative findings in relation to qualitative in this study, the qualitative discussion with the ward sisters, identified a clear change in perception of the importance of nursing quality indicators in their clinical settings. The meaningless burden of data collection, without any ownership or purpose for the ward sister shifted to a much more engaged conversation about the impact of their role on the indicators and the importance of engaging their junior team in the value of the information extracted from the metrics was considerable. These findings support work done by the Audit Commission which found a key factor underlying poor quality data to be related to frontline staff and a limited understanding of the rationale for collecting data and the benefits it provides to the quality agenda. The commission recommend stronger focus in NHS leadership at all levels in relation to improving data quality to avoid the risk of undermining the impact of clinical outcome measurement such as nursing quality indicators (Audit Commission, 2009).

Debate remains for example in relation to the value of the national friends and family quality indicator, with clinical staff remaining unconvinced about the central methodological testing process, suggesting that it is not intuitive and is misleading. In addition, the debate continues about the interpretation of the friends and family question itself; these issues combine to impact on the enthusiasm across clinical teams to engage with this quality indicator (Davis and Panagiotopoulou, 2014). Similarly, critics of the national patient safety thermometer indicator have raised debate relating to the reliability of data, due to the variation in its collection methods across the NHS. This again leads to a lack of confidence within clinical teams with regard to its meaningfulness (Armstrong, et al., 2018).

Shifting the perception of front line clinicians that data collection for quality indicators is worthwhile, and therefore requires their engagement, is critical to the value of the indicators. The current disengagement is often attributed to a lack of belief in the systems involved, but it is also frequently influenced by a lack of confidence in the reported outcomes, or lack of incentive to engage with the processes (Mannion and Goddard, 2002). This study has shown by empowering ward sisters to take greater control of their roles and responsibilities they engage in greater ownership of the relevance to data collection within their ward areas. This combined with strong intelligence in the form of real-time data collection can influence the quality impact of good indicator monitoring (Raleigh and Foot, 2010).

# CHAPTER 7

# Conclusion

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### 7.0 Introduction

The aim of the study was to explore factors that influence the supervisory status of ward sisters in an acute hospital Trust and examine the impact that the role has on the quality of care both perceived and actual. I adopted the principles of hermeneutic phenomenology in my approach in order to develop a deeper and more complex understanding of the factors influencing their feelings of empowerment throughout the role change process as structural changes were made through management interventions. The empirical setting was a large NHS teaching hospital in the UK. The study set out to answer two research questions:

* Research Question -1: What is the lived experience of ward sisters who move from non-supervisory to supervisory status?
* Research Question 2: What is the impact of supervisory role change on quality of patient care?

Chapter 1 introduced the research study and the area for the investigation. Chapter 2 presented the literature review and the policy perspectives around this issue. From here the study narrowed its specific focus to examine the factors which influence supervisory status for ward sisters and the impact of this role change on quality of care. Chapter 3 described the methodology, including the overarching philosophical orientation of the research, and also described the methods used to collect data from five embedded units in a single organisational case study, as well as the analytical approaches utilised in the study.

Chapters 4 and 5 presented the findings of the semi-structured interviews which were conducted with the ward sisters’ pre and post-supervisory role change, and also the quantitative analysis of nursing quality indicators observed over the duration of my study. From the analytical process, four key themes emerged. These were conceptualised as:

* Feeling (un)prepared for the role,
* Moving from disempowerment to empowerment
* Perceptions and relationships,
* Relationship of supervisory role and quality of care.

Within each of the themes, the following categories were identified:

1. Feeling (un)prepared for the role

* Variation in training and role of the in-house programme
* Finding own way

2. Moving from disempowerment to empowerment

* Loss of control of the ward
* Competing demands
* Becoming empowered

3. Perceptions and relationships

* Confusion about what the role meant
* Navigating the hierarchical structures including support from Matron
* Patient and family relationships

4. Relationship between supervisory role and quality of care.

In Chapter 6, I discussed the findings in relation to the theme of empowerment which developed through both the extant literature review surrounding the research topic and from the lived experience themes emerging through the first analysis of the ward sister interview transcripts. Therefore, empowerment theory was used as the theoretical lens through which to understand the findings. I concluded that ward sisters feel empowered when purposeful and effective structural changes are made to their working practice.  These findings make a theoretical contribution to the evidence that suggests structural empowerment leads to psychological empowerment and perceived improvements to quality of care.  Chapter 7 concludes the study and outlines its contributions towards theorising empowerment, and towards practice in terms of ward management, patient care and the impact of the ward sister role in relation to a set of nursing quality indicators. Chapter 7 also describes my personal research journey.

**7.1 Methodological reflection**

The use of quantitative data within case study research is well described in the literature. Yin (2012) suggests that good case study research utilises a range of sources in order that the phenomenon can be investigated from a number of perspectives, allowing the development of thick description by establishing converging and robust lines of evidence, (Denzin, 1978; Kimchi, Polivka and Stevenson, 1991).

Analysis of the qualitative findings from the ward sister interviews, revealed that when ward sisters felt empowered they reported perceived improvements to nursing quality indicators. Feeling empowered by structural changes that went with the role change led the participating ward sisters to feel there was a positive impact on patient care. However, the quantitative analysis over the study period of each ward sister’s nursing quality indicators showed no significant relationship with the change to supervisory status. Closer inspection of the indicators at this time revealed an unexpected outcome which was the inconsistency in the way in which the data were collected, leading to unreliable results, which was amplified by a change in data collection method at the time of the study when a real-time data capturing system was introduced.

As a result of this important finding, the study makes a unique contribution to our understanding of the long-established practices around collecting nursing quality indicators. The qualitative interpretation around individual experiences revealed strong statements about how much more empowered the ward sisters felt in relation to control of their nursing quality indicators and perceived improvements in practice - despite there being no real quantitative impact. This finding challenges the taken-for-granted routines we follow when designing, implementing, using and relying on nursing quality indicators to measure quality.  The embedded cultures of long-established practices can lead to the process becoming more legitimate than the data itself. The questions raised around nursing quality indicators and how they are gathered, interpreted and analysed within the quality assurance process has implications for on-going development in this area in practice and how as an executive board director, such indicators are understood within this setting. As practice moves to a digital approach, with real-time data collection across the NHS, the opportunity to improve data gathering, interpretation and analysis will be a key aspect of quality improvement.

### 7.2 Contribution to practice

The main aim of the professional doctorate is to deepen and advance my professional nursing management practice. As has been highlighted in chapter 6, the research outcomes presented in this thesis have direct relevance to NHS strategy on ward management and quality of patient care. In addition to the important aspect of data collection around quality indicators identified from the quantitative findings of the study, three significant aspects of the research study have led to implications for practice within my own organisational setting.

Firstly, the lack of preparation for the ward sister role was a huge area of concern for me on embarking upon the supervisory pathway, and the importance of role preparation has a critical implication if the supervisory ward sister is to become normal practice within my own organisation and that of the wider NHS. Ensuring that there will be an on-going opportunity for ward sisters to prepare for the role and develop will be an important feature in going forward. In particular, the transition from their ‘clinical expert’ roles as senior staff nurses and junior sisters, to the expert supervisory role of the ward sister.

Secondly, the impact that the role change in one area has upon other nursing roles has significant implications for the success of the programme. Ensuring the matron role in particular is well prepared and engaged with the initiative is an important area of learning and will need to be continued in practice. This included ensuring the matron role is clearly defined and distinct from the ward sister role.

Thirdly, a further piece of the jigsaw relates to the importance of the current picture of safe and effective nurse staffing levels (RCN, 2017). The on-going challenges of nurse recruitment will continue to impact on the supervisory role, this study along with others shows the impact inadequate numbers of staff have on the ward sister role. Ensuring robust staffing levels are in place to support the role is a critical factor to its success. The study evidences how crucial staffing resources are in relation to a ward sister’s ability to act in a supervisory way.

Whilst throughout the year of this study staffing levels were seen to fluctuate as the individual sister’s position on recruitment and retention shifted, it was revealing to observe the change in mind-set of the ward sister despite not always being able to be physically supervisory. This offers important insight for management learning - that the psychological empowerment which results from what the ward sisters experienced as structural support, unlocks a new approach to working – which is not just facilitated by time.

### 7.3 Contribution to the body of knowledge

My study also makes a contribution to knowledge by considering the relationship between the ward sister role and quality of patient care in the context of gaps in the literature. There are calls that suggest this field of research would benefit from studies of practice-based interventions that change leadership practices and which examine the impact of such changes on the individuals, their teams and patient outcomes (Gilmartin and D’Aunno, 2007; RCN, 2015a). Theorising this impact to concepts of empowerment using this case study has provided empirical evidence for Kanter’s theory of structural empowerment as well as Spreitzer’s theory of psychological empowerment.

Findings from the study therefore offer two areas of contribution to the literature. The first supports the notion that structural empowerment leads to psychological empowerment in a group of ward sisters who move from non-supervisory to supervisory status. Then building on from notions of psychological empowerment, the second contribution lies in the area of impact on organisations that empowered employees feel they make – in this case not only their influence on nursing quality indicators, but also their contribution to the development of their team including succession planning and personal development for team members.

### 7.4 Limitations

In this section I discuss the constraints relating to the generalisability of the research findings. I also highlight the limitations of the study associated with the quality of the research project, and its ability to address the overarching questions posed from the outset.

### 7.4.1 Sample size

Five in depth case studies were included in the sample size using case study methodology. The five ward sisters were considered appropriate for the research undertaken, based on the arguments of Flyvbjerg (2006, pp.3-4) who argues there are five misconceptions in relation to case study research, these being: (a) theoretical knowledge is more valuable than practical knowledge; (b) one cannot generalise from a single case, therefore, the single-case study cannot contribute to scientific development; (c) the case study is most useful for generating hypotheses, whereas other methods are more suitable for hypotheses testing and theory building; (d) the case study contains a bias toward verification; and (e) it is often difficult to summarise specific case studies. Others may not support this view but Flyvbjerg proposes that thoroughly executed case studies will provide exemplar information, and that the concept of focussing on the numbers of case studies will deter from this. It is argued that the aim of the approach within this case study, was to achieve rich high-quality data within a time limited period (McConnell-Henry, Chapman and Francis, 2011, p.34).

### 7.4.2 Participant gender

The sample was all female; whilst the proportion of male and female nurses is set out in the introduction to the study, purposive sampling of the ward sisters did not capture any charge nurses within the study. It is not known whether the inclusion of charge nurses would have identified a difference in findings. This does have important implications, however, in terms of whether charge nurses would recognise the experiences outlined within the study as ones with which they are familiar. The “thick description” of case study research with a focus of the context of the case, should enable anyone (including charge nurses) to determine the transferability of the findings to their own context.

### 7.4.3 Study setting

The study explored the experiences of one group of ward sisters, within one NHS hospital setting, at one point in time. Whilst the aim was to seek deeper meaning and understanding of the ward sister role, it would be useful to explore whether ward sisters in comparable organisations had similar experiences and observations relating to the overall focus of the study. However, case study research is bounded by time and place and is therefore methodologically sound in this setting (Yin, 2009).

### 7.4.4 Quality of the nursing quality indicators

Whilst the study used the nursing quality data in use at the time of the study, as has been seen in the analysis and discussion relating to the nursing quality indicators, flaws in the data collection tool led to unreliable information relating to the majority of nursing quality indicators during the study period. This was confirmed when compared to real-time data. The conclusions therefore that there was no significant change on quality indicators in comparison to supervisory status require further testing. Consideration therefore to the reliability of quality indicators remains an important factor in their use within such a study.

### 7.4.5 Influence of the researcher

Although the ward sisters appeared to share their experiences in detail during both the pre- and post-supervisory interviews, my role as chief nurse may have limited the extent of discussion about the experience of being a ward sister within the particular setting. This limitation could stem from anxiety that their performance could be viewed in an unfavourable light by a senior professional (Holloway and Wheeler, 2002). Whilst Chapter 3 set out attempts to minimise the power effect of the researcher’s position, it is not known if this was an inhibiting factor for some of the ward sisters.

### 7.5 Recommendations

**7.5.1 For practice**

In relation to the impact on the hospital organisation, the management of its wards and the impact on patient care (notwithstanding the contradictions found within the quality indicators, recommendations for which will be discussed), leaders should consider the supporting evidence of this study which advocates the implementation of supervisory status as the expected norm for ward sister roles. My study has demonstrated that there is wide-ranging impact across the ward sister role when it is elevated to a supervisory status.

**7.5.2 For education**

Chief nurses and higher education institutions would benefit from increased collaboration on this topic to move to a more standardised approach to ward sister development, linked to education and training of the registered nurse. This should include early preparation at pre-registration. When nursing students are given access to support, opportunity, information and resources during their student training they feel more effective and empowered (Avolio, 1998, cited in Siu, 2005, p.461) in line with Kanter’s (1995) theory. Similarly, structurally empowered nursing students report feelings of self-efﬁcacy for caring – accordingly exhibiting professional practice behaviours (Almost and Anthony, 2002 cited in Siu, 2005, pp.461-463) which supports notions of psychological empowerment. Such insights theorising empowerment indicate the factors that contribute to learning effectiveness in nursing education settings. It has been said in earlier sections that when nurses are promoted to ward sisters, they can feel unprepared for the markedly different occupational challenges that await them and the preparation for this transition is crucial through training and development programmes at an early stage which can then be built on as the registered nurse moves through the professional career structure.

This would ensure that the ward sister role had clear boundaries and common understanding in all clinical settings and would move away from the haphazard and disjointed preparation, development and execution of the ward sister role.

**7.5.3 For further research**

Following the introduction of real-time nursing quality indicators through the electronic patient record system alongside the supervisory role, the study should be repeated to explore again the impact of the role of supervisory ward sisters on quality outcomes for patients using nursing quality indicators within NHS teaching hospitals. Although this study did not demonstrate a significant quantitative impact as defined by the nursing quality indicators available at the time, my hypothesis is that there was an impact but the methodology of data submission and collection masked the effect; with enhanced real-time collection of quality indicator information this masking will be removed, and could demonstrate impact, or otherwise.

**7.5.4 For health care policy makers**

As a direct result of exploring the ward sisters’ changing perceptions of the quality indicators and finding this was not supported by evidence in the quantitative data, the study recommends that leaders and managers continue to challenge the taken-for-granted routines we follow when designing/ implementing/using/relying on nursing quality indicators to measure quality in NHS hospitals.  Further research could explore these indicators in greater detail as well as the nature of institutionalised practices around their use to unpick the deeply intertwined issues of NHS practices, leadership and management dependencies and the institutional arrangements that maintain such processes/structures so that we can open up that ‘black box’ of accepted ways of doing things as an aid to deeper understanding (Walsham, Robey and Sahay, 2007, p.324).

### 7.6 Researcher’s reflections

The purpose of this section is to demonstrate the changes that have occurred during the process of developing and completing this thesis. In my capacity as a researcher, I critically reflect on the research journey that resulted in this Professional Doctorate thesis.

### 7.6.1 Choosing the programme of study

When I enrolled on the Professional Doctorate programme, I was undertaking my first executive director of nursing role in a small tertiary hospital. Critical to the role of the executive director of nursing is ensuring the right balance of staffing to patient acuity and dependency. At this time, the ever-growing challenge of unprecedented financial constraints on the NHS alongside growing reports of failings in quality of care dominated Board discussions and operational management of the organisation. Ensuring therefore, as director of nursing, that all nursing resources were evidenced-based and appropriate for the individual setting led me to seek a programme of study which would help to support this from an academic perspective. Challenges in relation to my research studies arose on moving to a new hospital. Whilst the role was the same, the scope and scale of the organisation was significantly larger meaning I had to adjust my research approach to a meaningful and manageable scale in relation to the study period remaining. Fulton, Kuit and Sanders (2013, p.132) identify the challenges that professional doctorates raise specifically in this aspect of changes in role and continuity of studies.

Utilising stage one components of the study however enabled me to develop my original ideas into a narrower field of practice within my new role and to focus on the ward sister status within the organisation. Utilising the professional doctorate route to address the complexities which exist in nursing is a recommended approach within the literature (Fulton, Kuit and Sanders, 2012).

### 7.6.2 Learning from the programme assignments

During stage one of my doctorate, paper one allowed me to explore within the literature the original basis for my thesis. I set out to examine the importance of nursing roles including the ward sister and the impact of these roles in relation to quality of care. I examined workforce design and planning within the context of significant financial challenge. This allowed me to examine the literature and research evidence and in doing so contribute to the broader debate. In particular, as an executive director within an NHS Trust, I was able to link this to the professional practice for which I was responsible ensuring that the Board was sighted on appropriate nursing and allied health professional staffing levels.

Preparing paper one, exposed me to the challenges associated with researching my area of interest from the perspective of a lead professional as well as that of a researcher. It was at this point I began to understand the complexities of how I would obtain my data in an objective way, and how I would separate my day to day role from the research questions. I also considered how I would disseminate my findings if they were out with my own beliefs and values and how I may be able to influence the wider policy and practice of the profession. In an attempt not to miss vital components, my early work explored all angles superficially and failed to analyse key areas of focus. As part of this section of the programme and my reflections on the work, it became clear that in order to produce work of substantial and useful professional value focussing in depth on a small number of key areas is by far the most effective way of writing, and hopefully produces work of significance to the readers of the thesis.

I have developed my skills of selecting the most relevant aspects of my argument as opposed to an earlier style of working through all of the various angles and points for fear of excluding key arguments. I developed my reflective skills and ability to critically reflect on my professional context which enabled me to clarify in my own context how I would be able to move forward with my studies.

Paper two allowed me to build on paper one and explore the critical role of leadership in my proposed area of research: the role of the ward sister within the context of healthcare. The paper explored leadership at both personal and professional levels and demonstrated how understanding the types and styles of leadership within an organisation is critical for any Board of directors, not only in the key roles of the chief executive and executive team, but throughout all front-line management teams. These teams are positioned to deliver the operational strategy, against a backdrop of ever increasing financial and political constraints which requires the constant reviewing of workforce structure and roles. The importance of the role of leadership of change in difficult times is well argued, but the danger of ‘bad leadership’ (Kellerman, 2004) was a significant point addressed within the paper. The paper demonstrated the pivotal role leadership has in facilitating research and emphasised the importance of research within managerial processes and leadership strategies (Middlehurst, 2008). It is also highlighted the need for self-awareness as a leader of the broader context of the research setting. Leaders must have an insight into personal strengths and weaknesses, as well as understanding how one’s own leadership style and abilities must be considered in the context of the organisational setting, and the characters, styles and values of the team in which one is working. Without this awareness, it will be impossible to undertake and implement research successfully within the practice setting and unlikely that there will be a strong body of support for the leader proposing change.

### 7.6.3 The doctoral study

Paper three allowed me to narrow down my research focus. By developing my original thoughts of examining the ward sister role as part of a wider nursing workforce and its impact on patient care, it was apparent this was far too broad and would not allow me to focus in sufficient depth to contribute originality to the body of knowledge within the subject area and too large in scope for a doctorate. The research was therefore narrowed and focussed on the aims and research questions covered within the study. It was disappointing not to be able to include the wider concept of workforce planning, within this study, due to the scope of the study, however this can be revisited at a future point.

Most significantly in my reflection on the programme as a whole has been the opportunity to research my specialist area in the practice setting and to have the opportunity to undertake a phenomenological approach to explore the lived experience of ward sisters has been both inspiring and rewarding, whilst providing the bedrock for professional change in practice which will ultimately enhance patient care.

The privileged insight I have gained into the ward sister role, coupled with my own life experience and professional responsibility will ensure my practice remains current and reactive to the challenges ward sisters are facing today in the NHS. Returning to my early aim, I am able to speak with confidence at board level discussions about the impact of ward leadership on patient care. I have also developed my skills as a researcher which will allow me to continue to address the challenges of NHS leadership within the discipline of an academic approach.

### 7.6.4 Selecting a theoretical lens

At the start of the research phase I had not determined the theoretical context with which to interpret my data. I had completed the three previous assignments without a theoretical foundation so this presented an academic development opportunity to consider data through a predetermined lens. The unintended consequences of having to conduct the first phase of semi-structured interviews early in the research process (due to time constraints in the organisation) meant I was also still exploring the literature with a broad viewpoint. However, upon reading the transcripts of those early interviews before their formal analysis, high level themes began to emerge in relation to ward sisters not having sufficient time/authority/power to do their job and to feelings of being constrained/limited/disempowered. This early exposure to their lived experience narratives provided an orientation for my continued reading and I spent a good deal of time exploring literature around the field of nurse leadership, management and empowerment.

In the professional doctorate workshops, I was able to share, challenge and check my assumptions and thinking, and this allowed me to review theories of leadership, management and institutions. As my reading progressed and I gained more understanding of theoretical perspectives I began to feel confident that empowerment theory provided the best ‘fit’ to the problem I was intending to address.

Choosing the theoretical perspective after a preliminary interpretation of the interview data meant that the early interviews were constructed without theoretical bias. Inevitably this would have influenced my reflexivity when I approached the second phase of interviews which I recognise as a possible limitation but also an unavoidable challenge to most research – since all knowledge is based on theory.

### 7.6.5 Closing remarks

Despite a job and location change shortly after starting the Professional Doctorate programme, the overall experience and research outcome remains significant. Reflecting now at the final stages of this long project, I can appreciate the significance of the academic process which has given meaning to data that may otherwise have been simply taken for granted at ‘face-value’ including its flaws. I am now cognisant of the tremendous value that theory and method make to the collection, interpretation and challenge of data – before it becomes the management information by which we lead organisations. However, that said, empowerment and phenomenology, are just one such theory and methodological approach, and although there are large bodies of literature which have added to our understanding there is no single best way to use them.

For me the great advantage of this study - despite the significant time challenges to conducting and completing it – has been the opportunity to immerse myself in the research field and to gain first hand intimate connection with the lived experiences of ward sisters - a role I have previously occupied and for which I have enormous respect in its contribution to effective patient care. The doctoral programme gave me the academic confidence to explore notions of empowerment which I had for many years recognised but lacked the theoretical scaffolding to express with convincing arguments.

I feel that the Professional Doctorate has been a conduit for several important improvements in my professional role. Whilst the NHS continues to be subject to ever increasing challenges against ever decreasing budgets and a constant strive for efficiency, I am re-energised by this study and hope that my timely research findings will make a valuable contribution to the solution and that we can continue to develop the important role of the ward sister - *“For we who nurse, our nursing is something which, unless we are making progress every year, every month, every week, we are going back. No system will endure what does not march” (Florence Nightingale 1859).*

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# APPENDICES

### Appendix 1: Outline of the contents of the development programme

|  |  |  |
| --- | --- | --- |
| **WORKSHOP OUTLINE OBJECTIVES** | **TOPICS** | **PROPOSED FACULTY** |
| * Chief Nurse introduces programme * Create an understanding of Senior Sister role * Creativity: Sisters creating a vision through art * Create a shared understanding and engagement of the programme | * Chief Nurse vision for supervisory sisters * Role profile * Programme elements and outline – coaching, action learning and workshops * Expectations of the programme and ways of working * Creating an art work | Chief Nurse  Heads of nursing/Matrons |
| * Knowing yourself * Developing self-awareness * Understand the impact of your personality traits on your team * Consider strategies for working with other with differing traits * Review Healthcare Leadership model and self-assessment | * Identify your Myers Briggs personality type * What does this mean when working with your teams and others * Leadership healthcare Framework self-assessment * How will this help me work with others in my team? * Learn how to access Coaching on Call | Leadership Development  Chief Nurse Office |
| * Leading in context/leading others * Meet Executive Directors to gain a more strategic understanding of Trust business and have an opportunity to discuss clinical leadership issues and problem solve solutions * Operational priorities and drivers: what, who, and why? * Participate in a Schwartz round * Values in the context of leadership and challenging operational times * SCNT pilot process development | * Update and discussion with Chief Nurse * To understand the operational priorities and drivers for the Trust and discuss what it means for SS and their teams * Reflect on the Trust Values and leadership in context of current challenges * Safer Nursing Care Tool: Update * Participate in a Schwartz Round and use the findings to become more compassionate carers for patients | Chief Nurse  Director of Operations  Director of Workforce |
| * Leading Change: Patient safety and quality * Safety lessons from the airline industry * Understanding Trust quality strategy * Patient experience – knowing the evidence and using it with the clinical team * Developing a positive personal presence | * + Learning from the airline industry   + Understanding Trust quality strategy   + What does quality look like on my ward? Any gaps? * Patient experience data: where to find it; how do you make sense of it; how do you use it with your teams; sister rounds * How to create a positive personal image | Director for Clinical Quality  Assistant Director Nursing  Patient experience project manager  Director of Communications |
| * Leading in the wider NHS context * CEO leadership insights & developing personal resilience * The bigger NHS structure – making sense and putting the jigsaw together. * Understanding the financial flows in the NHS and the ward budget * Sharing ward projects and best practice * Observations on ward * Writing up your nursing experiences | CEO leadership insights (& personal resilience)   * Financial flows in NHS and the Trust – impact on wards * Budgets: responsibilities; challenges and practicalities * Learning from each other   + ward projects that have made a difference to care   + observations on others ward * Getting your evidence to wider audiences | CEO  Deputy Finance Director  Corporate Finance Lead  Commissioning Lead  Chief Nurse and team |
| **Courageous conversations –** using your vignettes forum theatre and practice in a safe environment | * Interactive day with actor facilitators using * Rehearse and practice difficult conversations with patients, staff and managers and working with your teams * Getting the best out of people * Leadership Values | Practice:  Leadership/actor/  Facilitators |
| Identifying and managing the talent in your teams  Developing personal and team resilience  Networking and making connections | * How to recognise talent in your teams and how can you enable it to flourish * Maintaining yourself and your team * Raise your profile and getting noticed | Chief Nurse and team  Leadership Team |
| Marking the end of a phase in Supervisory Sister journey.  Review, reflect and evaluate our learning and achievements  Identify next steps | To be agreed with our partners | Chief Nurse Team  The King’s Fund  Coaching on Call |

### Appendix 2: Ethics approval

### Appendix 3: Interview schedule

The role of the ward sister in the context of healthcare practice

Interview guide

Date:

Venue:

Time allocated:

Welcome

* Hello and thank you for attending.
* Introduce self.
* Check participant has read information sheet and signed consent form.
* The purpose of the interview is to understand your views and thoughts about your experience in the role as a ward sister, and your experience of undertaking the supervisory sister’s programme.
* Please speak freely; say whatever you would like to
* The recording will be used for analysis purposes only and all names and other identifiable information will be removed.
* Please speak clearly in the direction of the audio recorder.
* You are free to withdraw from the study at any stage.

The initial areas for discussion are:

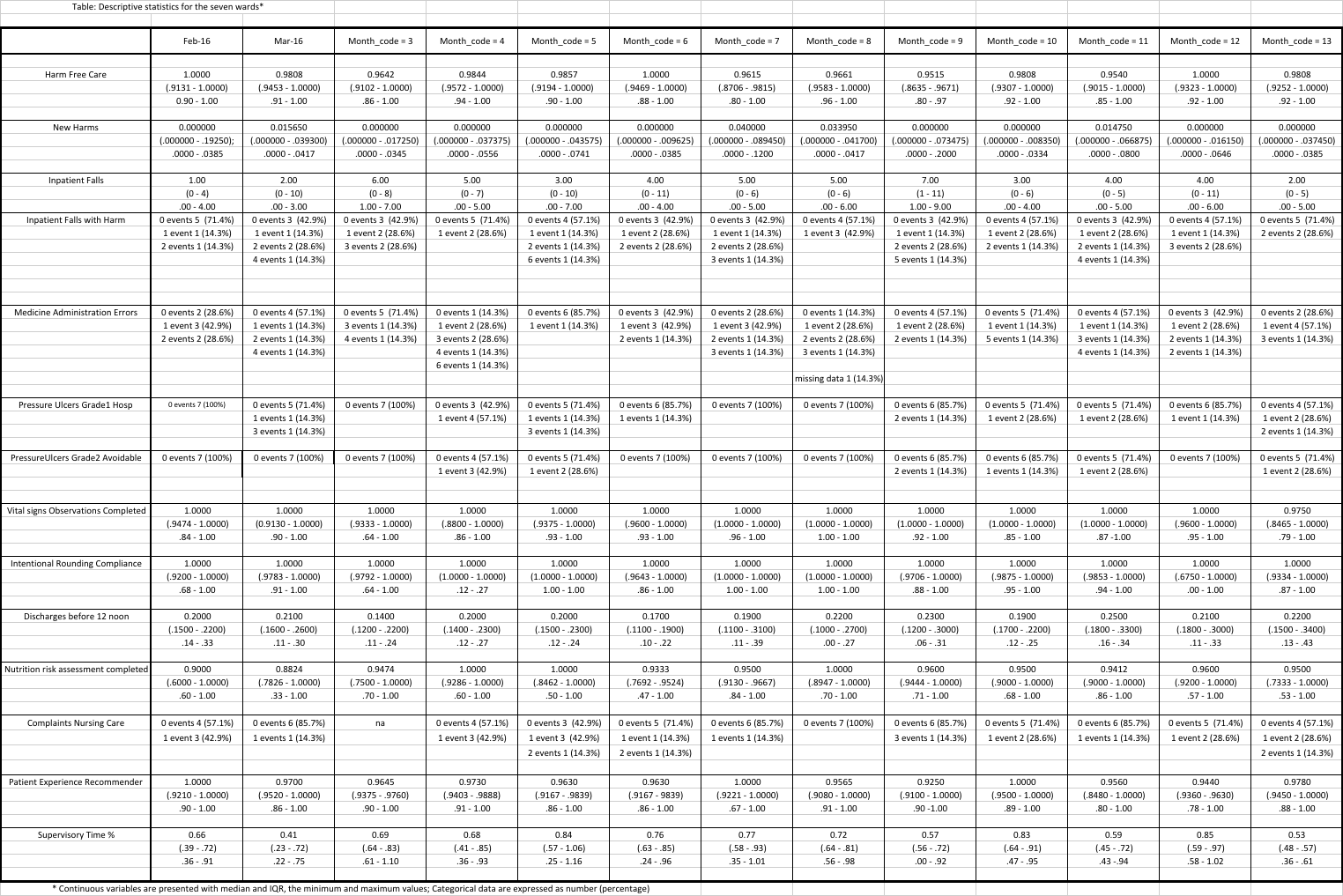
* Tell me about your experience in the role of ward sister – start wherever you like.
* What are your thoughts and feelings about the supervisory ward sister role?
* How do you feel about the transition to supervisory status?
* What difference do you think your roles make
  + To patients?
  + To other staff on the ward?
  + To you?
  + To the organisation?

Possible prompts for use during interview

* Tell me more about the barriers to the role
* Tell me more about what helps you in your role
* Describe what is important to you on a typical day in your role?
* Is there anything you would change?
* Could you explain that in more detail for me

### Appendix 4: Participant information sheet

### Appendix 5: Summary table of descriptive statistics across the study period



### Appendix 6: Relationships between supervisory time (%) and each of the quality indicators at each month (N\_maxmum = 7 wards)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Supervisory time | | | | | | | | | | | | | |
|  | Feb  2016 | Mar | April | May | | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan  2017 | Feb  2017 |
| Harm Free Care | - | r=  -0.82, p=0.046 | r=  -0.89,  p=0.045 | | - | - | - | - | - | - | r=0.85,  p=0.03 | - | - | - |
| New Harms | - | - | - | | - | - | - | - | - | - | - | - | - | - |
| Inpatient falls | - | - | - | | - | - | - | - | - | - | - | - | - | - |
| Inpatient falls with harm | - | - | - | | - | - | - | - | - | - | - | - | - | - |
| Medicines administration errors | - | - | r=0.87,  p=0.01 | | - | - | - | - | - | - | - | - | r=  -0.92,  p=0.004 | - |
| Pressure ulcers grade1hosp | na | - | na | | - | - | - | na | na | - | - | - | - | - |
| Pressure ulcers grade 2 avoidable | na | na | na | | - | - | na | na | na | - | - | - | na | - |
| Vital signs observations completed | - | - | - | | - | - | - | - | na | - | - | - | - | - |
| Intentional rounding compliance | - | - | - | | na | na | - | na | - | - | - | - | - | - |
| Dischargesbefore1200 noon | - | - | r=0.74,  p=0.058 | | - | - | - | - | r=  0.82,  p=  0.02 | - | - | - | - | - |
| Nutrition risk assessment completed | - | - | - | | r=  -0.79  p=0.035 | - | - | - | - | - | - | r=0.74,  p=0.057 | - | - |
| Complaints nursing care | - | - | na | | - | - | - | - | na | - | - | - | - | - |
| Patient Experience recommender | r=  -0.79,  p=0.035 | - | na | | - | - | - | - | - | - | - | - | - | - |

Note that:

NA: not available.

“ – “ means that the relationship between the two variables is not significant .

r: the correlation coefficient.