The Changing Role and Identity of the Contemporary Ward Manager

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Abstract

This study explores the role of the contemporary ward manager in the NHS. Using a grounded theory methodology, 9 ward managers and 32 other clinical staff participated in semi-structured interviews. In addition, ward managers were observed in practice on eight occasions. A pragmatist philosophical tradition informing symbolic interaction guided the interpretive analytical framework to generate a substantive theory of the role of a modern day ward manager through the analysis of their narratives and by observing them at work. The simultaneous collection, coding, memoing and analysis of the data, together with the body of existing literature, enabled a process of theoretical sampling to build an emerging theory of identity and agency.

The current role of the ward manager in an acute hospital is complex and varied. The data revealed that ward managers struggle to maintain their identity in an environment that no longer values the skills of traditional ward sisters. Centralisation of ward services, the development of specialist nurse roles and the introduction of modern matrons has forced ward managers to adopt the role of administrators and managers rather than clinicians or role models to junior nurses. The responsibilities for care have become blurred as patients follow rigid pathways, manufactured to encourage fast throughput and reduce length of patient stay. As a consequence, modern ward managers have reduced their legitimate power and have become isolated from patient care.

This study concluded that the contemporary practice of a ward manager bears little resemblance to the aspirations for the role held by those in post. Previous research on the role has concluded that ward managers require leadership and managerial skills to be effective but it is also apparent that whilst these are necessary skills, the significance of identity and social agency within their role has not been understood.
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By biggest thanks is to the nine ward managers who gave their time to talk to me. They were illuminating and inspiring, with moments of kindness and compassion that I was privileged to witness. At other times the honesty with which the difficult and sad discussions were conducted were touching and gentle. My respect for their ability to work in this difficult and challenging role is immense. I hope this study has done justice to their commitment to their role.

My role as a researcher has at times been difficult and I am deeply grateful for the support and encouragement that has been shown to me by my lovely family, friends and colleagues. My special thanks to Myrna, Anna and Simon for keeping me going and making me laugh when I really didn’t want to.

Finally to my fantastic four. Gavin, Felix, Harry and Angus. Without you I am nothing and I could not have done this without you.
Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not previously been submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

Dated
Introduction

1.1 Organisation of this study

The purpose of this study is to understand the role of the contemporary Ward Manager in acute medical and surgical wards within the National Health Service. It will explore how and why this role has evolved through the rapidly changing climate of health care and it will examine the effects of these changes on the role itself. The study will explain why expert ward leadership is needed in NHS hospitals and it will identify the diverse skills and characteristics that combine to create Ward Managers who are experts in their field. It will demonstrate the reasons why it is timely to undertake a study if this nature.

Chapter 1: Introduction

Chapter 1 describes the factors that were the motivation and inspiration for this study. It introduces the reader to the context and setting of the study and explains why there is a timely need to understand the role of the ward manager in depth. It provides an overview of the literature surrounding the role of the ward manager.

Chapter 2: Contextual background

Chapter 2 presents the contextual backdrop to the subject. Firstly, it explores the political reforms and developments within NHS policy that have influenced the professional practice of care delivery within hospital wards and it discusses the effects of increased managerialism on the nursing workforce. It describes developments within the nursing profession that have resulted in changes in education, the introduction of new roles, and the loss of others. Within this chapter, the study shows how the profile of the ‘expert’ nurse has evolved from its traditional
image. The chapter discusses the implications of this on clinical leadership and nursing hierarchy. It suggests that the emerging role of the contemporary ward manager has altered the identity of its traditional predecessors and explores the significance of this.

Chapter 3: Methodology
Chapter 3 describes the methodology used for this study and explains the reasons for its choice. It explores the theoretical underpinnings of the methodology and identifies its criticisms and limitations. It explains the process of theory development and demonstrates why this methodology provides validity for a study of this nature.

Chapter 4: Method and Design
Chapter 4 explains the process of data collection, describing how the research sample is selected. It demonstrates how the ethical issues of entering the field are addressed and it explores the significant issue of confidentiality. The chapter explains how interviews and observation sessions are conducted and discusses the limitations of these methods in data collection. It explains the data coding process and demonstrates how saturation is identified.

Chapter 5: Contextual Profile
Chapter 5 sets the local scene by providing a contextual profile of the organisation in which the study is undertaken, including its history and structure. It explains how changes in healthcare delivery nationally and government reform have affected the culture of the organisation during the period of data collection.
Chapter 6: Findings
This chapter presents the findings of the study and demonstrates the concepts and themes that emerge from analysis of the data.

Chapter 7: Discussion
Chapter 7 discusses the findings of the study and examines them in the context of the policy and professional issues described in chapter 2.

Chapter 8: Conclusions
Chapter 8 draws conclusions from the discussions that have developed in chapter 7 and provide a summary of the role of the contemporary ward manager.

Chapter 9: Reflections and Recommendations
Chapter 9 contains my thoughts and reflections on this process of research. It provides recommendations as a result of the conclusions drawn and states the contribution that this thesis makes to the existing body of knowledge. It provides a summary of the study and acknowledges that contribution made by others.
“Let whoever is in charge keep this simple question in her head - not, how can I always do this right thing myself, but how can I provide for the right thing to be always done.”

Florence Nightingale

1.1 Introduction
The death of a loved family member is often a time for reflection. When my Great Uncle died in his local hospital I spent some time reflecting on the care he and my Great Aunt received at the time. He died of a stroke at the age of 92 having lived a full and inspirational life. He had fought in the Second World War, had been a curator of the British Museum and was a Professor of Geology. He had been married to my Great Aunt for 65 years. Her account of his death as an inpatient on a general medical ward in a National Health Service district general hospital left me with feelings of shame and embarrassment. She described his admission to the ward as ‘confusing’ and ‘frightening.’ She did not understand the doctors, she never saw the same nurses more than once. She did not speak to a Ward Sister or Charge Nurse during the three days leading up to his death and was never once offered a cup of tea.

I had been a nurse for 20 years but I could not defend my profession at this time. Perhaps the nurses were too busy, understaffed or too tired to give my relatives the attention and care that they needed. Perhaps there was a
shortage of nursing staff that week. Perhaps there were sicker patients on the ward who needed close attention. These were all possibly legitimate excuses for the poor care that my Great Aunt received, however I felt her care during a hugely stressful and emotional time was nevertheless unacceptable. It raised questions for me that as a professional nurse I struggled to answer. My Great Uncle had received the correct medical treatment, his diagnosis had been swift and he was kept free from pain. Nurses washed him and made him safe. His clinical needs, although minimal, were addressed. Why then did I feel that the ‘care’ my relatives had received was unacceptable? What should have happened and why did it not?

My Great Aunt’s story is not an isolated event. In recent years the Care Quality Commission (formally the Healthcare Commission) and the Department of Health have investigated many incidents that reflect poor standards of hospital nursing care in the UK (Healthcare Commission 2007, 2008, 2009, 2010, DH 2010). Accounts of neglect, dirty hospitals and poor attitudes have been described all too frequently in the media (Health Advisory Service 2000, Steane 2007, Dispatches, Channel Four February 2011,) and often a shortage of staff, poor leadership and lack of resources are the reasons often given to explain these failings (Francis Inquiry Report into Mid-Staffordshire NHS Foundation Trust, DH 2010). Yet these accounts form only one side of a complex picture. There are many hospital wards where the traditional nursing skills required to provide good care are clearly
evident to patients and families (Healthcare Commission 2008, 2009,) and there are many anecdotal accounts in the press and from the public that describe extraordinary high standards of nursing care and compassion throughout NHS hospitals. The striking contrasts in these stories often appear to feature common themes and similar issues. Patients and families frequently describe the same hospital ward environments and similar circumstances yet the contrasts in their experiences appear to differ in the extreme.

The reasons behind these varied experiences demand deeper investigation. How can care in one hospital ward be so vastly different from care in another? Why are high standards so well maintained on some hospital wards and yet so desperately lacking in others? How and why do some wards flourish and excel, demonstrating continuously high standards of care, whilst others do not appear to do so?

This study will examine the various components that contribute to the management and make up of modern hospital wards. It will explore how these components relate to one another within the context of the organisational culture within which they are formed, and it will explain the developments and changes to the traditional identity of hospital ward managers that have occurred within acute healthcare over time.
1.2 Ward Sister or Ward Manager?

Juliet:

"What's in a name? That which we call a rose
By any other name would smell as sweet."

*Romeo and Juliet (II, ii, 1-2)*

Throughout this study, both the title of Ward Sister and Ward Manager are used to describe the person in charge of the ward. The title refers to both male and female ward leaders. Whilst it may appear that the titles are interchangeable, throughout this study the reasons for selection are considered and relevant to the context in which they are used.

Traditionally, prior to the mid 1980’s, the ward leader was usually referred to as the Ward Sister or Charge Nurse. Changes in ward leadership during the 1980’s (see chapter 2) resulted in a move towards ward management roles. In line with these changes, many, but by no means all ward leaders became known as Ward Managers. Within the literature, both titles continue to be used when discussing or describing the role; however, in the recent report by the RCN (2009) exploring the role of ward sisters and charge nurses, the issues around role title are discussed at length. These will be addressed and discussed further during the study.
1.3 Policy, practice and the historical emergence of the role

In 1948 when Aneurin Bevan and the Labour Government established the NHS, the management of individual hospitals was led by the clinical teams within them. Nursing was managed by a hierarchical senior team of nurses who were responsible for their own budget and workforce. They were accountable to the governing board of the hospital.

Since then, the NHS has changed significantly. Medical treatment has developed at an immense pace and the use of technology to support advanced drug treatments, complex surgical procedures, and rapid diagnostics now demands a hospital workforce that is knowledgeable and skilled to administer and deliver very specialised and complex care.

Since 1948 governments have sought to reform and develop the health service in order to uphold the principles for which it was established, whilst maintaining a financially viable service, and allowing the advances in medical treatment to emerge and develop. In doing so, the way that the NHS is controlled and managed has had to change to meet the demands of a changing clinical model of care.

As the NHS has developed its services for patients, individual hospital management has been replaced by a centralised management structure.

Chapter 2 will explain the changes to government policy that have resulted in centralisation and government control over departments of hospital
nursing and will explain how the effect of increased managerial control over
the nursing profession as a whole has implications for the way care is now
delivered in hospital wards.

The ward manager is central to the coordination of the care of patients in
acute hospital wards and in order to explain why this is so the context in
which the role has been located is significant.

An increased level of government control over the management of the NHS
has occurred gradually and throughout the entire life of the NHS, but within
this evolution there have also been key policy reforms that have resulted in
periods of significant and rapid change. (See Chapter 2, fig. 1)

The nursing profession has reacted and responded to changes in health
care policy in two distinct ways. It has continuously sought to heighten its
position within the NHS structure, raising both its national status and
academic profile (RCN 2003, RCN 2010). At the same time leaders of the
profession have endeavoured to ensure the relationship between
managerialism and the core values of the nursing profession have been
upheld (DH 2010). Within this agenda, ward nursing has had to promote
itself as a cost effective activity. In 1999, Traynor described how, over time,
this has created a hostile relationship between nurses and hospital
managers. Nurses, describing themselves in terms of moral agency were in
opposition to the managers whose performance and measurement of quality
focused solely on throughput and financial prudence. A decade later, the
long term effects of increased levels of managerialism, relentless scrutiny of
performance and continuous pressure to reduce costs have resulted in a nursing workforce which has to focus on efficiency, standardisation and lean processes as a measurement of quality within their wards. In a profession that has its identity firmly rooted in the delivery of kind, compassionate and therapeutic care, it is timely to explore whether the qualities of moral agency, fundamental to the identity of the nursing profession are still able to thrive in a modern hospital ward.

This chapter will introduce the issues within the NHS that have influenced and affected the success or failure of the profession to thrive within the confines of the modern hospital ward. Critically, it will demonstrate the significance of the ward manager and provide justification for the need to explore this role in detail.

An overview and exploration of the literature surrounding the subject will be presented, and following this critique, the political and professional evolution of the role of the ward manager will be explained.
1.4 Search Strategy

The following section will explain the search strategy adopted for this study. It will examine the policy documents and professional literature that have determined changes and developments within ward nursing. It will present an overview of the literature that surrounds the role of the ward manager, examining its historical and political context. In order to present a theoretical argument when defining the research questions for this study the key themes that emerge from the literature will be discussed.

Throughout the research process data was compared and tested against the body of knowledge that surrounds ward managers and their varied roles. Literature was examined from a variety of sources including journals, textbooks, publications from the Department of Health and the Royal College of Nursing and the media. Sources were examined from the UK and overseas.

This study draws on Grounded Theory as its methodology (see Chapter 3) and within Grounded Theory a debate exists as to the point at which a detailed literature review should be undertaken (Glaser and Strauss 1967, Glaser 1992, Strauss and Corbin 1998). In keeping with Grounded Theory methodology, background literature and policy documents were examined at the onset of the study, and a detailed review of the literature occurred.
throughout, and as part of the data analysis process and the development of theory (see chapter 4).

Several strategies were adopted to identify potential relevant literature for review. These included a keyword search of relevant databases: - CINAHL, JSTOR, Medline, Science Direct, Pubmed, Department of Health, Royal College of Nursing.

Keyword searches included: hospital wards, nursing identity, ward manager, ward sister, nurse in charge, ward leader, ward-based learning and ward leadership.

1.4.1 Inclusion and exclusion criteria

The comprehensive process that was adopted in the selection of literature included specific inclusion and exclusion criteria.

Potential studies were identified by a systematic review of relevant journals in the area of nursing management and leadership in acute hospital care. Literature searches highlighted many articles relating to organisational culture dated 1980 and later so this time frame was selected for systematic journal searches. However relevant articles relating to the role of the ward manager dated earlier than 1980 were included in the review.
Reference lists for articles that related directly to the role of the ward manager were inspected. In each case articles and chapters that were potentially significant to the subject were collected and assessed.

Inclusion criteria

i. Research reports about nursing, nursing management and education

ii. Research reports on the organisation of healthcare in the UK

iii. Policy documents

iv. Research reports on management and organisational culture

v. Articles published in nursing and healthcare journals

vi. Articles / books and reports published in English

Exclusion criteria

i. Anecdotal stories

ii. Articles published in other languages other than English
1.5 Overview of literature

There are two parts to the literature that was reviewed. The first section examines the literature around NHS reform that has influenced the delivery of inpatient care in hospital. Key policies have been introduced that have significantly altered the philosophy and culture of the NHS both nationally and at local ward level. Since the introduction of the NHS in 1948, advocates and critics of government health policy reform have written at length about the implications of changes in NHS structure and delivery of care. Key authors (Harrison et al 1990, Klein 1995, Traynor 1999, Allen 2001, Rivett 2009) have emerged from each period of NHS reform who have explored the implications of policy change on organisational culture and management of hospital care. Their views are explored within Chapter 2 where the political and professional context for this study is discussed in detail.

Fig 1. provides a chronological list of key government reports that have influenced the provision of care in the NHS. An overview of their content reveals the extent to which the service has evolved yet the consistent themes of organisational re-structure, funding and resource allocation are clearly evident. This is significant because it demonstrates that whilst the original vision in 1948 for the NHS has been maintained, the management of the health service has been constantly reviewed and revised (Allen 2001, Traynor 1999, Klein 1995, Harrison et al.1990).
### Fig 1: Key Policy reports 1948-present

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<td>Ministry of Health and Scottish Home and Health Department. Report of the committee on senior nursing staff structure. (Chairman: Brian Salmon.)</td>
<td>London: HMSO, 1966</td>
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<td>NHS Management Inquiry Report . Letter to the Secretary of State, Norman Fowler, from Roy Griffiths, Michael Betts, Jim Blyth and Sir Brian Bailey (Known as the Griffiths Report)</td>
<td>Letter dated 6 October 1983</td>
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The second part of this overview of literature introduces the narrative that surrounds the role of the ward manager from the perspective of the nursing profession. Despite there being over 3200 ward managers in the NHS (NMC 2009), the role itself is not one that has directly been the focus of close attention in the past. Studies have been undertaken that have examined many different aspects of the role, such as leadership (Willmott 1998, Wade 1998, Savage 2004) stress (Allen 2001) reflective practice (Jasper 2003) and skill mix (Buchan and Dal Poz 2002). Other studies have explored the context in which ward managers work, and the organisational culture of healthcare (Fineman 1996, Scott et al 2003, Carney 2006).

There is a wealth of literature surrounding the wider context of 'management'. Leading authors describe it not only as the ability to lead an institution but also as a discipline (Bennis 2000, Watson, 1986, Drucker (1979). Drucker highlights the significance of marketing and innovation within this discipline, whilst Watson suggests that management is both an art and a science, as it requires skill to make sense of both complex and ambiguous situations. Brech (1975) supports this theory, and identifies four main elements of management:-

- Planning – creating operational plans, and setting standards for performance
- Control – monitoring performance against standards
- Co-ordination - balancing and maintaining the team
• Motivation – inspiring morale, accompanied by a process of supervision or leadership

Bennis (2000) strengthens these elements further by focusing on four additional factors: vision, communication, positioning, and positive self-regard. He stresses the need for effective leaders and managers to develop emotional wisdom and a need to ‘know yourself’. These key elements of management have been identified within nurse management. Swansburg and Swansburg (2002) describe nursing management as a systematic body of knowledge that includes concepts, principles and theories applicable to all nursing management situations. They highlight key principles of nursing management that are synonymous with those identified by Bennis, Drucker and Brech, such as planning, decision making, communication, vision, identity, control and reflection.

More recently, Boomer and McCormack (2010) have demonstrated the need to develop communities of reflective leaders to meet demands within contemporary healthcare. They highlight the importance of active collaboration and participation of clinical nurse managers as crucial in the facilitation and sustainability of cultural change.

Nurse education and ward learning is well known to have been a part of the ward managers’ role and an area where much research was undertaken during the 1980’s (Fretwell 1982, Ogier 1982, Orton 1981). These elements however are insufficient on their own to generate a theoretical explanation for the complex role of the modern ward manager.
More recently the Royal College of Nursing published a report ‘Breaking Down Barriers, Driving up Standards: The Role of the Ward Sister and Charge Nurse.’ (2009). This significant report highlights the need for the role to have authority and status, whilst at the same time it acknowledges the lack of support and training that exists to develop ward sisters as leaders, teachers and clinical experts. The report shows, through evidence that improved patient outcomes, lower rates of staff sickness and higher levels of patient satisfaction are a result of effective ward leadership. Whilst this report raises important issues facing Ward Sisters, it does not address issues within the wider organisational culture and political arena that have implications for the identity of the role and its ability to thrive.

There has been a significant volume of literature from Canada and the USA that has addressed this by exploring the political changes in hospital nursing (Rankin and Cambell 2006, Weinberg 2003, Buresh and Gordon 2006, Gordon and Nelson 2005) and there are many theories that evolve from these works that are transferable to the UK. Gordon describes at length the increased disillusionment of the American nursing workforce, and discusses the effects of reduced finances and lack of voice on the morale and identity of hospital nurses. Whilst the American health service faces challenges and pressures that may differ from those experienced in this country, the themes that emerge from her work are significant to the context of the UK nursing workforce.
This study is written at a time when both government reform of the NHS and developments within the nursing profession are advancing rapidly. As such, the literature surrounding both policy and profession is intractably connected and cannot be examined separately. This was demonstrated in ‘A Framework for Action’, published by NHS London in 2007, written by Lord Arul Darzi. It presented a strategy to meet the health needs of Londoners over the subsequent 5-10 years.

Darzi’s final review (High quality care for all: NHS Next Stage Review final report, 2008) focused on the issues and agenda of quality, as a shared responsibility across the healthcare workforce. His vision is based on five key principles:-

i. Fairness – an NHS equally available to all, taking full account of personal circumstances and diversity.

ii. Personalised – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice.

iii. Effective – focused on delivering outcomes for patients that are among the best in the world.

iv. Safe – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

v. Local accountability – change only when clinically necessary, early and effective engagement with the public and resources to open new facilities.
Addressing both the physical and emotional needs of patients, and understanding the patients’ experience of hospital care are essential to the management of Darzi’s quality agenda. Experts in the past have explored the theories behind emotional care and have made connections between high quality care and the emotional understanding of health and healing (McLeod 1994, Frank 1995). From different angles their powerful works have shown the overwhelming need to incorporate emotion and experience into care and quality.

McLeod’s seminal work in 1994 explored how experienced ward sisters recognised that when the ‘little things’ on wards were managed well, patient’s recovery improved. She understood that the ‘little things’ of nursing practice make a difference to patients because they are imbued with nursing knowledge and skill. Her research is significant when defining the contemporary role of the ward manager as it demonstrates the importance of experience and education at ward level in driving improved outcomes.

Whyte (2011) describes the balance between clinical professionalism and kindness and humanity as critical to the provision of seamless clinical care. She discusses the need for ward managers to take the lead in adopting a supervisory role and seeking the authority to match the greater responsibilities involved in effective ward management. Whilst this is a significant step in raising the profile of the role, and is consistent with the
RCN’s (2009) report on the role of ward managers, it exposes an area within the literature where information is lacking. The literature demonstrates that effective leadership at ward level is required, that policy reforms have a direct impact on the culture and organisation of a ward, and it recognises that ward managers are struggling to manage the administrative and managerial requirements of the role, whilst at the same time delivering the quality of service that patients and relatives expect.

What is unclear from the literature is the impact that constant reform and change has had on the identity of this role. There is a need to understand the significance of identity and social agency within nursing leadership so that measures can be put in place that will allow ward managers to thrive. Given the importance of this subject to the current NHS agenda and the lack of specific research that exists it would seem timely to focus on a detailed study of this nature.

The following chapter will explore what is known of the historical role and the evolution of the ward manager and it will determine how and why its identity has changed over time.
1.6 Summary of Chapter 1

Chapter 1 has introduced the subject of this study. It has explained the motivation for undertaking this thesis and it has commenced a dialogue to explain how both government policy and professional developments within nursing play a significant part in understanding the contemporary role of the ward manager.

It has provided an overview of the literature that exists about the role, highlighting key issues around leadership, policy and organisational change, and complex roles and responsibilities. It has explained why literature will continue to be examined and reviewed in greater depth throughout the study as data is collected and analysed.

The following chapter will continue to explore the background to the role of the ward manager. It will look at the significant political reforms that have altered the way hospital care has been delivered and it will explore the consequences of these on the role at ward level.

The chapter will also map out the changes in the nursing profession that have had an impact on the role. It will explore how the essence of ward based leadership and management care has remained true to the principles established by Florence Nightingale despite the effects of changes in delivery of care, culture and expectation. It will also identify the challenges and obstacles that make it difficult for ward managers to uphold these principles in a contemporary setting.
The parallel pathways of both NHS policy and professional nursing development will be brought together and the conclusion to this chapter will provide three key research questions, which have developed from the themes that have been discussed.
CHAPTER 2

The Contextual background

“If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge.” (DHSS 1983)

2.1 Introduction to the chapter

This chapter presents the contextual backdrop to the role of the ward manager.

The first section discusses the political health reforms and changes in government healthcare policy that have affected the professional practice of nursing care delivery within hospital wards. It explores the effects of increased managerialism on the nursing workforce and discusses the implications on ward management of having centralised and standardised care within the organisational culture of a hospital.

It will further discuss developments within the nursing profession that have resulted in changes in education, the introduction of new roles, and the loss of others. Within this chapter the study demonstrates how the profile of the ‘expert’ nurse has evolved away from its traditional image and discusses the implications of this on clinical leadership and nursing hierarchy. It suggests that the emerging role of the contemporary ward manager has altered the identity of its traditional predecessors and it explores the significance of this.
2.2 The Political Agenda

The National Health Service has been established for over 60 years. Its development and transformation since 1948 has followed a unique and extraordinary path. Its journey has been a process of rapid and complex change, characterised by significant advances in the science of health and disease and the development of technology to support treatment. Despite advances in medicine and technology the service has remained true to one of Aneurin Bevan’s original objectives, to be free at the point of delivery for all.

The NHS has evolved into a multi-billion pound organisation that now employs over 1.5 million people. In 2009-10 it treated 16.8 million people (NHS Information Centre, Feb 2011). Since its inception the NHS has faced three main challenges to achieving and sustaining its original vision and these factors have continued to dictate the direction and nature of NHS care (Rivett 1998). Each government has faced the issues of i) management and organisation of the service, ii) the provision of adequate funding, and iii) the ability to target resources where they are needed.

During its first two decades, the NHS was largely managed by the medical profession. Rivett (1998) describes how hospitals were managed by administrative staff who recruited local boards and committees. A significant proportion of medical staff made up the membership of these bodies. The
Government set fixed budgets and local diversity was considerable. At the level of patient care and clinical decision-making, the autonomy of the medical profession was unchallenged and there was little accountability for how funds were allocated and spent. Hospital nursing was managed within its own hierarchical department, responsible for its own budget and workforce, and accountable to the governing body of the hospital.

A series of government reforms (Guillebaud Committee of Enquiry 1953, Hospital Plan 1962, Cogwheel' Report 1967, Salmon Report 1967, National Health Service Reorganisation Act 1973) attempted to provide a management structure to both regional and local services, and curtail financial expenditure and manage increasingly spiralling costs.

During the 1960’s associated health professions, such as physiotherapy, dietetics, and occupational therapy were becoming increasingly integral to hospital patient care. These professional groups managed themselves and provided services to the wards. As these groups increased both in variety and experience, the ward sister relinquished the day to day management control of the services they provided, instead becoming co-coordinator of an increasingly complex network of care rather than a skilled provider of it. The publication of the Salmon Report in 1967 formalized this change in working patterns and hospital care. It established a new senior nursing structure for nurses. The hospital nursing workforce was led by a Chief Nursing Officer, and a team of experienced Senior Nurses replaced the
traditional role of hospital Matron. The Salmon report recommended that Ward Sisters took on the ‘proper function of first-line management nursing’ (Salmon 1966), clarifying previously confusing lines of communication and providing support from middle management. It advocated that ward sisters should be relieved of non-nursing duties. Ward clerks were introduced to alleviate time spent on clerical duties, and ward housekeeping became managed centrally by domestic staff. At the time the Salmon Report provided hospital nurses with a line management structure that had not previously existed, and in doing so, acknowledged the varied role that Ward Sisters were undertaking. However in its attempt to create a better environment, with a support structure and a focus on nursing duties, the Salmon Report began a process of fragmentation of the traditional Sister’s role, whereby direct management control of key services such as housekeeping, catering and cleaning was lost (Ball 1998). Whilst the Salmon Report had identified the ward sister as the key figure in the management of patient care, the Salmon structure had inhibited the development of an autonomous clinical role at this level (Pembury 1980).

In 1983 the government published The Griffiths Report (DH 1983). Traynor (1999) describes this report as a significant milestone in NHS history as for the first time the lack of NHS performance monitoring and measurement of health outcomes was highlighted. Prior to the report, hospital administrators were largely viewed as having a role to facilitate the work of the medical and nursing workforce; however the Griffiths Report radically changed this
culture along with the organisation and structure within hospitals. The government introduced a structure of general managers and created a managerial hierarchy with accountability to central government. The outcome of the Griffiths Report had a profound effect on hospital nursing in two ways; prior to the Griffiths report, management of nursing was the responsibility of the senior nursing team who maintained control of their own, often extensive budgets (Allen 2001). Following the Griffiths Report, nursing management was placed under the control of general hospital management and lost its ability to control financial decision-making. Traynor (1999) describes how this resulted in financial efficiency becoming elevated as a major policy objective. As a result at a local level hospital management were strongly positioned to cut services, reduce workforce costs and encourage health professionals to “embrace a more ‘business-like approach” (Allen 2001, p7). Allen describes how this was further strengthened by a belief that managerialism would enable the direct manipulation of organisational cultures, forcing a modern corporate culture of members sharing common values and goals. For the first time, the previously separate identity and values of hospital nurses began to be diluted in a corporate organisational identity whose focus was increasingly becoming centered on the measurement of performance and cost efficiency.

This had a significant effect on the philosophy of hospital nursing (Bowers 1988, Traynor 1999). Griffiths had argued for lines of responsibility to be made clear, with accountability passed down from the centre to the front line
of the service. Bowers (1988) describes how the reorganisation that followed had a profound effect on the philosophy of hospital nursing. The ward sister had up until this point been responsible for nursing issues within the ward. The Griffiths Report forced them into roles that required a greater managerial focus.

“Suddenly the management function of the charge nurse/ward sister has been rediscovered” (Bowers 1988, p15). This rediscovery forced a change in the way that nursing staff delivered care for patients and created a structure for accountability that had not previously been evident. By moving ward sisters into a managerial position, increasingly office based and away from the patients, the day-to-day responsibility for patient care fell to more junior nursing grades.

The new wave of hospital managers introduced as a result of the Griffiths report were tasked by the government to tackle the rising costs of hospital care. In doing so, they began to contract-out key hospital support services, such as catering, cleaning and portering. A competitive market place drove down the costs of these essential services that had up until that point been managed in-house. Disintegration of these services became a common feature of the NHS throughout the 1980’s, and their impact on generating financial savings was considered significant. However, for ward sisters who had previously employed their own cleaning staff and ward house keepers, who had control over the provision of food and who had been integral to the planning of every element of their patients’ management and care, their
sphere of influence and responsibility around these significant issues appeared to be gradually reducing (Bowers 1987).

During the 1980’s the spiralling costs of the NHS were seen to result in a more complex service with a larger workforce. Savings measures were introduced to create a service that could be more efficient and cost effective. Conflicts between politicians and professions arose over the extent of cost saving measures as bed numbers were reduced, patients were unable to access timely care, and reductions in workforce budgets resulted in an over stretched and increasingly disillusioned workforce. The BMJ described the NHS as a political, statistical and managerial battleground (Devlin 1996).

Thus, professional bodies were beginning to question the quality of the service that was being provided (Rivett 2010). Rivett describes how the period of time that followed the Griffiths report in 1983 marked a change in the culture of the NHS that fundamentally influenced the identity and make up of the workforce, the management function and the ability to provide care. There was little consensus and partnership between politicians and professionals, and graphic portrayals of poor standards of care at the front line were frequently evident in the national press.

An understanding of the changing culture in the NHS during this decade is particularly significant to this study. Prior to 1983, Ward Sisters had been autonomous, in charge, and senior members of the hospital structure but as
a result of a political move to managerialism, their remit and role shifted to one that had little political power and was accountable to hospital administration. At the same time, the financial position of the NHS resulted in cut backs at ward level, including staffing and training budgets (Bowers 1987).

Whilst Margaret Thatcher’s government invested an additional £101 million into the NHS, the costs of the service continued to spiral. The effects on the front line were such that over the next decade, cuts were made to the nursing workforce that had a significant effect on ward staffing levels (O’Dowd 2008) and skill mix (Stilwell 2000). In parallel, whilst the nursing profession was making advances in academic status and heightening the professional capabilities of nurse practitioners (see section 2.10), the less academic state enrolled nurse training was phased out (see section 2.8).

The number of available places for nurse training was reduced and for the first time in 1984 the number of people applying for nurse training dropped (O’Dowd 2008). The effects of these changes filtered through to front line nursing over the next 3 years and resulted in significant changes in available ward skill mix. Whilst opportunities to improve the skills and academic status of nurses were positive and welcome developments there was a gradual decline in the number of nurses available to provide basic bed-side care (National Audit Commission 2001). This in turn resulted in a heavier reliance on agency nurses, which were an expensive resource and
created issues of their own (National Audit Commission 2001) (see section 2.8).

In 1988 further reforms by the Conservative Party were introduced. Two white papers ‘Working for Patients’ and Caring for People (HMSO 1989) led to the NHS Community Care Act (1990) ‘Caring for People’ which created an internal market. This aimed to improve the responsiveness of the service to the patient by creating competition between service providers. As independent organisations competed against NHS providers for business, pressure rose to reduce costs. Whilst this was the government’s intention, the effects on hospital care were such that processes and pathways were introduced that focused on saving money as a primary objective. This translated into the development of pathways of care that streamlined procedures and reduced lengths of stay. Whilst more patients could be treated and with greater efficiency, patients were discharged more rapidly and there was pressure on ward staff to achieve faster patient throughput.

Whilst there is little evidence to suggest that the internal market delivered very little measurable impact (Ham 1999), Le Grand et al (1999) attribute this to the behavior of doctors, nurses and managers who are alienated rather than motivated by healthcare markets.

A report from the Audit Commission (1991) which explored the use of nursing resources on wards during this time highlighted lack of consensus on clinical practice, poor admission and discharge procedures, and outdated bed allocation systems. It also stated that hospitals were unable to
demonstrate a link between the amount spent on ward budgets and the quality of care that patients received.

Rivett (2010) describes the following decade of health care as one that demonstrated an unparalleled level of change. A succession of reviews and reorganisations resulted in the publication of the NHS Plan in 2000.

The Department of Health publicly recognised that the NHS was failing to keep up with changes in treatment options and was struggling to meet the demands of the population (DH 2000). Its solution was to develop the NHS Plan (DH 2000). The NHS Plan laid out an ambitious plan for reform of the NHS and introduced a process of clinical governance to ensure accountability at board level for outcomes. It acknowledged that the health service had failed to keep up with changes in society and proposed a strategy for improvement:

“This is a Plan for reform with far reaching changes across the NHS. The purpose and vision of this NHS Plan is to give the people of Britain a health service fit for the 21st Century; a health service designed around the patient. The NHS has delivered major improvements in health but if falls short of the standards patients expect and the staff want to provide.”

(NHS Plan: A Summary 2000).
The Plan included the appointment of Modern Matrons with responsibility for hospital hygiene and nutrition. It highlighted proposals to improve the health of the nation and reduce inequality and it outlined plans for building new hospitals and improving primary care to reduce overcrowding and the need for people to wait for treatment. It also emphasised the need to have experienced staff and to invest in these staff through training.

The NHS Plan was heralded by the Government as a plan for reform with far reaching changes across the NHS:

“The task for this plan is to show how we can bridge the gulf between the reality of the NHS today and the vision of what it should be like tomorrow.” (NHS Plan, DH 2000)

Whilst this plan brought a very welcome and thorough strategy to improve the NHS, it is evident throughout that its ‘revolutionary vision’ also reflected the same core values that Florence Nightingale promoted throughout her life. Whilst the complexities of a modern health service today have little in common with hospitals in the 19th Century, it would appear that the principles required to underpin the modern national health service including clean hospitals, a high standard of nutrition, health promotion and investment in staff are not new.

These principles were again echoed in 2008 when, after a lengthy consultation period with both NHS staff and patients, Lord Darzi published a
further review of the health service. High Quality Care for All (DH 2008) aimed to set a vision for the Health Service for the 21st Century that had:

“quality of care at its heart…… . to continue the NHS journey of improvements and move from an NHS that has rightly focused on increasing the quantity of care to one that focuses on improving the quality of care. …In developing these visions the NHS has had to face up to the significant variations in the quality of care that is provided. Tackling this will be our first priority.”

(High Quality Care for All: Summary letter, p8 Darzi 2008)

The Darzi report identified the need for healthcare to encompass excellence within its priorities. It defines quality as personal to the individual and includes safety, access, choice and affordability as its defining parameters. However, how this is translated to the individual plan of care for patients in hospital wards is not defined and it is unclear where the responsibility lies for the implementation of Darzi’s core values into high quality individualised care in wards.

Ward teams are comprised of staff from a huge variety of disciplines and with a wide variety of skills – nurses, doctors, pharmacists, dieticians, physiotherapists, specialist nurses and others make up a vast team of visiting personnel, each with a significant stake in managing patient care. This raises issues around responsibility and accountability, and questions arise as to ‘who is in charge? Wide variations in accountability, hierarchy
and line management within the NHS make a simple answer to this question difficult. Whilst management structures in some hospital wards suggest that hospital wards are managed by the Ward Manager, other roles within the hospital structure also appear to have responsibility for specific patient groups on wards, specific clinical ward areas, or patients following specific care pathways (RCN 2009). Staff who work on the wards are line-managed through a variety of different departmental structures and hierarchy (Doherty 2003). For example, junior doctors may regularly work on a ward but be managed by a consultant team who visit the ward infrequently. Physiotherapists deliver care on wards but are accountable to the physiotherapy manager. Social workers plan care for ward based patients and yet are managed and report to the community social services teams. The lack of clarity surrounding the lines of accountability and responsibility for the management of patients lays the foundation stones for the emerging questions asked of this study. It is understood that effective management is aided by clear lines of responsibility (Hersey and Blanchard 1984), yet within ward management it appears that there is a complex and thus confusing set of hierarchies and reporting structures across the different professional groups.
2.3 From Ward Sister to Ward Manager

The previous section discussed the political background and context to this study. At the same time a series of significant developments occurred within the Nursing Profession that are intrinsically linked to the reforms and changes within the National Health Service.

**Fig. 1** illustrates a timeline depicting health care reform and nursing policy since the inception of the NHS. It highlights the significant milestones that have generated NHS change and development since 1948.
Fig. 1 Timeline showing key milestones within the NHS and Nursing Profession.
Throughout the last century there have been many significant developments within hospital nursing, such as the growth of specialist and advanced roles, nurse-led services and training and educational posts, but there has been little that has challenged the traditional staffing model on the wards. As a result, the position of ward sister / ward manager is one that has been a significant part of the hospital workforce for well over 100 years. During this time, the role has been described and analysed in different ways and from different perspectives. From scrutinising these views it is clear that these descriptions and perceptions of the role vary widely.

By contrasting the contemporary role with that of its historical predecessors it is possible to explore the evolution of the ward sister / manager role in the context of key milestones in nursing and the National Health Service that have caused it to change.

The role of the ward manager 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 (1900). In the seminal works of both Abel Smith (1982) and later Monica Baly (1997) historical accounts of healthcare development and the nursing profession focus on the importance of the leadership responsibilities and the management requirements of the role within the inpatient setting.

The role was formalised in 1857 when Dr John South, an eminent surgeon at St Thomas’s Hospital, London, stated that nurses ‘need not be of the
class of people required for sisters, not having such responsibility.’ His publication ‘Facts about Hospital Nurses’ (cited in Dingwall et al 1988), documents a specific distinction between nurses and ward sisters. Sisters and matrons tended to be recruited from more elevated social backgrounds than ordinary nurses. Sisters at St Bartholomew’s Hospital in 1830 were described as ‘widows in reduced circumstances’ and ‘persons who lived in a respectable rank of life’ (Rafferty 1988).

Memoirs of Guy's Hospital during the 1870's further distinguishes differences between the role of a nurse and that of the ward sister:

'It appears to have been the custom at all times for each ward to have the benefit of supervision by a separate sister who in addition to the care of the sick should have the charge of the ward stores and also be the medium of communication between the patients and the medical staff (Guy’s Hospital Reports 1871:541-3 quoted in Williams 1980:60 cited in Dingwall et al 1988).

Its distinction from the nursing workforce was further identified with the foundation of the National Heath Service in 1948. The ward sister's role was defined by three key 3 tasks (Goddard 1953):

- The supervision of nursing care and treatment including the interpretation of medical instructions
- The coordination of services to patients
- The training of student nurses
Within this remit, the need to satisfy the requirements of the medical team remained a priority (Runciman 1983, Bendall 1975) and ward rounds dominated the ward routine. Bendall (1975) describes this time as a doctor-centred rather than patient-focused era and the ward sister’s role was at the disposal of the medical team.

Despite changing patterns in healthcare delivery over many decades hospital wards have always remained the centres of inpatient care. Long before the inception of the National Health Service in 1948, patients in hospital were cared for in wards and early records of hospital care (Royal London Hospital 1760) demonstrate how patients were accommodated in this way. Traditionally wards were led by the ward sisters who managed a team of nurses assigned to them. Both ward sisters and nurses were employed to work on specific wards and rarely moved to other wards or departments. In the vast majority of hospitals in the UK today this model has remained unchanged. New hospital designs throughout the UK continue to use the concept of the ‘ward’ to cohort patients and deliver care. Despite advances in care and treatment pathways for patients hospital wards continue to be led by a ward sister, now more frequently referred to as the ‘Ward Manager’ and the line management responsibility for the clinical nursing staff on the ward remain with this role.

By definition the role of a ward manager is simply to manage a ward but in reality a modern day ward manager has a job that is diverse and complex and can include a multitude of responsibilities: clinical leader, staff
manager, accountant, administrator, teacher, mentor, role model and many more (Wade 1998). Job descriptions for ward managers, taken from a variety of sources, focus on a wide range of issues (Ball 1998, NHS Jobs 2007). Levels of responsibility and control differ considerably, and since the introduction of the Department of Health’s single pay system, Agenda for Change (DH 2004) levels of pay, clinical grade, and required minimum levels of experience and expertise have varied widely. Ward managers typically, but not always fall into pay bands 6 and 7. This provides a wide salary range between £25,528 and £40,147.

Yet despite these variations the ward manager has held a profile that is widely recognised by professions and the public alike.

Despite changes in job title and job description ward managers have always been a familiar and constant part of the hospital workforce. Traditionally their role has been one that bridges the gap between nurses and other hospital disciplines, particularly that of the medical profession, acting as a channel of communication between the ward staff and the medical teams (Wade 1998).

A hospital ward was seen as a place of quiet efficiency where patients could recover from illness or surgery in an environment controlled by strict rules (Baly 1998). These rules, instigated by the ward sister and upheld by her team, were fundamental to the provision of a high quality service. Issues
such as hygiene, visiting times, meals, ward rounds, and patient’s resting times were priorities, addressed on a daily basis. It was the ward sister’s responsibility to ensure discipline amongst staff and maintain high standards of bedside nursing, maintaining the learning environment for student nurses, and supporting the workforce to carry out their routine daily tasks.

Historically it has been the ward manager who is involved with discussions regarding medical treatment and patient care rather than individual nurses, with the expectation that instructions for care will be passed down to junior colleagues.

This traditional role continued to evolve, resulting in wards that were run by sisters who maintained a high level of control over all aspects of patient care (Runciman 1983). The role held a strong identity within the culture of the hospital setting. It was a clearly defined, recognisable, respected position of responsibility whose traditional stereotype generated patterns of behaviour that enhanced its ability to command and lead.

For patients the ward manager fulfils a significant and complex role. Wheeler (1999) described the 19th Century position as someone who brought to the patient “a selfless devotion of a mother”, and although Wheeler’s role of a mother figure may struggle to fit into that of a contemporary ward manager, the ‘maternal’ elements of the nurse-patient relationship have been identified in studies carried out in more recent times (Tschudin 1992, Savage 1995, Kitson 1999).
Salvage (1998) describes the role as central to the hospital system suggesting that they should be honoured as the pivot of the hospital team.

### 2.3.1 Developing an educated workforce

Since 1948 the skills and educational status of nurses working in hospitals has changed significantly. The image of nurses as handmaidens to the medical profession has been replaced by a professional and educated workforce (Stilwell 2000). Nursing now offers university training to degree level and post graduate opportunities and training in advanced and specialist practitioner skills (Pemberton and Reid 2005). Nurses form the largest workforce within the NHS and latest figures taken in October 2010 there were 354,432 qualified nurses registered as working in the NHS (NHS Information Centre, November 2010).

However, despite the increased educational status of the hospital nurses and the radical changes to disease management, there has been little development in the way that patient care in hospital is organised and managed since Florence Nightingale established formal nurse training in 1885 (Abel-Smith 1960). Nurses are employed to specific wards or units, led by a ward manager, where they work shifts in teams based on skill mix and patient acuity levels. In many hospitals, similar wards are cohorted into groups and managed by a matron.

This model is underpinned by the basic principles that Florence Nightingale introduced into hospitals throughout her career. From her experiences in the
Crimean War in 1854 Nightingale produced evidence to show that poor and dirty conditions in overcrowded hospitals could result in unnecessary morbidity and death of patients. Using her evidence from the war she developed and promoted core values. These principles focused on good nutrition, the promotion of good health along-side the management of disease, hygiene, particularly hand washing, recognition that recovery was both a physical and mental process and an educated and well-trained nursing workforce. She also highlighted the crucial role of the ward sister as a manager of staff and an advocate of her patients (Abel-Smith 1960). Nightingale was instrumental in embedding these core values into nurse training and believed that it was the responsibility of the nursing staff in hospital wards to uphold these principles.

The reason why it is important to recognise the significance of the work of Florence Nightingale is two-fold. Firstly, she highlights the need for effective leadership at ward level in order to uphold what she considered to be the key principles of hospital nursing and provide adequate training for student nurses. The second reason for returning to the core values established by Florence Nightingale is that they hold within them an identity of a nurse and an image of a ward ‘Sister’ that is easily recognisable both within the profession and to the public. The history of her nursing life is well known (even taught in primary schools at key stage 1 level) and her iconic role as a leader in nursing provides an identity from which perceptions of nursing and nurse leaders can be drawn.
Despite clear evidence of ward ‘Sisters’ throughout nursing literature, little was written specifically about the role itself until the 1980’s. This decade marked a significant period of change in both hospital nursing and nurse education and training. The Griffiths Report (1983) challenged the management and structures of hospitals and the introduction of centrally imposed clinical policies and changes in patient care meant that hospitals, and importantly the wards within them, no longer functioned in the way that they once did. Professionally, nursing educationalists and academics were realising the need for strong and clear nursing leadership within hospital wards.

Up until the beginning of the 1980’s academic studies and post graduate nurse education was rare. Studies that were undertaken by nurses tended to address clinical rather than professional issues. During the 1970’s battles over nurses’ pay dominated the nursing agenda. Training and education had not been reviewed (Pembury 1980). Hospital wards were staffed by nurses who were encouraged to learn whilst at work rather than in educational establishments. Nurse training was undertaken in the workplace (Briggs 1972) and in 1979 75% of patient care was delivered by student nurses (Fretwell 1982). The ward workforce was heavily reliant on these trainee nurses (O’Dowd 2008).
Key research was undertaken by nursing educationalists, Pembury (1980), Orton (1981), Allen (1982) Ogier (1982) and Fretwell (1982) who identified, through research with nursing and midwifery students, the characteristics that were key to the development of an effective ward learning environment. Fretwell (1982) highlighted the importance of the ward sister's leadership role in the development of an effective team who provided a nurturing environment where students could learn the art and skills of nursing. She provided a model of learning based on four key characteristics. These were factors identified by students that were found to create an optimum environment for learning:

- The use of a humanistic approach to learning;
- A good working team spirit within the clinical team;
- An efficient but flexible management style with teaching being recognised
- Teaching and learning support from qualified staff.

The work identified the ward sister as key to the development of effective ward leadership.

Repeated research (Fretwell 1983, Ogier 1982, Lewin and Leach, 1982) reaffirmed the importance of the relationship of the sister to student nurses. At the same time their seminal works recognised that wards where the climate was categorised as ‘good’ for work placed learning also provided
high standards of patient care (Orton 1981, Fretwell 1982). Smith (1987) describes how communication, team working, and the management of the emotional needs of both patients and staff were met by wards that had strong leadership.

Whilst the work of nurse educators Fretwell, Orton and Ogier looked specifically at the ward as a learning environment, their research was significant in that it came at a time when academic nursing research was increasing and emerging as a widely recognised and integral part of professional nursing and the way forward to develop nursing practice (Polit and Beck 2007). Previously changes in practice had been imposed or rejected by nursing management at hospital level, but these works heralded the first steps towards improved evidence-based training within the universities. In doing so, this raised the academic status of the profession (Burns and Grove 2002). The reason this is significant to this study is because, at a time when the profile of nursing research was increasing, their widely acclaimed research consistently recognised the importance of the role of the ward sister. They not only demonstrated the significance of the role in relation to learners but also identified critical links between effective ward management and quality of care, patient attitudes to getting better, and their subsequent recovery rates (Smith 1986).

Saarikoski and Leino-kilpi (2002) undertook a study in Finland which further supported Fretwell’s theoretical construction. Their study indicated that the
supervisory relationship was the most significant factor in a student’s clinical ward placement. The study showed that the most important aspect of a good clinical learning environment was the management style of the ward manager.

The resurgence of old ideas into modern thinking resonates with the vision of the Darzi Report (DH 2008) which focuses on the connections between quality of care and process improvement such as the reduction in length of stay and reduced rates of infection and clinical leadership.

The Griffiths report (1983) recognised the potential for the ward leader in a management role yet the seminal works of Ogier (1982) and Fretwell (1983) demonstrated their significant role in reducing length of stay and improving the patient experience by being a role model, clinical expert and creating a good ward climate. Since the NHS Plan (2000), hospital management has channelled resources into achieving government targets around length of stay and improving the quality and safety of the patient’s experience. The structure of ward management has altered to meet these targets. Gradually the clinical and teaching role of the ward sister has been eroded to create a managerial position reflecting far more Griffiths’ view of a ward structure. Teaching is provided by facilitators and practice educators whilst the once clinical expert and role model ward manager focuses on managerial, administrative and frequently office based activities. The research of Fretwell and Ogier that demonstrated the significance of good clinical leadership for not only students but also for good patient outcomes appears
to have taken a back seat in the contemporary ward structure. This is despite the NHS Plan that clearly emphasised the need for effective leadership at ward level:

“a new generation of managerial and clinical leaders, including modern matrons with authority to get the basics right on the wards”.

(NHS Plan DH 2000, p12)

The NHS Plan pledged to support the development of clinical leadership by establishing a Leadership Centre to focus on training for front line staff. It acknowledged that up until this point effective clinical leadership had been lacking.

At the same time the NHS Plan (DH 2000) also addressed the need to drive down costs and increase efficiency. It recognised that financial management had been centralised and proposed to devolve this to local providers. In addition, hospital governance and performance management were beginning to emerge as tools to monitor and improve local services.

The impact of these aspects of the NHS plan resulted in ward managers taking on responsibility for a range of management tasks including financial responsibilities, performance management reporting and governance. This represented a significant shift in the ward manager’s role. Changing priorities from clinical responsibility to managerial accountability appears to
have had implications for not only the ward manager, but for the ward staff, the ward infrastructure and patient care. In order to identify these complexities and understand how ward managers dealt with frequent conflicting responsibilities, it is necessary to explore the ward within the organisational structure of a hospital.

At the same time as nurse educationalists sought to develop the ward as a learning environment the first nursing models for patient care were being developed and implemented across the UK (Roper, Logan and Tierney 1980). Up until the 1980’s nursing duties were allocated by task with little formal consideration to the requirements of individuals. Whilst nurses provided excellence in care, little opportunity arose for intellectual systematic evaluation and learning from experienced nurses was more difficult where little documentation was evident to support rationale for care (Roper 1980). Roper et al’s nursing model enabled patient care to be planned around patient’s daily needs and activities. Patients were assessed daily and care was updated and changed according to needs. Roper intended the model to provide a cognitive approach to the assessment and care of the patient and in doing so move away from task orientated allocation of nursing duties. This contributed significantly to the emergence of nursing as a ‘process’. The development of ward nursing models and the simultaneous focus on the ward as learning environment demanded management, leadership and an ability to teach and educate that had not previously been formally brought together at ward level. As these
requirements became part of the core components of a ward manager’s role, the traditional role of the ward sister began to separate out into key constituent parts – the teacher / educator and the leader / manager.

In 1980, Pembury, undertaking research into ward based learning, stated:-

“The ward sister remains the key nurse in negotiating the care of the patient because she is the only person in the nursing structure who actually and symbolically represents continuity of care to the patient. She is also the only nurse who has direct managerial responsibilities for both patients and nurses. It is the combination of continuity in a patient area together with direct authority in relation to patients and nurses which makes the role unique and so important in nursing.”

(Pembury, RCN 1980)

As a consequence of both academic attention and clinical focus the ward manager whose role up until then had undergone little development or challenge was scrutinised not as a result of poor standards or inefficiency, but because of the potential that the role had to offer in a new era of nursing and healthcare that was becoming increasingly governed and measured.

The development of the historical role therefore emerged through two distinct and separate routes: leadership and management. In order to keep up with the changing demands of hospital care, the evolution within each
route was rapid and the disparity between the leadership component and the management requirements became increasingly evident. In a role anchored in its historical roots, recognised for its status and responsibility, the 1980’s was a significant decade of rapid change for ward sisters. As the role embraced new ways of working, adapted to changed responsibilities, and adhered to regulations around governance and accountability that had not been required previously, the identity and perception of a role that had previously been very clear, became muddled and blurred. Externally the traditional perception of a ward sister began to differ from the actual reality of undertaking the role (Orton and Allsopp, 1992). Internally, as the crucial reference points that formed self-definition began to dissipate, ward sisters no longer had control over their once distinct identity. As their role entered an immense and rapid period of change it appeared that the anchors that had rooted them in deep waters were being pulled in different directions.

2.4 Leadership and management - a separation of roles

"There is a profound difference – a chasm - between leaders and managers.. Managing is about efficiency, leading is about effectiveness. Management is about how, leadership is about what and why." – Warren Bennis (2003 p7)

The research carried out by Fretwell, Ogier and Pembury in the 1980’s, demonstrated the need for expert nurse leaders to create clinical
environments for learning, provide role models and inspire others, particularly students. However the process driven models of nursing, defined by Roper, Logan and Tierney, supported a shift in focus to outcome based care and measurement. As hospital care during the 1980's became increasingly focused on increasing efficiency and throughput, duties around patient management, staff training, and ward administration became increasingly complex. The management elements of the ward sisters’ role became increasingly time consuming. Ward sisters were more frequently away from the clinical areas often with long periods of time undertaking office-based activities (Yassin and Paget 1996). Their lack of visible presence on the ward limited their ability to role model good practice and to provide direction and leadership to junior members of staff (Doherty 2003).

Whilst Fretwell and Pembury demonstrated that a good learning environment was dependent on the presence of and the relationship with the ward manager, they had also shown that a good learning environment was consistent with high quality patient care. Despite this widely published and significant research, the ward manager’s combined role of leader and manager became increasingly separate over the subsequent decade as the NHS faced challenges from many angles. Whilst managing finance, improving performance and developing organisational efficiency became key drivers for change within acute hospital care it appeared that hospital management failed to recognise or acknowledge that the ward manager could make a significant contribution to these challenges by combining
visible leadership with efficient and effective management. Instead, Yassin and Paget (1996) describe how increasing pressure from the hospital management to improve efficiency and manage budgets meant that ward managers spent an increasing amount of time on administrative and managerial tasks away from the clinical environment.

It was evident that the modern ward manager had a complex role combining a wide range of responsibilities for patient care with the support and development of a team of staff. Whilst their reporting structures and levels of accountability were varied essentially, as their job title suggests, they were responsible for the management of their ward. How this responsibility manifested itself and was translated into the delivery of patient care was clearly variable (Healthcare Commission 2008, RCN 2009). In 2009 the Chief Executive of the Royal College of Nursing in 2009 stated that “Ward sisters and charge nurses have many roles, but their responsibility is clear – to oversee patient care on a ward” (RCN 2009, p2).

This demonstrated recognition and support for the ward sister’s role but the reality of how it would manifest itself in a clearly identifiable and defined role remained unclear.
2.5 Managing nursing care

Whilst the general management of hospital care was undergoing radical reform the concept of ‘individualized patient care’ was becoming a key component of hospital nursing. The profession focused on a way of providing care that allowed the ideals of the nursing process to be put into practice (Bowers 1988). Primary Nursing was a model of nursing care from the USA devised in the late 1960’s by Marie Manthey. Bowers describes the nucleus of her innovation as a variant of the key worker system, applied in the nursing context, which emphasised accountability and professionalism. Primary Nursing involved a systematic organisation of the ward nursing team whereby patients were divided into groups and allocated a specific nurse. This ‘primary’ nurse was responsible for all aspects of care for their allocated patients. They were responsible for the assessment, planning and evaluation of that care, and for supervising its implementation. Associate nurses worked along side the primary nurse carrying out the planned care and this ensured that the patient was cared for throughout the day and night by a small team of nurses who knew them well and understood their individual needs.

At the time critics of the primary nursing concept were rare. The nursing profession had recognised the importance of nursing as a process and an increasing volume of nursing research pointed towards the application of scientific methods to nursing (Mason and Attree 1997). The nursing process was integral to the development of individualised patient care and it was clear that models of care that adopted task allocation in hospital
could not provide this. In reality, providing individualised patient care was hard to manage. Shift patterns and ad hoc allocation of nursing staff to patients on a daily basis created difficulties in communication and the building of nurse-patient relationships.

However, primary nursing provided the framework for individualised patient care to flourish and in so doing had the potential to raise the professional status of nursing by providing a scaffold for autonomy and self-direction. It provided the chance for nurses to work as individual practitioners which required decision-making, independence, control and accountability. The relationships with medical teams were deemed to be more of a partnership than the previously known dominance/deference (Bowers 1988).

On the surface primary nursing had much in its favour and its timely introduction fitted well into the model of healthcare that the government and society was demanding at the time. However on closer scrutiny the reality of primary nursing raised questions about the key concepts of autonomy within the nursing profession and the issue of accountability around patient care. These issues had a significant effect on the role of the ward sister/charge nurse.

As primary nurses had responsibility for all aspects of care for their patients, decisions were made and care was planned by the individual nurse, working autonomously. Prior to the adoption of the primary nurse model, there was within the wards a well-established hierarchical structure
that contradicted the autonomous working practices required of a primary nurse. Until this time the ward sister unquestionably held overall responsibility for the patients on the ward. When ultimate responsibility for the care of patients fell to the primary nurses the function of the ward sister and their relationships with the wider clinical teams was forced to change. Their position as provider of clinical expertise and wisdom began to erode. Whilst it can be argued that this devolvement of responsibility freed up time for ward sisters to focus on managerial and non-clinical issues, as advocated by the Griffiths Report (1983), there was little evidence to suggest that any consideration was given to this change (Savage 1995). Bowers (1988) suggests that the failure to provide clarity about ‘who was in charge’ led to ambiguity and confusion. The ward sister employed in a position of managerial authority maintained a duty to ensure the safety and welfare of patients on the ward. There was potential for conflicts to arise when disagreements arose regarding care.

In addition to changing relationships between the ward sister and the nursing team, primary nursing forced new associations between the ward staff and the multidisciplinary teams that were involved with planning and delivery of patient care. Amongst the most complicated of these was the changing doctor-nurse relationship. The hierarchical structure that had been typical in the majority of hospital wards prior to the introduction of primary nursing involved clear lines of communication between doctors and nurses. Ward rounds and multidisciplinary meetings were conducted at times to suit the medical teams and rarely involved any nursing staff.
other than the ward sister, who, after discussions with medical teams, would feed back changes in care to the nurses on the ward. Primary nursing required medical teams to liaise directly with the autonomous primary nurse by-passing the ward sister all together. Ward (1986) highlighted this as an issue and suggested that ward nurses were less inclined to seek creative solutions to patient care because they felt that medical staff might not support them. His study, carried out in a mental health setting, up-held the views of Roberts (1980) who explored job satisfaction in Canadian primary nurses. He reported that medical teams were less willing for the doctor – nurse relationship to change than the nursing staff, suggesting that they had difficulties abandoning the ‘hand maiden’ image of nurses and were not supportive of the autonomous role that primary nursing demanded possibly reiterating the view of Salvage (1985) who argued that it is the medical team who are ‘in charge’ of patient care, yet it is the nursing teams’ responsibility to see that it is delivered.

Salvage (1985) adds further to the discussions surrounding accountability in primary nursing. Whilst Manthey’s model from the 1970’s portrayed the primary nurse as accountable for patient care Salvage criticises this concept, believing that nurses can never be solely accountable for their care as they are not in control of the key factors that enable or inhibit their ability to provide this care. Factors such as staffing levels, allocation of resources and skill mix will impact on the care that can be delivered but are out of the control of the primary nurse. She acknowledges that part of the nurse’s role is to carry out the instructions of the medical teams and to
make that nurse accountable for the provision of that care would be unreasonable.

Bowers (1987) concluded that whilst primary nursing ensured the focus of nursing attention was centred on individualised patient care, the model fragmented the ward nursing team. The primary nurse became the fulcrum of communication – a role that up until then had been the responsibility of the ward sister. It appeared to provide nurses with greater identity and power but by devolving responsibility for patient care down the hierarchical ladder it de-robed the ward sister of status and position amongst multidisciplinary colleagues, the newly emerging NHS managers and patients. The ward sister no longer managed ward rounds, or medication administration and had little input into discharge planning with patients and family as she was no longer familiar with the patient’s needs. The pivotal organisational role that had held a visible presence on the ward was diffused.

Primary nursing was a significant factor in the erosion of the once clearly identifiable role of the ward sister, and its contribution to the modern day role of ward manager is therefore significant. Its impact on the distinctive identity of the ward sisters is worthy of investigation. Primary nursing resulted in a reduction in the authority and autonomy once held by the ward sisters and its benefits to the individualised care of patients was widely recognised. It blended with the social changes that shifted balance between nurses, doctors and health care professionals. However,
ultimately the inherent identity of ward sisters, which until that point had been enveloped in an authoritative role that had traditionally focused on the care of patients, was challenged.

2.6 Changing skill mix

In the early 1990’s nurse training fundamentally changed and the effects of these changes at ward level were significant. Project 2000 was established to develop a greater academic approach to nurse training (Department of Health 1997). This came at a time when nursing was going through a period of transition. As ‘non-nursing’ duties were carried out by untrained support staff, trained nurses were encouraged to extend their roles. They took on specialist skills previously carried out by junior medical staff and to meet the increasing demands of a modern health care system nurses needed to improve their academic knowledge and develop their skills.

To achieve heightened academic status, Project 2000 saw the beginning of nurse training in Universities. This training was initially far more theoretically based than traditional teaching and students spent 50% of their time in the classroom (far greater than they had done previously) (Crotty 1993). Clinical placements were reduced and students were no longer used as part of the ward workforce and were paid a bursary rather than a wage. Whilst this style of educational preparation produced a very different style of nurse it also dramatically changed the dynamics of the
hospital ward. The focus on wards as learning environments for students changed and the role of the ward sister and senior colleagues as clinical educators to students altered significantly (Allen et al 2008). Over time the senior tier of ward nurses and the Ward Sister became increasingly deskilled in teaching as students no longer adopted an ‘apprenticeship’ role within a ward placement.

In addition, without a constant stream of students working on the wards as part of the establishment, often making up over 50% of the workforce, staffing levels plummeted. Student nurses were replaced with untrained auxiliary nurses and the decade saw a huge rise in the role of the agency nurse which resulted in a significant rise in staffing costs for the NHS.

In 1997, the Department of Health published a report Project 2000: Fitness for Purpose. This suggested that Project 2000 did not produce nurses who would lead nursing into the research –based profession that it desired (Department of Health 1997). Recruitment of student nurses into Project 2000 was beginning to reduce and in 2001 a report by the National Audit Office (February 2001) showed that 20% of all nursing students left their course and a further 20% did not join the NHS on completion of their nurse training.

The United Kingdom Central Council Education Commission had recognised issues with the Project 2000 training and in response to concerns, produced a report: Fitness for Practice (September 1999), based on findings gathered from student nurses, nurses and other
stakeholders. This report provided a blue-print for the strengthening of nurse education. The recommendations from the report resulted in a further development of nurse training leading to a BSc/Diploma in Nursing (Godin 2000).

Student nurses now follow a diploma or degree course with clinical experience occupying approximately fifty per cent of their training. Their ward-based learning is largely competency based practical training with significant mentorship and supervision from more experienced ward nurses, returning to roots that may have stemmed from the ‘apprentice’ style training prior to Project 2000. Student nurses have maintained their supernumerary status. It is frequently the ward manager’s role to organise mentorship of students and ensure ward staff are trained to supervise and assess the competencies of students (Godin 2000).

Changes in nurse training meant that student nurses could no longer be counted as part the established ward workforce. This left a void in the ward establishments. Student nurses had provided many of the simpler bedside nursing duties on the wards and replacing this essentially free tier of the workforce with trained nurses was a significant cost. Initially the void was filled by enrolled nurses, and later health care assistants engaged in vocational training.

Enrolled nurses were frequently described as the ‘backbone’ of a hospital workforce (Webb 2000). A two year practical nurse training programme for enrolled nursing had existed since the 1940’s which admitted nurses to
level 2 of the Nursing Register. In 1997 there were 110,529 level 2 registered nurses in the UK which represented just under one-fifth of all registered nurses compared to 23 per cent in 1992/3 (Seccombe et al 1997). Enrolled nurses provided a solid and practical nursing workforce. They were not permitted to progress up the professional ladder to become ward sisters or specialist nurses which resulted in many enrolled nurses remaining at ward level where they built up vast practical experiences. These experienced nurses were an invaluable resource for both patients and nurses. Enrolled nurses could teach students the practical skills required to nurse and because they tended to remain in one clinical setting they provided core stability to a ward team (Webb 2000). As the move towards a more academic training developed in the early 1990’s, training to be an enrolled nurse ceased. Enrolled nurses were offered the opportunities to develop their enrolled nurse qualification to that of Registered Nurse by undertaking a 12-month conversion course established by the English Nursing Board. Many enrolled nurses took up this opportunity which resulted in removing a further section of the workforce from the wards. Managing recruitment and skill mix became a serious problem for ward managers and this resulted in a further increased reliance on agency nurses to staff the wards.

By the end of the 1990’s NHS hospitals were making high use of agency nurses to fill the gaps left by a shortage of permanent nursing staff. In 1999/2000 the NHS spent over £790 million on temporary nursing staff, a 20% increase on the previous year (National Audit Commission 2001).
Agency nurses had become an essential and expensive part of the hospital workforce, draining ward budgets and creating problems for ward managers needing to manage skill mix and competencies. Not only did they cost more than their permanent colleagues but there was considerable variation in their levels of competence, nursing knowledge and experience, which was hard to assess before they arrived on the wards to undertake their shifts. Often working in unfamiliar and different clinical areas, agency nurses filled the gaps in staffing across the clinical specialisms on a daily basis. Maintaining continuity of care for patients, whilst known to improve patient safety and experience, was difficult as agency nurses were often allocated shifts and clinical areas at very short notice. A report by the Audit Commission (2001) demonstrated that this had a detrimental effect on patient care: -

"..When bank and agency staff are asked to work in an unfamiliar area, or only work on an occasional basis, it can be more difficult for them to provide the same standards of care, and the continuity of care for individual patients may be interrupted"

Audit Commission 2001

As the ward managers adopted a more typical managerial working week (Monday - Friday) agency nurses were often employed to provide cover at weekends and at night when direct supervision was less likely to be available. As a result, mandatory induction courses, manual handling and
drug administration training were not available or offered. Agency nurses had little time to get accustomed to the policies of individual hospitals. They may have been unfamiliar with the patients under their care, with local procedures, practices and equipment, and with their surroundings and colleagues. All these factors, combined with generally poorer attendance at mandatory and clinical practice training, increased the chances of patients receiving care of a poorer quality than they would otherwise get from a permanent ward workforce (Audit Commission 2001).

Ward managers experienced difficulties staffing wards safely with nurses whose skills and levels of competencies were unknown. The lack of permanent staff meant junior staff members could be unsupported. Students did not receive the levels of supervision and assistance that had been agreed. Many hospital policies do not permit agency nurses to perform key tasks such as administration of intra-venous medication and care of infusions. On-going assessment of patients’ health or plans for discharge and further treatment may be complicated to manage for an agency nurse who may be only spending an isolated shift on a ward. These factors placed additional burdens on the role of the ward manager who not only had to staff a ward safely but had the responsibility for leading a workforce that appeared to be increasingly weary of battling against staff shortages and financial constraints (Buchan and Seccombe 2004).

Project 2000, together with the cessation of enrolled nurse training, and high use of agency nursing came at a time when approximately 5,000 UK nurses
each year were applying for jobs overseas (Royal College of Nursing 2003). In 2001, to combat this increasing problem, Alan Milburn Secretary of State for Health pledged to increase the number of nurses by 20,000 by 2005, and to this end the Department of Health established an aggressive recruitment drive to encourage foreign nurses to work in the UK. In 2001/2 over 50% of new registrations to the UKCC came from abroad (Buchan et al 2003). Most came from non-EU countries, particularly the Philippines, South Africa, Australia, New Zealand and the West Indies. Whilst this may have contributed to solving an immediate crisis in recruitment there remained a longer term problem to address, that of an aging nursing workforce (25% of nurses were aged over 50) (Buchan et al 2003). The impact that inevitable retirement over the next decade would have on the number of experienced nurses remaining in the profession was significant (Buchan et al 2003). With nurses leaving Britain to work abroad each year and the average length of service for foreign nurses being somewhere between 2 and 6 years, (Department of Health 2003) the problems in ward staffing were considerable.

The Acute Hospital Portfolio Review carried out by the Healthcare Commission in 2005 found a direct relationship between poor standards of care and inadequate skill mix. Managing skill mix is influenced by factors such as increased turn over of patients, rapid changes in patient dependency and a workforce made up of different grades of qualified nurses, temporary staff and students requiring supervision. In a study carried out by Allen, ‘Stress among Ward Sisters and Charge Nurses’ (Allen
2001), the greatest anxiety felt by the participants (all ward sisters and charge Nurses) was about how their wards were to be staffed each day. Allen describes this pressure as ‘unremitting’ with chief concerns being directed at the level of competency of agency or bank staff. She paints a picture of an unstable nursing workforce with little sense of continuity or common purpose. Difficulties building up team spirit or feeling of identity within a ward when the staff were continually changing were identified, with little support to overcome them.

2.7 Clinical Leadership

It is clear that since the early 1980’s NHS reforms and changes in nursing practice have resulted in a series of subtle but significant changes to the ward manager’s role. Management responsibilities have taken priority over clinical duties and many ward managers anecdotally describe how they spend much of their working day attending to office based tasks.

Lord Darzi’s review (DH 2008) highlighted the need to develop leadership amongst clinical front line staff. It pledged to train leaders and recognised that up until this point the NHS had failed to address the issues around leadership. When exploring the role of the ward manager, the timeliness of Lord Darzi’s pledge is significant. As the ward manager’s role has evolved there has been a striking lack of specific training to manage new responsibilities.
During the 1980’s, The Kings Fund Report (Lathlean 1988) advocated the need for ward managers to receive training. However formal training was limited, sporadic and inconsistent (Ball 1998, McGibbon 1997, Allen 2001). When questioned many ward managers describe how they learned their skills ‘on the job’, as an ‘apprentice’, working their way up the professional ladder from junior staff nurse. Increasingly job descriptions for ward managers require evidence of a first level degree but this is not a mandatory requirement and many ward managers currently in post do not have this qualification (Williams 2001).

In 1999 the Royal College of Nursing responded to the need for effective nurse leaders by developing a twelve –month program of learning and reflective practice. The RCN Clinical Leadership Programme aimed to develop transformational leadership behaviours in its participants. The part time programme requiring a commitment of between 2 and 4 days per month enabled clinical leaders to develop the necessary skills to set and maintain high standards of patient focused care, to lead by example and to inspire, motivate and empower their teams (Long 2006). The Programme was open to clinical leaders from all disciplines in health care settings, but was predominantly offered to nurses in leadership roles. To take part, local trusts had to sign up to the programme and support their staff through a seconded local facilitator.

An additional course (frequently requested on job descriptions for ward manager posts) is the Leading an Empowered Organization (LEO) course. This was a 3 day course designed by the Centre for Development of
Healthcare Policy and Practice that was developed in the late 1990’s to contribute to the modernisation agenda of the NHS. It focused on proven strategies for developing leadership teams that can change the culture of their organizations (Faugier and Woolnough 2002), empowering professionals by addressing responsibility, autonomy and accountability. It has been delivered to 40,000 front line managers in the NHS among them many ward managers. A study to assess its value reported that it has a “positive impact on the leadership behaviour of participants” (Block and Manning, 2007). However Hancock and Campbell (2006), in a study to evaluate the benefits of LEO, describes how the ability to apply LEO principles were both restricted and assisted by the culture in which the staff worked, stating that a partnership between theory and practice was needed. They described a need for it to be implicit in the local philosophy so that the working context and people within it are closely engaged with the individual undertaking the course (Hancock and Campbell 2006).

Both these courses have clearly been shown to develop management and leadership skills amongst ward managers (Hancock and Campbell 2006) but evidence also exists to show that for ward managers to access these courses and utilise and implement the skills learnt from them, hospitals must commit to the professional development of their staff not only financially but also by engaging with the principles of leadership that are taught (Cooper 2003). Both the Clinical Leadership Programme and LEO principles include developing skills of autonomy and authority such as managing staffing.
levels, and selecting one’s own team. However in hospitals where higher level management dictates expenditure, sets budgets, controls staffing levels, and where ward cleaners are managed by external contractors, there is a theory – practice gap, as the potential for ward managers to implement and embed these leadership principles within their own wards is limited.

In October 2006 it was reported in the national press that up to 30% of training budgets for qualified nurses and midwives were being cut by Strategic Health Authorities in attempts to reduce hospital debt (Hall 2006). Not only did this have implications for the quality and experience of the future nursing workforce but it contradicted key objectives of the NHS Plan to invest in its staff. It also did little for morale within the nursing profession, offering little incentive and reduced opportunities for professional development. Whilst investment in NHS staff and strengthening leadership were key objectives of the NHS Plan (DH 2000) in reality individual hospitals’ commitment to this end has been compromised by financial and operational imperatives.

2.8 Clinical Expertise – The Expert Nurse

 Significant advances in training and education have come about since the development of graduate programmes for nurses in the 1980’s. This has led to opportunities for nurses to increase their skills and develop expertise in many different fields of care (RCN 2005). There is little evidence to suggest
that the implications for Ward Managers as a result of the development of the ‘expert’ nurse has ever been explored in depth, however in order to understand the contemporary role of ward managers it is critical to determine the effects that the evolution of the ‘expert' nurse has had on the role that historically was once seen as expert in its own right. Many of the specialist skills now undertaken by nurses with advanced training and post graduate qualifications were once an integral part of the ward sister’s role (RCN 2009). Not only was the ward sister key in undertaking clinical procedures, or managing complex cases, but she was also responsible for teaching junior staff. With the introduction of specialist nurses, matrons, consultant nurses and advanced nurse practitioners, these critical elements of the role have gradually been dispersed amongst a wider, and more highly qualified team.

‘Expert’ or ‘Specialist’ roles within nursing have existed formally since the early 1970’s when nurses began to develop a higher level of ‘specialist’ knowledge through post basic education (Hunt 1999). Since then, the growth of the specialist role has been rapid. The increasing public demand for specialized services in hospitals has required an expansion in knowledge and skills amongst the workforce which has combined with the timely desire of the nursing profession to enhance its academic status (Royal College of Nursing 1988). Specialist nurses now occupy a well-recognised and largely welcome position within hospital care. Cardiac specialist nurses, diabetic specialists, Intravenous specialists, and wound care specialists are common examples of the variety of specialist roles that
exist (Bale 2002, RCN 2010). Their roles, training requirements and job
descriptions are extremely varied and, whilst this has resulted in a wealth of
expert knowledge, it has at times led to a blurring of role and responsibility
within the hospital settings (Royal College of Nursing 1988, Castledene et al
1996, Mills 1996). This poor role definition, combined with inconsistencies in
educational requirements, has created confusion about the essential clinical
practice skills needed for this advanced role (Steele and Fenton 1988).
Consequently Hunt (1999) suggests that healthcare professionals’
perceptions of a specialist nurse are subjective and grounded in their own
experiences. This will be a critical factor in examining the relationship
between ward manager and nurse specialist.
How a ward manager works with a nurse specialist varies from one
individual to another. Such is the diversity of role within nurse specialists
that no blueprint exists to define expectations or level of commitment (Ball
2005). A ward manager may have several nurse specialists working within
the ward, but each may work in different ways, offering different levels of
staff training, patient care and support. Whilst this may provide the ward
manager with expert support in a variety of clinical areas, it has the potential
to become problematic if roles are not clear and expectations from each
side are different and represent a divestment of clinical expertise (Ball
2005). These unclear lines of accountability serve to further fragment the
role of the ward manager.
The professional relationship between a ward manager and a nurse specialist is not a subject that has come under scrutiny yet it is worthy of examination. Both roles are senior positions within hospitals and are intrinsically linked with one another. The ward manager’s responsibilities for patients covers a 24-hour period where specialist nurses are ‘invited’ in at the request of the nursing and medical staff, to assess, review, and plan a pathway of care. They usually attend during the normal working day and rarely provide out of hours services. On average 60% of a specialist nurse’s day is spent in direct contact with patients (Ball 2005). Their role within the ward team is therefore crucial. Not only do they play a significant part in planning care for patients, administering specialised medication and performing complex clinical procedures, but they also have a key role in the education of ward staff. As a result of the varied role definition of specialist nurses concerns have been voiced that where there is a lack of effective ward training the potential exists to de-skill ward nursing staff (Mytton and Adams 2003).

The ward manager has a responsibility for the learning environment, particularly in areas that support student nurses in clinical placements, such as the development of staff as mentors. The specialist nurse may also have a significant role to play in staff education. Well-trained ward staff are needed to carry out specific tasks not only when the nurse specialists are absent, but during their daily care of the patient. Every nurse must be able to support and educate patients (NMC 2008). Therefore the success of a
ward-training programme may well rest on both ward manager and specialist nurse working closely together to support this. This inevitably involves a commitment from both sides and clear definition of role responsibilities and the use of mentors.

Nurse specialists in acute settings are paid on average one pay band higher than their ward manager colleagues (Ball 2005). Whilst this may reflect a role that requires post-basic education and advanced training that is very different to the requirements necessary to be a ward manager, the higher levels of pay can also suggest that the role is regarded as a more senior position, with greater responsibility and autonomy and one that requires greater skill and knowledge. When examining both roles in context, it is questionable that this is so. Higher levels of pay, better working hours, greater autonomy and an enhanced educational status may well suggest that the role of nurse specialist is the more desirable career pathway for motivated nurses who choose to develop their skills. A survey conducted by the Royal College of Nursing (Ball 2005) that examined the working patterns of nurses in specialist roles highlighted high levels of job satisfaction. Specialist nurses felt that their work was valued significantly more (62%) than was felt in a cross section of RCN members (54%) assessed at random. A further study (Coster et al 2006) explored the role of the specialist and consultant nurse and showed findings consistent with those of Ball (2005). The study demonstrated however that there was dissatisfaction with the level of pay that they received and highlighted a concern that other
nursing roles did not always appear to recognise the remit of the nurse specialist or consultant role.

2.9 Modern Matrons

Both The NHS Plan (DH 2000) and Lord Darzi’s review (DH 2008) reaffirmed the need for ward leadership and supported the need to train clinical staff in leadership skills (see section 2.1). In 2000, The NHS Plan introduced a new leadership role for senior nurses - the Modern Matron. Alan Milburn, then Secretary of State for Health, described this role as an experienced leader and someone who was intended to:-

"play a key role in the Health Service, putting power back into the hands of frontline staff.” (Milburn 2001).

Modern matrons were given ten key responsibilities which included leading by example, resolving problems for patients, and making sure patients received quality care. Their tasks were to tackle hospital cleanliness, improve hospital food, prevent hospital-acquired infection and empower nurses to take on a wider range of clinical responsibilities. A key objective was to maintain a visible presence to both public and staff:

“ Matrons will be accountable for a group of wards. They will be easily identifiable to patients, highly visible, accessible and
authoritative figures to whom patients and their families can turn for assistance, advice and support and upon whom they can rely to ensure that the fundamentals of care are right.” (NHS Plan, Department of Health 2001).

The introduction of the modern matron is highly significant to this study. Its creation suggests that the need for a visible and experienced leader on the wards had been identified and that issues such as patients food, cleanliness, hygiene and infection control had until then been overlooked at that level.

As managerialism of the NHS in the 1980’s resulted in ward managers spending increasingly more time off the ward undertaking non-clinical duties there was also a corresponding fall in standards of hygiene, increased hospital acquired infections, low morale and difficulties in nursing recruitment across NHS hospitals (RCN 2009). How far the removal of the ward manager from the clinical area contributed to these changing patterns in hospital care is unclear but it can be argued that the role of the modern matron replaced elements of what had up until then been key priorities for ward managers, and areas for which they were accountable.

Politically, modern matrons were heralded as a major step forward in improving the hospital standards. They were given higher salaries (a Modern matron currently earns between £32,000 – £73,000, although few earn more than £45,000; NMC 2010) and a high public profile (Read et al 2004). There were 5500 matrons employed in the NHS (Mooney 2008).
The creation of a new tier of nurses at this level has resulted in further change to the role of the ward manager. Many of the modern matron’s ward responsibilities such as hygiene and infection control had previously fallen under the remit of the ward manager (Mooney 2008). In a comprehensive review of the role commissioned for the Royal College of Nursing, Read et al (2004) suggests that distinctions between the two roles were at times unclear, with lines of responsibility and accountability sometimes blurred or undetermined.

There has been little work to date that has understood the significance of the relationships between senior nursing roles (Matron, Specialist Nurse and Ward Manager) and consequently how the roles are defined and interface with one another remains unclear. It is timely that this study explores the relationships between these roles and, in defining the contemporary role of the ward manager, is able to determine how the changing dynamics has affected its inherent identity.

**2.10 Conclusion**

This chapter has explored the historical evolution of the role of the ward sister to the contemporary role of ward manager.

It has sought to contextualise the role of the ward manager and has examined the political and professional issues that impact on the work that
they do. It has explained how changes to the ward manager’s role have evolved over several decades and it has highlighted the impact of these changes. It has discussed the effects of government policy reforms on the management of hospital wards, and has highlighted the Griffiths Report in 1983 as a milestone in NHS managerialism.

It has shown how developments in nursing and nurse training have affected the role and it has identified that the introduction of specialist and senior nurses has had an effect on the identity of the ward manager. There has been little research that has explored the implications of this relationship.

It is evident that the ward manager’s role has become increasingly fragmented since the 1980’s and key elements of this traditional role are now undertaken by others. With little investment in training or leadership, and to meet the operational demands from hospital management it appears that ward managers have taken on roles that support operational and administrative functions rather than the clinical and educational needs of patients and staff.

The Darzi report (DH 2008) illustrated the need to focus on high quality care for all and the government has supported this as a priority for the NHS. Ward managers will play a significant part in the delivery of a ‘quality’ agenda, but how this will occur is as yet unclear.

The timeliness of this study is significant. It is crucial that in order to deliver high quality care to patients on hospital wards, in the current cost cutting
climate, the role of the contemporary ward manager must be understood. This understanding will come from recognising the impact of the changing context of hospital care on the role and by identifying the effects that the changing workload and responsibilities has on the identity and expectations of those who seek to perform it.

It is these themes that form the structure to the research questions for this study.

- What is the contemporary role of the ward manager?
- What are the contextual factors that influence the ward manager’s ability to undertake their role?
- What are the implications of a changing identity on the role of the ward manager?

The following chapter will describe the methodology that was used during this study to explore these issues.
CHAPTER 3

Research Methodology

3.1 Introduction

This chapter explains the methods that were adopted to engage with the issues that surround the role of a contemporary ward manager in general medical and surgical hospital wards of a large NHS Trust hospital. It demonstrates the methods of enquiry that enabled the reality of being a ward manager within this context to be understood.

Initially the chapter describes the epistemological position that this research has expressed and defines the essence of the enquiry. The chapter then discusses the methodology selected and demonstrates why it is an appropriate choice for research of this nature. The chapter then describes the philosophical stance that lies behind the chosen methodology and explains how it provides both a context for the process and establishes its logic and criteria.
3.1.1 Epistemological Perspective

No ‘blue print’ exists that can define a contemporary ward manager, so in order to create a detailed portrait of one, it is necessary to build this from observation and interview in context. The aim of this is to gain a deep understanding of the social processes that occur when contemporary ward managers undertake their role. This reflects the pragmatist philosophical tradition of Strauss’s Chicago school doctrines whereby the theoretical perspective of pragmatism informed symbolic interactionism, assumes society, reality and self are constructed through interaction (Charmaz 2006). This relies on language and communication. Charmaz describes this perspective as one that assumes “interaction is inherently dynamic and interpretive and addresses how people create, enact, and change meanings and actions” (Charmaz, 2006 p13).

Ward managers were observed in their own environment and watched as they carried out their work. Through semi structured recorded interviews and by listening to their personal narratives, their reflections and experiences were heard. The research took on a dynamic processural nature as negotiations and interactions within and between people and departments at various organisational levels were analysed.
To capture the dynamic and complex reality of the ward manager's role it was essential to locate myself as the researcher in the clinical environment and observe the role in action, and understand what their lives are like. I assumed the role of participant observer in medical and surgical wards of a large NHS Hospital Trust. I observed ward managers during their working day, as they carried out their work. My intention was to capture and explore the different interactions that occurred between ward managers, their colleagues and the patients, linked to the context in which they arose.

Data was also collected from detailed personal reflections from ward managers, nurses and other key hospital staff through ‘semi structured interviews’. These were tape recorded, enabling continuous review, so that detailed theoretical analysis of the data could be developed. Grounded Theory techniques were used to understand and analyse key themes that emerged from both the observed and recorded data. The technique of constantly comparing data, using coding, categorisation and memos was used to analyse data from the very beginning of the project, and emerging themes were re-visited with individuals wherever necessary for clarity, further investigation and verification. Throughout the research process, data formed the foundation of the theory and constant analysis of the data generated the concepts that were constructed (Charmaz 2006).

Throughout this process of research it is acknowledged that my position as researcher was not a neutral one. Having spent 20 years working as a
nurse in a variety of hospital wards, the environment, ward traditions and routines that exist within wards are very familiar. Grounded Theory allows the perspective of the researcher to be acknowledged and owned without detracting from the ultimate validity of the results (Glaser and Strauss 1967) (See section 3.2). Strauss and Corbin describe grounded theorists as researchers who are “unafraid to draw on their own experiences when analysing materials because they realise that these become the foundations for making comparisons and discovering properties and dimensions” (Strauss and Corbin, 1998 p5). Throughout the research process it was necessary for me to clearly acknowledge my own experiences and the context in which they occurred, and use these constructively to compare with the emerging data. Mason (2004) describes this active reflexivity, scrutinizing and challenging the changing perspectives and assumptions of the researcher throughout the process, as an essential component of an effective research methodology. Charmaz (2009) builds on both Mason and Glaser and Strauss’s conceptions of grounded theory in a contemporary revision that assumes a relativist epistemology, seeing knowledge as socially produced by acknowledging the multiple standpoints of both the research participant and the researcher.

3.1.2 Research Methodology

The historical and sociological background to this role, described in Chapter 1 has suggested that ward managers require special skills over and above
those taught during nurse training or from on-going professional development in order to carry out their multifaceted job successfully. The methodology used to understand more about these special and personal skills must therefore allow the researcher to open a door into the lives of ward managers. It must provide a set of principles and practice that encourages freedom to follow through lines of enquiry, thought and narrative wherever necessary in order to discover their real meanings. It allows meanings to be understood from the perspective of those who interpret them, and enables meaning to be deduced from the context of the social interaction within which they occur. At the same time, this chosen methodology must provide a recognised framework to support the research questions and ensure that conclusions drawn are credible, authentic and robust (Charmaz 2006).

To understand the current role of the ward manager their interactions and actions must be observed and interpreted by a process of gathering data that captures perspectives that are both rich and varied in content. This would give the subject a voice to express feelings, thoughts and experiences and expressions to common as well as idiosyncratic perspectives. By processes of negotiation, multiple voices can be heard that combine to generate wider understanding and meaning. This reflects a pragmatist viewpoint, and relativist epistemology that will assume multiple realities and multiple perspectives on these realities (Charmaz 2009).
There is no single reality when examining the experiences and feelings of individuals. Ward managers have had different career paths, different journeys and work within different contexts. Their differing interpretations of the role can be wide and far-reaching.

To explain the social process and reflect the reality of the Ward managers the techniques and principles of the methodology must enable the nuance and complexity of individuals to be captured. Methods of research that demand fixed parameters and limits would be unable to explore the thoughts and feelings of the individuals under scrutiny.

Charmaz (2006) describes the need for a flexible constructivist methodology (see section 3.2) that allows the researcher to develop a view from multiple standpoints and realities, including that of their own. This is important in order to examine the process of negations within the organisation and the relative positions and discourses of the individual as they communicate within it.

Throughout this study the key to understanding this complex role is to interpret meanings from many different accounts and from multiple and different perspectives.

There is more than one way to understand the role of the ward manager, but in selecting an appropriate methodology, consideration was given to methods that allow the researcher to interpret the meanings of their
interactions within the context to which they occur, whilst acknowledging the
reflexivity of the researcher.

Grounded Theory was the methodology adopted for this study. The
following section will discuss the model and tradition of Grounded Theory
that was adopted and explain the reasons for its selection. It will provide a
history of the development of this methodology and examine its benefits and
limitations to a study of this nature.

3.2 Grounded Theory

3.2.1 Introduction

This study draws on methods from Constructivist Grounded Theory.

Grounded Theory is a social process that provides systematic, flexible
guidelines for collecting and analysing qualitative data to construct theories
that are ‘grounded’ in the data themselves (Charmaz 2006).

Constructivist grounded theory is a contemporary revision of the grounded
theory methodology created by Barney Glaser and Anselm Strauss in 1967

The classical Grounded Theory has three overriding characteristics (Glaser
and Strauss (1967) :-

i) It is relevant in studies that have diverse areas and disciplines

ii) It provides a framework to think about, and conceptualise data
iii) It uses a constant comparative method to analyse data

Constructivist grounded theory has evolved its ontological and epistemological position to represent a “constellation of methods” (Charmaz 2009, p128) that:-

i) assumes a relativist epistemology

ii) sees knowledge as socially produced

iii) acknowledges multiple standpoints of both the participants and the researcher

iv) takes a reflexive stance towards actions, situations and participants in the field

Constructivist grounded theory allows the researcher to dig deeply into the beliefs, purposes, actions, and reasons for actions and inactions, and views these from their perspectives. The role of the ward manager is a complex one. It cannot be viewed in isolation, nor can one ward manager be considered the same as another. Constructivist grounded theory supports the need to locate participants’ meanings and actions in larger social structures and wider context. Its reflexive stance also recognises and promotes the position of the researcher within the field of enquiry. As a nurse with considerable experience at ward level, the constructivist methodology acknowledges the difficulty in distancing oneself from the analysis and writing, instead reflexively embracing the experience and using it to build on emerging theory.
Understanding the complexities of what is observed requires data to be constructed rather than discovered. In order to elicit the interpretation and influences that may be unstated or unrecognised, it is necessary to understand the beliefs, reasons for actions and interactions from the perspectives of those observed and the relevant circumstances to which they appear. These can be reflected in larger social structure and discourses to which participants may be unaware.

Ward Managers work within a micro environment of their ward. Surrounding this is the culture and context of the hospital. Above this are the wider contexts of the NHS, government policy and the Nursing Profession. The social causes of a ward manager's way of thinking and acting may have been constructed by wider contextual influences of which they may be oblivious. Constructivist Grounded Theory enables the connections between micro and macro levels of analysis to be explored and exposed in conjunction with the participant's own beliefs and interpretations and those of the researcher. As a result, grounded theory allows the researcher to view the subject through different analytical lenses. Constructivist grounded theory promotes a reflexive position throughout this research process. Throughout this period of research, the depth of my involvement in this subject developed and my assumptions and beliefs about the role of the ward manager were challenged many times. Having worked on different wards for many years, my knowledge of wards and ward managers had grown from a variety of different personal experiences. Combining these with knowledge gained from research of the subject, and the complex
analysis of detailed interviews and observations in the field, requires a skill to ensure that personal experiences and views do not cloud the richness of data or the analytical impact of the sociological narrative (Charmaz 2009). This tension results from drawing a balance between the subjective and the objective perspective.

This chapter will now explore the Grounded Theory methods and describe its historical routes.

3.2.2 Grounded Theory - The Theoretical Background

Grounded Theory provides a framework for social research when little is known about the subject to be studied (Eaves 2001, Morse 1994, Haig 1995). From initial investigations into the literature that exists about the role of the ward manager (section 2.2), it is evident that since the seminal works of Fretwell, Ogier and Orton in the 1980’s, little detailed attention has been paid to defining this role.

Grounded Theory is used to explain a social process, and when a new perspective to a phenomenon is sought. It allows the researcher to return to the subject’s primary sources (Glazer and Strauss 1967, Stern 1980, Creswell 1998). It is a process whereby ALL gathered data is potentially significant. This offers the researcher the ability to explore core concepts and emerging themes from their original sources. The technique of constant comparison of data used in Grounded Theory enables the researcher to revisit these original sources to test and re-test hypotheses and emergent
relationships that arise from the data. This is of value to the study as it enables comparisons to be made and themes to develop between the unique and individual experiences of different ward managers.

The constant comparative method allows for contradictions to emerge that can be identified, investigated and checked or tested against the data by engaging in a constantly reflective process between the data and the theory that it generates (Chenitz and Swanson 1986). This contributes to the generation of rich data that again will provide a vivid and revealing portrait of the ward manager’s role.

The process of data collection is driven by complex data analysis, for the purpose of building theory.

Grounded Theory initially uses an inductive process to gather and interpret data (Glaser and Strauss 1967, Charmaz 2006). The standpoint of the researcher forms part of the data and the lack of rigid pre-determined concepts or hypotheses permits an unobstructed discourse between the interviewer and the subject. This is a vital part of the study, as it gives ward managers complete freedom to speak from their own perspective and about their own experiences, without boundaries, restrictions and assumptions. In this way, data is articulated by the person for whom it has the most significance.
Ward managers work in an environment that is constantly changing. Relationships are formed and at many levels with different team members, hospital staff and patients on a daily basis. Some may be visible and clear but others may be so intertwined with daily life that they may be barely noticeable. The researcher must actively seek out individuals who are part of these relationships, but until the data is generated, these key players may remain unknown and unpredictable. Grounded Theory requires that data is gathered and analysed simultaneously, that one is a driver for the other (Charmaz in Denzin and Lincoln 2000, Strauss and Corbin 1990). This would enable the direction of enquiry to follow many different streams, all of which have arisen from the data itself rather than having been pre-determined at the outset.

Ultimately the key reason for selecting Grounded Theory was its potential to develop explanatory theories about social patterns (Boychuk Duchscher and Morgan 2004, Denzin and Lincoln 2000, Charmaz 2000, 2006). Whilst other methods of qualitative research support enquiry into patterns of behaviour, interactions and perceptions, it is the development of a theory that provides explanations for these patterns that is key to understanding the ward manager’s role within the context and dynamic that they effect. This is a factor that distinguishes Grounded Theory from other qualitative approaches to research (Eaves 2001). Constructivist grounded theory builds on this, provides a constellation of ways to think about data (Charmaz 2009). This enables the researcher the ability to create an illuminating and descriptive
model of the unique individual that is the modern day ward manager, a model that is directed by the data and grounded in it.

Finally, integral to the dynamic of data collection in Grounded Theory is acknowledgement that the researcher has a standpoint (Glaser and Strauss 1967, Charmaz 2000, 2006, 2009). I entered the research field with prior knowledge of the subject and an understanding of complex issues that surround the role of ward manager. Whilst other qualitative methods require interpretive analysis by the researcher, Grounded Theory uses the role of the researcher as a central part of theory development (Glaser and Strauss 1967, Strauss and Corbin 1994, Charmaz 2000). Constructivist Grounded theory develops the perspective of the researcher without detracting from the ultimate legitimacy of the results.

3.2.3 Grounded Theory - The historical background

Grounded Theory was developed by Glaser and Strauss in the late 1960’s for the purpose of studying inductive theory formation on the basis of phenomena and social processes arising from the data (Denzin and Lincoln 2000). It was developed during the modernist phase of qualitative research\(^1\) when heavy emphasis was placed on testing theories through quantitative research methods (Haig 1995, Goulding 1999). During this time sociologists

\(^1\) The modernist phase in Qualitative Research also referred to as the ‘second movement’ occurred from 1945 –1970’s (Hammersley 2004).
were using research methods that largely focused on how to verify theories (Glaser and Strauss 1967, Strauss and Corbin 1998).

Glaser and Strauss believed that when too much emphasis was placed on the testing of theory, the concepts and hypotheses to be discovered became less prominent. They argued that sociologists had focused on the testing of theories at the expense of the hypotheses or theories themselves. They worked together to study dying patients in hospital (Time for Dying: Glaser and Strauss 1967) where they addressed this issue by developing Grounded Theory. It was conceived as a way to conceptualise data (Hekkala 2007) and develop rigour into analysis to build theory. Strauss and Corbin (1998) describe Grounded Theory as providing a view of the world and a way of thinking – “The vision of new understandings” (Strauss and Corbin 1998 p14). In their research, Glaser and Strauss followed a process of analytical treatment that produced theoretical analyses of the social organisation and sequential process of dying. It was influenced by both qualitative and quantitative perspectives as Glaser and Strauss came from different research disciplines. Glaser was a sociologist with a background in quantitative techniques, whilst Strauss was a medical sociologist with a history of ethnographic research into the sociology of illness.

Together they described Grounded Theory methodology as a process whereby theory is constructed from concepts that emerge from the data itself (Glaser and Strauss 1967). They developed systematic methodological
strategies that social scientists could adopt and advocated the development of theories from research grounded in data rather than deducing testable hypotheses from existing theories (Charmaz 2006).

3.2.4 Grounded Theory – Different Schools of Thought

The development of Grounded Theory by Glaser and Strauss in the late 1960’s was a significant milestone in social research and their book The Discovery of Grounded Theory (Glaser and Strauss 1967) has been described as one of the ‘hallmarks’ of the qualitative tradition (Babchuk 1996). It was a catalyst for further research and refinement of the methodology and over the next three decades, Glazer and Strauss worked together and with others to develop and debate the foundations of their initial methodology.

The focus of the discussions has largely centred on the separation of ideas between Glaser and Strauss (Bryant 2003, Charmaz 2000, Glazer 2002). This division resulted in two separate schools of thought referred to as Glaserian inductive theory formation (Glaser 1978, 1992,) and Straussian inductive-deductive theory formation (Strauss 1987, Strauss and Corbin 1990, 1994). There are distinct differences between the Glaser and Strauss schools in both their ontological and epistemological perspectives, evident in comparisons between Glaser and Strauss’s original (1978) work “The Discovery of Grounded Theory” (1978) and Strauss and Corbin’s book “The
Basics of Qualitative Research” (1990). Glaser and Strauss’s Grounded Theory has traditionally been recognised to be a process of inductive theory formation (Glaser and Strauss 1967), but Strauss later adopted an approach to theory generation whereby theory develops through systematic data collection and continuous theoretical analysis (Strauss and Corbin, 1990). Strauss developed a complex process of systematic coding that differed from the second stage of open and selective coding process devised by Glaser and Strauss together (Glaser and Strauss 1967). Strauss and Corbin’s coding process added a third stage, axial coding. This process joins data together in new ways, by identifying causal relationships between categories and separating out core themes (Strauss and Corbin, 1990).

Glaser argued that this stage of the process was unnecessary and deviated from the natural emergence of the story being told. He believed that this forced conceptual descriptions that did not arise from the data (Glaser 1992). Strauss and Corbin defended this process by arguing that strict adherence to induction had the potential to create sterile and dull research (Strauss and Corbin 1994). In addition, Strauss and Corbin observed that researchers were theoretically sensitised and that Glaser and Strauss (1967) had failed to estimate the extent to which existing theories could influence the coding process (Strauss and Corbin 1994).

Epistemological differences between Glaser and Strauss can be demonstrated in their approach to the research question itself. Glaser
(1992) does not advocate a predetermined research question or problem, preferring that the researcher examine an abstract problem and the processes that surround it. He argued that a pre-determined problem directs the researcher to generate data that contains a sufficient number of examples of the same problem. The focus on pre-determined problems may prevent the researcher from identifying real ones, forcing a theory to emerge. In his 1992 text, Basics of Grounded Theory Analysis, Glaser describes Grounded Theory as an inherently flexible methodology, guided primarily by the participants and their socially constructed realities. Here he believes that the participant's world would emerge naturally from the analysis with little attention to the process by the researcher (Glaser 1992). He advocates immersing oneself in data and trusting that theory will ultimately evolve. Glaser criticised Strauss and Corbin's work, suggesting that it forced the development of theory and required a more structured approach to the coding process. He preferred to “see what evolves...” (Glaser 1992, p93), This was at odds with his own text in 1978 which reinforced the need for grounded theory to rely on a series of steps that could not be omitted if high quality theory was to be generated (Glaser 1978).

In contrast to Glaser's position, Strauss repeatedly emphasises the need to retain elements such as verification, generalisability and significance that position him closer towards more traditional quantitative doctrines (Strauss1987, Strauss and Corbin 1990, 1994). Strauss and Corbin (1990)
emphasize the importance of research questions that stem from personal experience or arise from literature. The researchers’ experience and existing theories play a significant part in data analysis. They describe the research question as a statement that “identifies the phenomenon to be studied” (Strauss and Corbin 1990, p38). Glaser however argues that the research question is only discovered when it emerges as a by-product of open coding, theoretical sampling and constant comparison. He criticizes Strauss and Corbin’s emphasis on verification and validation of theory, believing that validation falls beyond the parameters of grounded theory, which should focus on the discovery of theory not the verification of it. The initial driver for Grounded Theory in 1967 had been to move away from studies that focused on the verification of theory (Glaser and Strauss 1967).

Debates have surrounded Grounded Theory and its evolution ever since its inception in 1967 (Charmaz 2000, May 1996, Melia 1996). Critics of Strauss and Corbin have questioned whether their coding technique forces the generation of data and theory rather than allowing this to emerge freely (Melia 1996). However, supporters of the Strauss and Corbin school of thought (Charmaz 2000, Bryant 2002, Benoliel 1996) believe it to be a development in the Grounded Theory technique rather than a deviation from it. When Glaser and Strauss wrote ‘The Discovery of Grounded Theory’ (1967) they described their book as a “beginning venture in the development of improved methods for discovering grounded theory” (Glaser and Strauss 1967 p1). Strauss and Corbin describe how their revised
methodology evolved through teaching and discussion and was not, as Glaser had suggested, a rigid and inflexible process but a procedure and technique that had been presented that did not imply rigid adherence (Strauss and Corbin 1990).

Annells (1997) suggests that the differences between grounded theory methods may have been influenced by the eras within which it has existed. Denzin and Lincoln (1994) place Strauss and Corbin’s work (1999) in the post-positivist era but Annells herself (1996) identifies ‘embedded evidence’ in their work relevant to the constructivist paradigm of enquiry 1. This view is echoed by Charmaz (2000 p510): -

“The grounded theorist's analysis tells a story about people, social processes, and situations. The researcher composes the story; it does not simply unfold before the eyes of an objective viewer. The story reflects the viewer as well as the viewed.”

Glaser (2002) however, contests this, arguing that the purpose of Grounded Theory is to discover the social processes that surround a phenomenon studied in context. Constant comparison analysis serves to reduce subjectivity, and knowledge is not mutually constructed. Annells (1996

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1 The Constructivist paradigm is a set of assumptions about the nature of human learning. It recognises that learning is initiated and directed by the learner and by reflecting on our experiences, we construct our own understanding of the world we live in. (Piaget 1968)
p128) describes Grounded Theory as “maturing and branching as it is affected by multiple experiences and new ideas in the world of enquiry.” This is the difference between the modernist reductionist view, and the post modernist approach, which sees everything as constructed.

The understanding of grounded theory is dependent on an awareness of the ontological, epistemological and methodological perspective. Since the divergence of Glaser and Strauss, research studies have been undertaken using Grounded Theory as a methodology that have not identified the schools of thought that underlie their research. Recognition of the ideological differences between Glaser and Strauss influences decisions on collection and coding of data, use of existing theories, review of literature and inductive suggestions. The debates that have existed, particularly Glaser (1992, 1994) and Strauss and Corbin (1990), suggest that there is no single way of conducting research using Grounded Theory. Hekkala (2007) advocates providing clear description if a combination of the two ideologies is applied. Charmaz further describes Grounded Theory as “an umbrella covering several different variants, emphases and directions” (Charmaz 2009, p128). Because of my past experiences of working with ward managers for many years, as a researcher in this area I am drawn to a position that reflects a combination of the Strauss and Corbin (1990, 1998) ideology and that of Charmaz's constructivist perspective. Together they advocate that the researchers experiences are drawn upon to become the foundations for making comparisons.
Whilst the strategy for data analysis proposed by Strauss and Corbin (1998) may influence the progression of this study, the constructivist viewpoint that is adopted sees data as constructed rather than discovered. Bryant and Charmaz (2007) define the difference as those “who count what they see and hear as objective and those who see participant’s actions and researchers’ recordings and reports as constructed.” (Bryant and Charmaz 2007 p 21).

The latter uses the process of research itself as an object of scrutiny and therefore incorporates contemporary views in symbolic interactionism. This differs from Glaser who emphasizes induction or emergence, and the creativity of the researcher within a clear research framework. Strauss focuses on a more systematic approach and validation criteria (Morse et al 2009).

3.2.5 The Constant Comparative Method

The principles that form the underpinning of Strauss and Corbin’s Grounded Theory (1998) form a 3-stage coding process described as a Constant Comparative Method:-

i. Stage 1, Open coding

ii. Stage 2, Axial coding

iii. Stage 3, Selective coding
Stage 1 involves theoretical sensitive coding, a data coding process with simultaneous analysis using a technique of constant comparison. No predetermined categories exist, thereby ensuring that all data can be included without being forced into pre-existing categories. As there are no pre-conceived or pre-determined theoretical models all data is relevant. Data items are called ‘incidents’ which can be coded into as many categories as is necessary. As incidents are coded they are assigned a descriptive category, and compared to other similarly coded incidents within that category. Categories undergo constant review and modification. This constant comparison of incidents begins to generate distinctive theoretical properties within individual categories to explain the phenomenon that is the ward manager’s role. The second stage of the process involves theoretical sampling as categories are integrated. Comparisons of incidents develop from comparing incident to incident to comparison of incidents with the properties of the categories within which they fall.

Comparison takes place between categories and emerging theory (Hekkala 2007). The researcher identifies compatibilities or uniformities in the original categories and formulates an emerging theory based on a reduced set of higher-level concepts. At this point saturation will be reached when new data incidents can be coded and placed in existing categories and no new information is gained.
The final phase of the process is the point at which theory can be devised, based on the conceptual categories that have arisen throughout the analysis process.

3.2.6 Grounded Theory - The Theoretical Underpinnings

In order to fully understand the process of Grounded Theory research, it is essential to recognise its early conceptual underpinnings. Grounded Theory has its roots set in Symbolic Interactionism (Crotty 2004, Glazer and Strauss 1967, Chenitz and Swanson 1986, Hammersley 1989, Bowers 1988). This can be described as a lens through which to see the world. Symbolic interactionism proposes that individuals interpret their experience and create meaning out of those experiences. It explains how people attempt to align their behaviour with others, interpret the response of others and reorganize their behavior in response to these interpretations (Blumer 1969). Its primary focus is to generate explanatory models of human social processes that are grounded in the data (Morse and Field 1995). Charmaz (1990, 2005) argues that constructivist Grounded Theory does not necessarily require a symbolic interactionist perspective, but “can invoke diverse theoretical starting points to open inquiry such as feminist theory, poststructuralism, Marxist theory, or symbolic interactionism” (p 134 Charmaz in Morse and Field 2009). Charmaz continues to suggest that few grounded theorists commit to symbolic interactionism orthodoxy, instead
drawing on a variety of concepts and theories as part of the analytic repertoire.

3.2.7 Symbolic Interactionism – the background

In the early 1930’s George Mead, an American social psychologist argued that people’s selves are social products but adds that these selves are also purposive and creative (Mead 1934, Blumer 1969). In addition, Chenitz and Swanson (1986) suggest that it is in social interaction that the individual achieves a sense of self. The philosophy of symbolic interactionism is based on the belief that humans should be observed in the context of their own environment (Benzies and Allen 2001).

Blumer later named this sociological paradigm “Symbolic Interactionism”, summarizing the perspective by three fundamental principles:

1. Human beings act toward things on the basis of the meanings that the things have for them.
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows.
3. These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters. (Blumer 1969).

Blumer’s social constructionist approach claimed that people interact with each other by interpreting or defining each other’s actions instead of merely
reacting to each other’s actions. People then respond to one another based
on the meanings that they attach to these actions, rather than directly to the
action itself. Human interaction is mediated by the use of symbols, by
interpretation, or by ascertaining the meaning of one another’s actions.
(Blumer 1962). Within research, it is the researcher’s role to capture and
unravel these complex interactions and interpretations. Close observation
and detailed questioning of participants can help the researcher to unwrap
and interpret the meanings that these actions have for the individuals under
scrutiny. These principles were applied to the process of data collection
through close observation of ward managers, watching interactions and
questioning interpretations and assumptions.

Hospital wards display symbolic systems that are unique. Interactions
between managers, nurses, patients and other staff require the
interpretation and understanding of these systems. To understand the
actions of a ward manager when leading the ward team there is a need to
recognise the potential impact of the symbolism provoked by the concepts
of leadership and management. Symbolic Interactionism traditions are
concerned not only with knowing the individual’s point of view but also with
understanding the process by which points of view develop (Benzies and
Allen 2001). The Sociologist, Erving Goffman (1959) adopted the metaphor
of the theatre – front stage, back stage and off stage- to describe the way
humans present different faces or masks, depending on the role they are
expected to pay. This element is integral to the development of theory for this study as it enables the growth of multi-dimensional data.

The second principle of symbolic interactionism is that meanings of social phenomena originates or arises from the social interaction between individuals. Central to this premise is that a sense of ‘self’ is developed through such interaction (Locke 2001). All participants who took part in this study would have a concept of themselves as ward managers that had grown and developed from many previous interactions. Their own individual perception of their role as a ward manager would mould their accounts and narratives. This symbolic interactionist view of the development of “self” is an important perspective when attempting to understand the role of the ward manager. Grounded Theory allows the researcher to pursue this ‘self’ image by exploring and unravelling factors both in the past and present, which have contributed to the individualism of this role (Glaser and Strauss 1967).

Blumer’s final principle of social interactionism is that meanings are assigned and modified through an interpretive process used by the individual in dealing with the things he encounters (Blumer 1969). Simply this means that meanings can change. Symbolic interactionism describes a reality that is fluid and changeable rather than fixed and static (Crotty 2004). This is an important factor for this study because instead of providing merely a one-dimensional ‘snap shot’ of a ward manager, it enables the researcher
to probe deeper into a far more complex and illuminating world where multiple realities are apparent over time.

Methodologically, symbolic interactionism directs the investigator to take, to the best of his ability, the standpoint of those studied (Denzin 1978 p99 in Crotty 2004).

Whilst Symbolic Interactionism equips the researcher with the ability to understand why and how people act, Grounded Theory then builds upon this by its systematic, inductive and deductive analysis approach to theory development (Glaser and Strauss 1967).

3.2.7 Criticisms and Limitations of Grounded Theory and Symbolic Interactionism

There are many elements to justify why Grounded Theory was the methodology of choice (3.1.3). It provides the researcher with the necessary “tools” to address the research questions and to provide a recognised and tested framework for discovering the answers to them. Within this selection, however, limitations exist that must be acknowledged and accounted for. The following section will clarify these limitations and explain how they have been addressed and managed throughout the research process.

This section will first examine and discuss the criticisms that surround Grounded Theory as an effective research methodology. The second
section will identify the limitations of using Grounded Theory for a study of this nature.

There are two elements to the criticisms that surround Grounded Theory. There are those who have issues with Grounded Theory itself, and there are other critics who have suggested that the symbolic interactionist perspective places limitations on Grounded Theory as an effective methodology.

It has been suggested that Symbolic Interactionism sensitises researchers to certain beliefs, and due to its nature, can never fully reveal all there is to know about human behavior (Benzies and Allen 2001). These limitations must be taken into account when using a methodology that takes its roots from this perspective.

Symbolic Interactionism has been accused of minimising or ignoring issues of social structure and culture, whilst overestimating the power of individuals to create personal realities (Ritzer 1996, Morse 2001, Meltzer et al 1975). Many sociologists argue that it is necessary to examine social structure in order to understand the complexities “through which the episodes of interaction are connected.” (Ritzer 1996). Without such a focus, symbolic interactionism can suffer from a lack of coherence. Within hospitals there may be many defined cultures. These may be hospital-wide but may also be localised and specific to individual wards. Social structures also exist in many different forms. A hierarchy can exist that may affect communication
channels and relationships, whilst clinical, non-clinical and management staff may develop social structures of their own. These cultures and structures may have influences over the role of the ward manager, and thus it is important to ensure that they are addressed within the study.

It has also been suggested that Symbolic Interactionism does not pay attention to psychological details such as needs, emotions, and the unconscious. Symbolic Interactionism focuses on the nature of social interaction. However, Nursing is not exclusively a social science. Research into the holistic approach to modern day nursing in hospitals (see Chapter 2), requires the inclusion of both physical and psychological factors, such as the psychological aspects of healing, or the therapeutic environment, as well as symbolic interactionism, in order to reach conclusions that are not only robust but that are relevant to the current climate of health care. This study is concerned with the contemporary role of the Ward Manager, and therefore it is important to include theoretical perspectives that can reflect this.

The theoretical viewpoint of symbolic interactionism can provide an important insight into human behaviour (Benzies and Allen 2001) but it cannot alone fully develop the body of nursing knowledge required for a study of this nature. Grounded Theory allows the development of knowledge from other research perspectives, through its constant comparison techniques and the ability to follow themes as they arise through the data.
This study whilst rooted in social science can legitimately include other theoretical perspectives when the data demands it. Thus adopting a methodology that had its roots in symbolic interactionism was not considered to be detrimental to this study.

Critics of Grounded Theory have accused it of adopting a subjective process that lacks objectivity (Goldthorpe 2000). Some of these voices have been from those who have developed research techniques in the quantitative paradigm, using a purely deductive perspective for theory development. These critics come from a school of thought that does not embrace these inductive processes. Grounded theory is a methodology that can incorporate qualitative and quantitative data. A major misconception is that it is a qualitative method per se (Glaser and Strauss 1967).

3.3 Theory Development: Coding

Since Strauss and Corbin (1990) published Basics of Qualitative Research, a debate has existed surrounding their use of axial coding (Kendall 1999). Both Glaser (1978, 1992) and Strauss and Corbin (1990) described coding as a necessary part of transforming raw data into theoretical constructions of social processes. The Discovery of Grounded Theory (Glaser and Strauss, 1967) and Glaser's subsequent work use two types of coding processes, called substantive (or open) coding and theoretical coding. In Strauss and Corbin’s work (1990), three processes are described: open,
axial and selective coding. Both approaches to open coding are similar; Strauss and Corbin (1990) describe it as “the process of breaking down, examining, comparing, conceptualising, and categorizing data” (p61). Glaser emphasises the need to allow codes and theory generation to emerge freely from the data, without pre-determined categories. Axial coding is an additional process described by Strauss and Corbin (1990) as “a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories” (p96). It makes connections between categories and sub-categories. It focuses on emphasising causal relationships, and fits things into a basic frame of generic relationships. The frame consists of the following elements: Phenomenon, causal conditions, context, intervening conditions, action strategies and consequence. Each of these elements is examined in terms of their links and relation to each other.

Glaser argues against the use of axial coding by suggesting that this process ‘forces’ the data into pre-conceived concepts that may prevent the researcher recognising the actual significance of the data, but Strauss and Corbin advocate its use in assisting researchers to construct complex and meaningful theory more reliably (Strauss and Corbin 1990). Charmaz (2006) advocates two main types of grounded theory coding: 1) initial line-by-line coding, a strategy which prompts interrogation and close scrutiny of the data, allowing ideas to become conceptualised, and 2) focused coding which separates, sorts and synthesises large amounts of data. She
suggests that certain codes can crystallise meanings and actions in the data.

3.4 Theoretical Saturation

“The criterion for judging when to stop sampling the different group pertinent to a category is the category’s theoretical saturation. Saturation means that no additional data are being found whereby the sociologist can develop properties of the category” (Glaser and Strauss 1967, p61).

When the researcher has reached this point, and considers that there is no useful benefit in continuing to collect data, this process stops. Because theoretical saturation is a central feature of Grounded Theory, the point at which this is reached is crucial. Strauss and Corbin (1998 p136) describe this point as “a matter of degree”, believing that the potential will always exist for the ‘new’ to emerge, and if one looks hard enough, the potential for additional dimensions will always exist.

Critics of Grounded Theory have highlighted this as a concern (Golding 2002, Flick 1998, Morse 1995). Failure to reach theoretical saturation, termed ‘premature closure’ can result in a detailed description or account but may fail to produce a substantive or formal theory.

Within this study the point of saturation is clearly defined. Charmaz (2000) describes a study reaching saturation when it resonates in intimate
familiarity with the studied world. When the constant comparison of data no longer reveals new concepts, and no new themes emerge from analysis, saturation will have been reached. The white noise that exists around the emerging theory will add nothing new. It is important to reach this point, in order to avoid the study falling short of presenting a theory that has practical implications for the future of ward management.

Due to the nature of Grounded Theory it is not possible to accurately predict the size of the sample to be studied at the outset. The study size will depend on the point at which no new data is gathered and saturation is reached.

Data collection commenced in one NHS hospital, interviewing ward managers and those who work with them. Potentially it would be possible to interview ward managers in many other settings, including those abroad, and as Charmaz described, it could be possible for new issues to emerge from every source.

The aim of this study is to examine the role of the contemporary ward manager. In a health care climate that is changing rapidly it is important to explore the meaning of ‘contemporary’ and to ensure that the subject remains focused on the current. How this is achieved is described in chapter 6.
3.5 Review of Literature

Reviewing literature has long been recognised as an essential component of research to provide a significant and valuable source of data. However debate has existed amongst Grounded Theorists as to the point at which a literature review should be undertaken in a study, and the extent to which it should permeate through the research (Glaser 1992, Strauss and Corbin 1998, Chenitz and Swanson 1986, Charmaz 2000).

Glaser and Strauss held different views on the use of an initial literature review. Strauss, together with Corbin (1990) supported an early review, believing it to establish the study’s purpose and significance. They support the use of literature as a source for making comparisons to data, stimulating and generating questions that can then be tested against data, and encourage the use of literature as a secondary source of data. They also promote the use of literature to direct theoretical sampling, and confirm findings that emerge from the data, providing supplementary validity (Strauss and Corbin 1998). In this study, early examination of literature was used to establish the context and policy surrounding the role of the ward manager, providing a contextual background to the study.

In contrast, Glaser strongly disagreed with this process, encouraging the inclusion of a literature review ONLY after the emergence of developing theory, when core categories had been established (Glaser 1992). He
argued that review earlier in the process obstructs the flow of the theory from the data, potentially forcing a theory that may not actually exist. Avoiding a literature review at the beginning of the study means that the emerging theory is more likely to be grounded in the data (Hickey 1997, Cutcliffe 2000).

Strauss and Corbin (1998), however, advocate a simultaneous review of the literature as the study progresses, comparing emerging data with the body of existing literature. Charmaz (2006) supports Strauss and Corbin’s view advocating a flexible approach to the timing of the review of literature, preferring to concentrate on analysis and the construction of original theory that interprets the data. The literature is part of this data.

McGhee et al (2007) suggest that any researcher who is closely involved in their field of study may already be theoretically sensitised and familiar with the literature that surrounds the subject. As Grounded theory uses the experiences of the researcher to form part of the data (Glaser and Strauss 1967), pre-knowledge of subject literature need not prevent the generation of theory from the inductive-deductive interactions. Glaser’s concern with early review of literature was that it could lead to distortions in the researcher’s perceptions of the data. Key to avoiding this lies in the researcher’s ability to demonstrate reflexivity throughout the research process. Constructivist methods focus on engaging in reflexivity, and hence
the data generated from literature forms a component part of multiple realities.

As a researcher with a long term prior interest in the subject under scrutiny, I was familiar with much of the work that had been developed in the 1980’s and recognised its potential to add huge value to the study (Fretwell 1982, Ogier 1982, Orton 1981). The significance of this data was such that its use as a comparative case was important, and therefore it was used to build emergent theory. As the aim of the study was to understand the role within the current health care climate, adopting Strauss and Corbin’s method of early literature review also enabled comparisons to be made between data and literature, which could potentially make a valuable contribution to the generation of theory. Strauss and Corbin describe this as furnishing initial ideas to be used for theoretical sampling, using the literature as an analytic tool (Strauss and Corbin 1998).

McGee et al (2007) acknowledge that the Grounded theory approach is evolving and as such need not produce a static or single reference point. Throughout this study the literature was reviewed simultaneously along-side the process of data analysis.
3.6 Reflexivity, personal perspective and researcher perspective

Grounded theory allows the perspective of the researcher to be acknowledged and owned without detracting from the ultimate validity of the results (Glaser and Strauss 1967, Charmaz 2000). Constructivist grounded theory takes this further by using the researcher’s perspective (abductive reasoning) as a core component of the data. Using the researcher as an ‘instrument’, Strauss and Corbin describe grounded theorists as researchers who are “unafraid to draw on their own experiences when analysing materials because they realize that these become the foundations for making comparisons and discovering properties and dimensions” (Strauss and Corbin, 1998 p5). Recognition and acknowledgement of my own position within the research was crucial. Despite my long-term relationship with NHS nursing, I had not been a ward manager. I perceived the role’s lack of flexibility, long hours and unsatisfactory levels of support to be incompatible with an acceptable work – life balance. Instead my career path led me to adopt specialist roles with hospitals that supported the ward manager and maintained my direct involvement with patients. Could I therefore engage in the study of a role that I had not experienced but only witnessed? Despite never working as a ward manager, my experiences of ward management were both positive and negative. I had worked with ward managers who I considered to be inspirational and who became my role models. I had also experienced poor management at work with disjointed
staff working in isolation rather than as a team. Constructivist Grounded Theory allowed my perspectives to interrogate and question the data, actively seeking to refute or challenge issues, personal assumptions that were raised. Through different types of memo-ing, and working hypotheses it was possible to use the self as a sensitising agent with which to draw out data and analyse theoretical possibility within the data at increasing levels of abstraction and interpretation.

Mason (2004) describes this active reflexivity, scrutinizing and challenging the changing perspectives and assumptions of the researcher throughout the process, as an essential component of effective research design. However by constantly comparing the data, and thoroughly testing theories against the data, it is possible to recognise when elements of ‘bias’ are intruding into the analysis. The reflective nature of Grounded Theory allows the researcher to ‘step back’ from the analysis and question again what exactly is being said.

3.7 Strategies for Theory Verification

Essentially, Validity is concerned with the ‘truth’ or ‘falsity’ of an observation with respect to an external reality (Trochim 2006). In quantitative studies validity refers to getting results that accurately reflect the concept being measured. In qualitative studies however, the researcher is presenting a “perception” of a reality and hence a different standard for assessing the quality of the research may be required. Qualitative researchers, Guba and
Lincoln (1989) rejected the traditional criteria for judging research (internal and external validity, reliability and objectivity,) proposing credibility, transferability, dependability and confirmability as four criteria better reflecting “the underlying assumptions involved in much qualitative research”. They offer the view that ‘validity’ cannot have meaning as a criterion in a paradigm that rejects a realist ontology (Guba and Lincoln 1989). Both views of validity direct the researcher to a similar end and it is with this in mind that the issue of validity was addressed by asking the following questions of the study:

1. Do the conclusions drawn justify the complexity of the subject under scrutiny, avoiding oversimplifications and offering internal consistency?
2. Has the researcher’s view of self been recognised and acknowledged as an influential factor within the research but without causing a biased or one-sided view?
3. Have all possible explanations been explored?
4. Have findings been triangulated with alternative sources?
5. Have the findings been fed back to respondents to confirm that it reflects their beliefs and experience?
6. Are the conclusions consistent with existing knowledge and literature?
How the study demonstrated its commitment to validity will be shown in the following section.

**Section 3.7.1 Credibility**

The purpose of this study is to engage with the issues that surround the role of the contemporary ward manager, through in-depth interviews and observation. It is thus only the ward managers who are able to legitimately assess the credibility and integrity of their “world”, as portrayed by the researcher. Only those who have taken part in the research can confirm that their story interpreted by the researcher is a true and authentic account. Guba and Lincoln (1989) describe credible research when those who took part in the study are able to recognise themselves within the analysis and findings. All those who took part in this study were asked to read transcriptions of their interviews, and read observational records to judge the accuracy of the data gathered. Emerging concepts were discussed with the participants.

As the researcher is the instrument in the process of data collection, Patton (1990) suggests that the credibility of a study may also depend on the credibility of the researcher and their qualification and experience to undertake the study. He suggests that there are no definitive questions that can determine the credibility of the investigator, but he discusses the need
to be open and honest about personal and professional information that could affect the interpretation of data.

My qualification to undertake the study has been described in section 3.1.2, together with an account of the reflexive management of the data. Key to applying Patton’s principles to the data collection and analysis processes was to remain internally logically consistent, constantly aware of my own views and behavior and ensure that these were challenged and compared with other data as it was analysed. This was particularly relevant when I changed jobs mid way through the study, and assumed a role within the organisation as opposed to outside of it (see section 4.8).

3.7.2 Transferability

This refers to the degree to which the results of the research can be generalized or transferred to other contexts or settings (Trochim 2006). This study looks at the role of the ward manager in medical and surgical wards in one hospital (see section 4.2). Its findings, through the use of both in-depth interviews and observation, may only reflect a unique population and therefore cannot be generalized to others.

The decision to transfer the results of this research to another context must be the responsibility of the person wishing to make this judgement. To assist this process, and enhance the transferability of this study, it is critical to
provide an in-depth, illuminating and rich account of the context of the study (Geertz 1973. This is demonstrated in Chapter 4.)

3.7.3 Dependability

Dependability is concerned with the degree to which the changing context of the study was acknowledged throughout the research process, and how these changes in context affected the way the study was approached. It relies on being able to track the process of change within the research study and can be established through descriptions of changes in the study.

The data collection period for this study took place over a 4 year period, and the analysis of the data clearly demonstrated that a very fast changing context had a significant impact on the findings. The study was undertaken during a turbulent time for this NHS Trust. Three separate management teams with distinct and different styles led the organisation during the period of data collection, and there were significant events that occurred in the Trust during this time that had an impact on the workforce, the reputation and the management of the hospital as a whole. Nationally, the NHS was going through rapid political change and the introduction of organisations such as the National Institute for Health and Clinical Excellence and the Care Quality Commission (previously the Healthcare Commission) both prompted significant change at local level. In addition, nursing nationally has been moving forward at pace, whilst at the same time facing difficulties in
areas such as recruitment, retention and access to training. The impact of these also affected the organisation. These issues are discussed in depth throughout the study.

An audit trail that contains a dense description of research methods can demonstrate dependability and in order to show how this was managed, a summary ‘time line’ that tracks the changing context of the organisation during the study has been drawn that tracks significant events and changes at both national and local level alongside the period of data collection (see section 4.6.6).

3.7.4 Confirmability

Confirmability refers to the degree to which results can be confirmed or substantiated by others. Whilst it is assumed that qualitative researchers bring a unique perspective to the subject they study (Glaser and Strauss 1967) it is necessary to ensure that those who are able to authenticate or refute the results are provided with the opportunity to do so. In this study, the Ward Managers were key to confirmability. A strategy for enhancing confirmability in the study included procedures for checking and rechecking the data throughout the study with those who had provided it. This meant revisiting the field to discuss the findings from both observation and interviews with the participants involved and sharing findings and conclusions with them.
3.8 Conclusion

This chapter has explained the reasons for drawing on the methods of Grounded Theory as a social process to explore the role of the Ward Manager. It has explained how the constructivist methods will allow deep critical analysis into their ‘real world’, whilst at the same time ensuring that emerging theory remains intrinsically connected to its social location. It has explored the interactive nature of data collection and analysis, and the critically reflexive relationship between the researcher and the data. It has examined its background and theoretical underpinnings of Grounded Theory and has introduced key elements of the process involved in analysing, comparing, contrasting and managing the data. Criticisms and limitations of the methodology and its theoretical underpinnings have been discussed.

In summary, constructivist grounded theory, when combined with the ideology of Strauss and Corbin, provides a methodology that will generate a rich and intimate knowledge of the subject from which theories can be tested and retested. In this way, the study will create a clear understanding of the role of the contemporary ward manager and the theories that underpin it.

The following chapter will discuss how the principles of Grounded Theory were applied to this study.
CHAPTER 4

Method and Design

4.1 Introduction

This chapter describes the process and selection of the study sample, and explains the techniques and procedures used for gathering and analyzing data.

The process of Grounded theory involves simultaneous collection, coding and analysis of data, combined with the selection of participants from the start of the research (Glazer and Strauss 1967). Drawing on this methodology, what data to collect and where to collect it, was determined and controlled by the emerging theory. The methods of sample selection and data collection are explained, followed by a discussion of the benefits and limitations of the methods adopted. The process of theoretical sampling is also described and discussed during this chapter.

This research study raised significant ethical issues and involved a complex process to gain ethical approval. These issues are explored further.

Finally the chapter describes the measures that were adopted to ensure theoretical sensitivity was maintained throughout the study.
4.2 Sample Selection

A total of 32 members of staff were formally interviewed during in the study and fell into 7 specific groups: -

<table>
<thead>
<tr>
<th>Member of staff</th>
<th>Number interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Managers</td>
<td>9</td>
</tr>
<tr>
<td>Junior sisters</td>
<td>6</td>
</tr>
<tr>
<td>Staff Nurses: - Senior</td>
<td>3</td>
</tr>
<tr>
<td>Staff Nurses: - Junior</td>
<td>6</td>
</tr>
<tr>
<td>Care centre manager / Matron</td>
<td>3</td>
</tr>
<tr>
<td>Specialist nurses</td>
<td>4</td>
</tr>
<tr>
<td>Junior doctor</td>
<td>1</td>
</tr>
</tbody>
</table>

8 x 2-hour sessions were spent on wards, observing ward managers at work. During these sessions, conversations were had with other members of the workforce. Observation notes were made as a result of these interactions.

Other groups of the workforce included:-

- Consultant
- Hospital Chaplain
- Cleaner
- Student nurse
- Health care assistant
- Volunteer
- Occupational therapist
- Physiotherapist
4.3 The Initial Sample (Stage 1)

The inspiration for this research project had come at a time when I was working as a ‘bank’ nurse at night in the hospital during 2000 - 2003. I had worked in many of the general medical and surgical wards during this time and was familiar with their structure and philosophy. From my experiences there I knew staff and particularly ward managers to be interested and willing to discuss issues surrounding roles within nursing. This is consistent with Morse (1991) who suggests that purposive sampling should include participants whose experience of a subject is typical with a broad general knowledge of the subject. Baker et al (1992) also maintains that the sampling process should be initiated by interviewing ‘significant’ individuals. At this early stage I selected sample ward managers from both general medical and general surgical disciplines, avoiding ward managers from specialist areas who may not have experiences that could be deemed ‘typical’. ²

This selection provided an initial ‘purposive sample’ of three ward managers from general medical and surgical wards. The three participants were selected because they had each been ward managers for more than five

² In this particular hospital, specialist wards, such as maternity, paediatrics, cardiac, ICU etc, are organised and managed in different ways. Team leadership and shared management structures exist which create different ways of working and require a variety of different management roles to that of the general acute medical and surgical ward setting.
years within the same hospital. This length of service suggested that they had experience in the role (consistent with Morse 1991).

Each ward manager was interviewed and observed at work and after the first analysis of this data the process of theoretical sampling was adopted to determine the direction of the subsequent participants and the questions that were put to them. (See Fig 2)

4.4 Theoretical sampling (Stage 2)

Following the interviews at stage 1 with the first 3 ward managers the interviews were transcribed, verified by the ward managers for accuracy, and discussed again during a second interview where more specific questions were asked based on the information gathered earlier. Questions were more reflective, such as “Can you tell me a bit more about ..? or “Can we reflect on why ….? “How did this (issue) make you feel? From the responses generated it was possible to begin to develop concepts and early themes. These prompted the next stage of sample selection which was directed by the emergence of very early thoughts around developing concepts and potentially emerging theory.

Participants were therefore selected to the second stage of the process on the basis that their contribution would enhance the body of knowledge in a particular direction – see example 1.
Example 1

Ward manager 1 described during her first interview that she felt isolated from other ward managers and largely worked alone. This was supported by the second ward manager interviewed who articulated a similar theme. Both confirmed these feelings when asked to subsequently reflect on them. Ward Manager 1 suggested that it may be specific just to her. Ward Manager 2 suggested that it was common to all ward managers in the hospital. During observation it was evident that she did not have a supportive manager and had no time in the day to meet up with her peer group ward manager colleagues. This led me to begin exploring the concept of isolation and loneliness and to request two further ward managers in similar ward environments to join the study so that their thoughts and actions could be similarly questioned.

In this way and as a large volume of data began to be gathered containing a wealth of information, from an initial purposive sample of 3, an additional 6 ward managers were recruited, a further 6 junior sisters, 9 staff nurses, 3 nurse managers (Care Centre Manager/Matron), 4 specialist nurses and 1 junior doctor. (See Fig 1 – Diagram to illustrate sampling process below.)
Fig 1. Diagram to illustrate sampling process.
It was noteworthy that no senior doctors were recruited to the study. Although field notes included brief conversations with senior doctors there were no lines of enquiry during data collection that led to the need to question senior doctors at length. Only 1 junior doctor was interviewed. This lack of connection with medical teams was explored within the literature and little relevant data was found beyond that of multidisciplinary team working. This disconnection holds significance by its absence and has potential for a detailed study of its own. During 4 sessions of observation, ward rounds were observed with senior doctors. Their interactions were exclusively with their medical teams. The junior doctors were observed asking questions of the ward manager to confirm arrangements, tests and clinical plans, but no other interactions were noted. Senior Doctors were not observed at any other time.

A further example of theoretical sampling occurred during the study when poor standards of care on a particular ward in the hospital were exposed and reported heavily in the national media. This disclosure generated substantial national interest amongst both health professionals and the public and resulted in intense scrutiny of the hospital nursing practices and the attitudes of the nurses towards their patients. It was evident from conversations with staff that this exposure had affected ward managers in various ways. Prior to this event data analysis had suggested that ward managers were struggling to balance their managerial duties with their
clinical responsibilities. They had articulated that at times they struggled to maintain the highest standards of care on the wards because they were often away from the clinical area, at meetings, or undertaking office based activities. **Lack of control** was a theme that was emerging from the data as a result of these and other comments, and had also raised itself as an issue within the literature. Theoretical sampling provided the opportunity to explore this emerging theme and examine it in depth within the context of this specific incident. Throughout the duration of the study this incident featured heavily. It was referred to during interviews, and prompted significant changes in the organisation as a whole.

The ability to constantly compare data, combined with the method of theoretical sampling, provided a framework for generating theory that was multidimensional, encouraging depth and breadth. The background to the study (section 1.2) had identified that the contemporary role of ward manager had developed through the combined evolution of a number of factors over time.

Empirical evidence suggests that issues such as the growth of the National Health Service, changes in nursing and medical education and developments in technology for managing health and disease have had huge impact on the care of patients in hospital yet the significance of these and many other factors to the role of ward manager at the onset of the study were unknown. Theoretical sampling allows the researcher to probe into specific areas that may or may not be of significance to the research.
Conventional methods of sampling may constrain the scope of the sample, limiting opportunities to probe into concepts that are generated. This was demonstrated when exploring the significance of relationships between the ward manager and the modern matron. There was very limited literature to suggest that this relationship, though potentially meaningful, had ever been studied in detail. Through experience as a ward nurse I suspected that this may be a worthy line of enquiry. Theoretical sampling provided a process for this issue to be addressed whereby questions could be asked of each that enabled the significance of the relationship to be understood from diverse perspectives.

Theoretical sampling necessitates the building of interpretive theories from emerging data and selecting a new sample that are selected specifically to examine and build on this theory. Both Strauss and Corbin (2008) and Morse and Field (1996) suggest that the purpose of theoretical sampling is to collect data from places, people and events that maximise the opportunities to develop concepts in terms of their properties and dimensions, uncover variations and identify relationships between concepts. With this in mind it was important to ensure that the sampling process was responsive to the data and remained open and flexible throughout the study. The benefits of this were demonstrated by the depth to which a concept could be explored, and the freedom it gave to explore events as they occurred within the hospital throughout the duration of the research.
Example 3: When exploring the ward manager’s relationship with the matron, each participant described the association from different perspectives, drawing on their own experiences. Review of literature provided further viewpoints

Questions asked included:-

(To ward manager) Tell me about the relationship with the matron?
(To matron) Tell me about the relationship with the ward manager?
(To staff nurse) What is your view of the relationship between your ward manager and the matron?
(Researcher) What is my understanding of this relationship? What does the literature tell us?

Words were used (see below) which held different significance from the different perspectives. This generated initial themes which were compared further with other participants.

<table>
<thead>
<tr>
<th>Matron’s view of matron/wm relationship</th>
<th>Wm’s view of matron/wm relationship</th>
<th>Staff Nurse view of matron/wm relationship</th>
<th>Researcher’s view of matron/wm relationship</th>
<th>What does the literature tell us?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advises</td>
<td>Supportive</td>
<td>Advises on staffing</td>
<td>Challenging</td>
<td>Leadership</td>
</tr>
<tr>
<td>Challenging</td>
<td>Troubleshooter</td>
<td>Covers</td>
<td>Muddled responsibility</td>
<td>Role model</td>
</tr>
<tr>
<td>Line manages</td>
<td>Governance</td>
<td>sickness</td>
<td>Unclear roles</td>
<td>Mentor</td>
</tr>
<tr>
<td>Checking up</td>
<td>Adviser</td>
<td>Supports each other</td>
<td>Trouble shooter</td>
<td>Support</td>
</tr>
<tr>
<td>Help out</td>
<td>Manager of clinical area</td>
<td></td>
<td>Pulled in different directions</td>
<td>Educator</td>
</tr>
<tr>
<td>Unclear</td>
<td>Always around</td>
<td></td>
<td></td>
<td>Clinical expert</td>
</tr>
<tr>
<td>Monitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sorts staffing</td>
<td></td>
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<tr>
<td>Manages sickness</td>
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<td></td>
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<tr>
<td>Controls budget</td>
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<tr>
<td>Chastises</td>
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<tr>
<td>Rarely around</td>
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</tr>
<tr>
<td>Operational responsibility</td>
<td></td>
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</tbody>
</table>
The following section will describe the process by which access to these participants was gained.

4.5 Access Negotiations

At the onset of the study a plan was drawn up to identify an effective strategy for gaining access to undertake this research. This plan outlined the actions required to enter the research field (the clinical area) and to the staff that worked within it. It outlined the support, agreement, and resources that were required at different stages to ensure the necessary engagement with the staff and also identified methods of feedback to participating staff and the Trust as a whole.

Throughout these negotiations it was important to be mindful of potentially sensitive aspects of the study and to ensure that the outcomes of the research were received positively and in the spirit with which this study was conducted. In order to obtain rich data it was expected that probing and difficult questions would need to be asked. At the point of negotiating access to the field it was important to reassure the hospital that my skills as an interviewer were sufficient to manage difficult situations and that I recognised the boundaries of research and limitations of my role.
I was also keen to ensure the research process was not one way. I recognised the need to contribute to the work of the Trust and offer to provide feedback and appropriate support where and when requested.

A letter together with the research proposal was sent to the Acting Director of Nursing to explain the purpose of the study. A meeting followed where the study was explained and discussed. Access was granted in full with the suggestion of presenting my study proposal to ward managers at their monthly meeting prior to commencing fieldwork. This would be to advertise the study and to explain the rationale and reasons for undertaking it.

I attended two meetings and Ward Manager ‘Away Days’ and spoke at each to explain the purpose and process of the study. Feedback was constructive as Ward Managers discussed the potential positive aspects that could arise from a study of this nature. There was no opposition to the study, but the meetings did not include all ward managers so this cannot be considered a unanimous view. This issue was identified as an early limitation of the study process.

Mindful of the time commitments that potential participants would commit in order to take part in the study, I approached the Deputy Chief Nurse. I was aware that interviews could take considerable time out of the ward manager’s already busy work schedules and was keen to ensure that this allocation of time was considered to be not only of value but a legitimate use of work time. The Deputy Chief Nurse was satisfied that work time could be
used for interviews and conversations if i) ward managers chose to take part in the study and ii) the wards were adequately staffed during the time spent being interviewed.

4.6 Entering the Field

4.6.1 Ethical Issues

The prime concern in any research that involves human subjects is the protection of human rights. These rights are set out in the European Convention of Human Rights and are concerned with freedom of the individual and the protection of that freedom by preventing violations (Hegarty & Leonard, 1999).

Research governance within health care exists and is rigidly monitored with strict ethical rules. There are key considerations that were addressed within the study design and these issues, together with a lengthy ethical questionnaire were presented to the Local Ethics Committee.

Key considerations included:

- Confidentiality – including safe storage of tapes and records.
- Anonymity – including removal of all names on transcriptions and notes
- Voluntary participation and the ability to withdraw from the study
4.6.2 Confidentiality

All participants who took part in the study were assured that their confidentiality and anonymity would be maintained unless a disclosure (either during an interview or whilst being observed) was made that put a patient or member of staff at risk of harm. (In the event of a disclosure being made of this nature, the participant was told that the relevant management body would be informed).

Issues around confidentiality and anonymity included protecting the identity of the hospital itself. Particular care was taken when describing the organisation. To provide a contextual backdrop to the study, it was important to describe its organisational structure, its buildings and history. These issues were significant to the findings of the study and therefore needed to be described in detail. However, a rich and descriptive portrait had the potential risk of unintentionally locating the hospital geographically and exposing its participants. Trochim (2006) recognises this tension between ethics, confidentiality and the quality of the description for the reader and suggests taking care to minimise this tension by ensuring that all references to specific events, building programmes, building names and
other potentially identifiable factors were removed and only replaced by
generic and non-specific language.

The study did not include names or personal details of any participants and
these were removed from all transcripts of taped conversations. All tapes
and transcripts were stored securely, accessible only to the researcher, and
all electronic documentation was password protected (in accordance with
the Data Protection Act, 1998).

Care was taken to ensure that any information within the study, particularly
in the form of quotes, descriptions and commentary could not lead readers
to determine the identity of the participants. Each participant and ward was
assigned an identification code, which was used throughout the study.

To ensure confidentiality was maintained, at the conclusion of the study a
proof reader, bound by a code of confidentiality, was asked to read the
thesis and note any references that may have inadvertently breached the
commitment to maintain confidentiality. These could then be removed.

4.6.3 Voluntary Participation and Informed Consent

Participation in the study was entirely voluntary and participants were fully
informed about the purpose and nature of the study before taking part. Initial
documentation, sent to each participant at the point of recruitment contained
written information about the study. This allowed each participant to make
an informed decision to take part or not (See Appendix 2). The document also emphasised that they were under no obligation to take part or continue with the study and could withdraw at any time.

All participants were invited to sign a formal consent form (see Appendix 3). This was to ensure that both researcher and participant had discussed issues of confidentiality and anonymity and had mutually agreed expectations.

Fine et al (2000) describe the aim of informed consent in research as a process to protect respondents, informing of the potential for harm, and permitting withdrawal at any point. Fine suggests that in addition to this, it releases the institution from any liability and gives control of the research process to the researcher. Informed Consent within hospital is familiar terminology, and taking consent from patients for procedures is routine. As a result of this, inviting participants to sign a consent form before taking part in the study was not met with surprise or challenge, and as such had the potential to become “a formulaic piece of the research process” (p113). It was therefore important to ensure that consent to participate was truly ‘informed’ and the participants had fully understood what they had signed up to.

The emergent nature of qualitative research has the potential to be problematic. Informed consent stems from a framework of scientific realism
whereby researchers are able to predict the events that will emerge in the field. Research methods from Grounded Theory allow the researcher and participant freedom to discuss subjects as they arise through discourse during interviews. All participants were provided with information about the subject and purpose of the study at the onset of recruitment and therefore the agenda of the interview session was not entirely unexpected. The nature of the interview process however meant that there was no prescriptive agenda. Participants could not therefore be completely forewarned as to the details to be discussed. Instead the consent process stemmed from a mutual trust between research and participant and clear understanding of the terms of engagement.

The relationship that is built at this point may have a significant bearing on the quality of the data that is gathered. The foundations of mutual trust, honesty and value encourage a greater openness during the interview process (Fine et al 2000). However Lykes (1989) suggests that the consent form itself reveals the complexity of both the role as researcher and the constraints on developing collaboration between subjects in a context of real power imbalances. She suggests that as an instrument to protect the research participants it becomes instead a barrier between the needs of the study and the rules of engagement, and the “systems of trust and mistrust and of sharing and withholding.” (p178)

Once again, the relationship between researcher and participant is significant.
Lykes (1989) suggests reiterating the purpose of requesting their participation as a means of developing a trusting relationship. She demonstrates the value in explaining how participants ‘stories’ are told to policy makers, and audiences who hear and act on them. In this way, participants and researchers alike are both informed and informing.

4.6.4 Ethical Approval

The study was accepted by the Local Research Ethics Committee with one stipulation which was that dying patients would not be questioned during the duration of the study. At no time in the study would it have been appropriate to discuss this subject with patients who were dying and I had not anticipated that this would be a group that would be involved in the study.

In addition to the acceptance of the study proposal by the Local Research Committee as a Registered Nurse I was bound by the Professional Code of Conduct: Standards for Conduct, Performance and Ethics (NMC 1992). This states a requirement for confidentiality, informed consent, trustworthiness and respect for the patients for whom we care. Within this remit is also the expectation that any disclosure of harm or risk of harm to patients will be brought to the attention of the relevant body. These standards were maintained fully throughout the duration of the study.
4.7 Data Collection

4.7.1 The Recruitment Process

Initial recruitment to the study was made when the first three ward managers had been purposively sampled. A letter was sent to each of the three ward managers to explain the purpose of the study and request participation (see Appendix 1). This letter gave details of the study, information about why they had been selected and requested access to their wards for observation and an interview. Approximately a week after sending the letter, each ward manager was contacted by telephone and asked if they would agree to take part. All three ward managers agreed. A face to face meeting was arranged with each ward manager to arrange a date and time for an initial interview, discuss practical arrangements such as location and duration of interview and to suggest displaying an A4 sized poster in each ward staff area to provide information to other members of the ward staff about the purpose and process of the study.

4.7.2 Organising Interviews with other members of staff

Further participants were selected following the interviews with the initial three ward managers who had been purposively sampled and interviewed. Whilst some of these participants were also ward managers, others were staff who worked alongside the ward managers or had at some stage been involved in their professional development. As themes began to emerge from the data, the direction of sampling became apparent. Other staff were asked to take part in the study using a similar method to that adopted to
recruit ward managers. Each potential participant was sent a letter describing the study. This was followed up with either a meeting or a phone call to discuss participation and arrange a time to meet for an interview. Written consent, as before, was sought prior to interview.

The interviews followed a semi-structured pattern and although the aim was to understand the role of the ward manager when seen from the perspectives of staff who were not in that role, it was important to direct the line of enquiry to focus on emerging themes that had arisen from the ward managers’ interviews. An initial open question was asked of each participant – ‘Describe your experience of Ward Managers?’

4.7.3 Methods of Data Collection

Strauss and Corbin (1998) and Charmaz (2000) support the use of multiple methods of data collection and in keeping with this, methods adopted for this study were:

- Taped interviews: unstructured and semi-structured
- Observation
- Review of patient records
4.7.4 Interviews, Observations and patient notes

In-depth, face-to-face unstructured interviews were considered the most appropriate way to allow each ward manager to talk freely about their role with no fixed direction or pre-determined focus. Their effective use in qualitative research is well documented, particularly for their value in exploring new ground (Mishler 1996 Silverman 2001, Seale 1999, Rubin and Rubin 2005,). They allow the researcher to foster learning about individual experiences and perspectives in their natural setting, exploring themes and concepts, and their relationships to one another. They allow subtleties to be discovered that may otherwise be unnoticed (Silverman 2001).

Individual participants were asked to choose where to be interviewed. All requested to use the ward offices because interruptions would be minimal but it provided immediate access to the ward in the event of an emergency. Whilst this was a practical solution, it also provided an environment where I, as researcher, was ‘invited’ in to the ward manager’s office. The interview took place in the environment where the ward manager was at ease and where he/she was ‘in charge’. The issue of power is central to the relationship between the researcher and the participant (DeMarrais and Lapan 2004). Britten (1995) demonstrates that interview data is considered to be of greater quality when the power between the researcher and the
participant is equal. Traditionally in interviews it is the researcher who owns the project, sets the parameters for discussion, and analyses the findings. This gives power to the researcher. However, the participants have the knowledge that the researcher needs and consequently also have power in that they can chose what information to disclose and share with the researcher. Collaborative processes that involve negotiation and sharing of ideas often result in a stronger relationship between research and participant, equalising power and frequently generating insightful and high quality data (Strauss and Corbin 2008). Suggesting that ward managers selected their choice of venue for the interview contributed to this.

Conscious of how I would be perceived, I was mindful of my presentation, my title and my manner. I was keen to develop a relationship based on equality. By discussing the plan for the interview process face to face in advance, I was hopeful that a relationship could build from this point, prior to the interview itself that would develop a rapport that would reduce my position of power and encourage a more open and shared discourse. In all cases I was confident that this occurred.

Morse and Field (1996) suggest that the quality of a research project relies heavily on the researcher’s ability to obtain information. Glaser and Strauss (1967) suggest that in order to allow the fields of enquiry to emerge at an early stage it is necessary to gain early access to the participants’ perspective. It is hoped that this prompts stories to unfold that lead to the
emergence of some early concepts and direct the researcher to theoretically sample future participants.

The interview commenced with a brief discussion to ensure that explanations of the purpose of the study were understood and formal written consent was sought. Simple demographic information was requested such as age range, length of nursing career, and length of experience as a ward manager. Following this, each Ward Manager was encouraged to lead the interview, internalise their thoughts, and focus on their story. Munhall (2001) cautions against having fixed interview questions particularly at the start of the interview process as the core concepts are unknown, and with this in mind, the first and only fixed question asked was a simple request: “Tell me about your experience of being a ward manager?” This opening request is consistent with Charmaz (2000) who advocates asking open questions at the beginning of an interview to encourage freedom of subject direction.

Each of the three initial participants responded to this request in different ways. Whilst one initially described the journey to becoming a ward manager, another focused on the experience and difficulties associated with managing a ward budget and the third spoke of the difficulties of working in a fast moving and changing organization. Together, these three interviews provided a wealth of data. From the outset concepts began to emerge that required further scrutiny and the interview process developed into a rich dialogue. At times clarity was sought, confirmation of understanding was
requested, and more probing questions were asked following specific comments or statements.

A key point worthy of note was the conclusion to the interviews. Ending a lengthy and emotional discourse was difficult at times. Stern and Kerry (2009) describe the need to end an interview by bringing it back to a normal level of conversation at its conclusion. To leave an interview ‘hanging’ provides the potential to leave the participant in a vulnerable place. Mindful of this fact, care was taken with the conclusion of each interview. On one occasion, this was not possible. The ward emergency bell was triggered and the ward manager had to end the interview suddenly and attend an unexpected patient emergency. In view of Stern and Kerry’s advice, I returned to the field later in the evening, to close off the earlier discussion and end the interview.

Participants were asked permission for their interviews to be recorded. There are debates that surround the use of recording versus taking notes during interviews (Weiss 1995). Weiss acknowledges fears that the recording equipment may intrude on the interview, resulting in the participant holding back, or guarded in discussions. Glaser (2004) does not advocate recording interviews, believing field notes to be more useful as transcripts of tape-recorded interviews often include much data that ultimately is not used because they are not salient to the core variable. Schatzman and Strauss (1973) however dispute this, suggesting that at
outset of the study, the core variables and initial concepts were unknown. By recording the interviews, all data was preserved and transcripts could be re-visited throughout the study and compared with new concepts as they emerged. In recognising Glaser’s reasons for supporting note taking, there were many times during the analysis process when I re-listened to the interviews on the tapes rather than analyse data from the transcriptions alone. This ensured that data remained multi-dimensional, with tone, inflection, hesitancy, etc giving meaning to the transcribed words on a page, and bringing them back to life so that their true meanings were recognised.

From the outset of the interview planning it was difficult to judge how long each interview would take. Whilst the time constraints of the ward routine could limit the length of time the ward managers had to spend being interviewed, initially it was decided to avoid suggesting a fixed duration, preferring to let the ward managers dictate the time they wished to take to tell their story. During the study, interviews took between 1 hr 15 minutes and 2 hours 40 minutes. Morse and Field (1996) suggest that it is rare to obtain rich data from the first interview. In light of this, at the end of the first session it was considered important to keep the relationship with the ward manager ‘open’. I requested a second meeting to bring the typed transcript of the interview for each ward

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3 With the exception of one interview that was interrupted for an emergency, all interviews with ward managers took longer than 2 hours. On many occasions there was a cathartic “off loading” of information. One ward manager spoke of a liberating feeling as she talked about all the things no one ever listened to.
manager to read and verify, and to add any questions or seek clarity on issues that had arisen from the interview.

When meeting face to face with ward managers prior to the interview process a request was made for permission to observe each of them at work in their natural environment, on the ward. This involved going into the each ward for observation sessions for different periods of time, and at different times of the day, watching ‘what was going on’ and describing and analysing what had been seen. All ward managers agreed to this observation. Observation took place on the ward, in the ward office and during handover sessions and during meetings. In order to use observation to support and validate comments made during interviews the observations sessions were always arranged to take place after the initial interview with a ward manager.

The purpose of observation in the clinical field was to add breadth to the research and to provide insightful and illuminating answers for contextual questions that the interviews alone could not explore. Kawulich (2005) describes observation as a method of research that is least likely to lead researchers to impose their own reality on the social world.

In this context it was used to understand and interpret the cultural behaviour of the hospital wards and to provide insight into interactions between ward managers and other members of staff. It was hoped that it would provide an illustration of the whole picture and capture the context within which ward
managers work. It would also generate data regarding the influence of the physical environment. Morse and Field (1996) propose that observation enables the researcher to view the ‘society’ independently and assists in the interpretation of information provided by participants. In addition to this it drew out subtleties and demonstrated interactions that may otherwise have been un-noticed or not acknowledged during interviews.

The value of observation in qualitative research has been widely recognised (Goffman 1960, Spradley 1980, Morse and Field 1996), and described as ‘fundamental’ to much qualitative research (Adler and Adler 1994, Silverman 2001) because of its ability to understand a particular culture. Goffman (1961) advocated that in order to learn about a social group, a researcher should submit themselves in the company of the members to the daily round of petty contingencies to which they are subject. The observation process also had the potential to uncover behaviours or differences in influence of which the ward managers themselves could have been unaware. These issues were then discussed and explored during subsequent interviews.

As qualitative observation involves recording what people say and do, it relies on the skill of the researcher to capture the relevant data. Questions arise over what exactly is relevant. In Grounded Theory Glaser (1990) describes all data as significant, but in observational field work it is unrealistic to assume that it is possible to record everything, particularly in an environment such as a hospital ward where activity and interactions are
constant and varied. This raises the issue that observation is subject to interpretation. Observation that is based within the constructivist paradigm recognises the co-construction of knowledge between researcher and that which is researched (Mulhall 2002 Charmaz 2000) in the process of seeking the truth. Spradley (1980 p57) describes this as using oneself as a research instrument, increasing one’s introspectiveness of ordinary activities in order to understand new situations and gain skill at following the cultural rules. Mays and Pope (1995) suggest the key to obtaining high quality data lies in the researchers’ ability to record the ‘world’ as he/she sees it. They advocate the use of field notes written either during or immediately after the observation which are systematically recorded and analysed. These notes should, as far as possible, record exactly what has happened together with the researchers’ own thoughts and reactions to the particular event. The subjective nature of the data is crucial to the filtration and analysis process as it plays a critical part in the development of core concepts and themes (see example of field notes, page 152).

4.7.5 Issues Surrounding Observation

My role as researcher was that of Participant Observer which enabled me to undertake intermittent observation of ward managers at work along side interviews with members of staff. This overt observer role and purpose was known to staff working on the ward at the time. There are many areas of research when observers have undertaken a covert role and whilst there
may be benefits to this in certain arenas (such as criminal investigation), concealment of the purpose of the research or deception of identifiable participants would not be considered ethical as they are contrary to the principles of respect and informed consent in the context of this study. During the study, a significant and serious covert journalistic observation was undertaken and used to highlight poor practise with a particular ward in the Trust (see Contextual Background, Section 4.1) This had caused a wave of unrest and anxiety amongst all staff and mindful of this I was very keen for my motives and rationale for observation to be open and honest. I was also keen to share the findings of my observations with staff, and at the end of each session I discussed the relevant points with members of the teams that were involved. Not only did this offer them a transparency around my research but enabled me to question issues that had not been clear at the time and confirm and validate the accuracy of my session.

In the role of participant observer I stood or sat in a position on the ward where I could clearly observe the ward manager and watch interactions between staff. In the majority of sessions I would sit near the main nurses’ station which gave me a clear view of ward activity. (This varied depending on the layout of the ward; a better viewpoint was found by sitting near the ward entrance on certain wards.) Ward staff were informed of my presence and purpose before I commenced the observation and the ward manager confirmed with me that all staff were comfortable with my presence before I began. Posters explaining the study and my role within it had been put up
in the staff coffee room and by the nurses station in advance of each session and during it. Visitors were made aware of my presence by either the ward manager or the ward clerk.

An issue that required significant consideration before commencing the observation process was that whilst the ward staff had agreed to be observed, other members of hospital staff who visited the ward, such as doctors, porters, social workers etc would not be aware that their interactions on the ward were being scrutinised. In addition to this patients and their relatives were not aware of my presence and consequently had not consented to be part of the study. This problem was discussed with the chairman of the Ethics Committee in advance of commencing the study and with each individual ward manager at the start of every observation session. It was agreed that:-

- I was to wear a hospital identity badge clearly stating my position as a researcher.

- Posters were to be displayed on the Ward where other hospital staff could see them on the days I performed the observation sessions.

- Before commencing each session I explained my role to patients and relatives situated near to me. As the study was not directly concerned with individual patients, their diagnosis or treatment it was felt that as long as they had no objection to my presence, patients’ right to confidentiality or privacy would not be compromised.
(N.B This process was agreed with the Ethics committee at the time (2005) however it is acknowledged that new structures and governance around seeking ethical approval for research in patient areas require that every patient who could potentially be exposed to the study should be given full explanation of the purpose of the study and be given the choice to opt in or out).

In addition to the arrangements above, it was also agreed that if during the periods of observation an intervention or disclosure was made that was deemed unsafe, I would report it immediately and discuss with the most appropriate member of staff available. At that point the session of observation would stop. If an emergency situation arose, such as a cardiac arrest, or a patient fall, I would provide appropriate support as necessary within my professional nursing boundaries.

The second issue worthy of investigation is that of the potential for people to act differently when they are being observed. Measures were put into place primarily to guard against this but also to acknowledge its existence and use this as data. Mulhall (2002) draws on her own wide experiences of observational research and believes that its effect in participant observation is overemphasised. She suggests that once the initial stages of entering the field are past most professionals are too busy to maintain behaviour that is
radically different from normal. As part of the data collection process several observation sessions were carried out on any one ward and at varying times of the day. This ensured that my presence became accepted on the ward and staff swiftly began to ignore me. Hospital wards are often busy with a variety of staff present at any one time. It was not difficult to feel ‘hidden’ amongst the ‘traffic’ of personnel on a busy ward and remain largely un-noticed. This meant that staff ‘forgot’ that they were being observed and frequently, after an observation session was complete, would comment that they had forgotten that I was there. It appeared from this that I had gained cultural acceptability in the field.

A second advantage of observing the same ward manager on several occasions provided the opportunity to confirm the validity of data gathered from previous sessions. Often different staff would be on duty working with the ward manager during a series of sessions. In many instances particular themes would emerge from all these sessions irrespective of the staff involved. Repeated observation also resulted in the eventual saturation of categories, when no new themes emerged (see section 4.12).

Observation field notes were recorded using a system developed by Spradley (1979) whereby it is suggested that four separate sets of notes are taken:-
• Short notes made at the time of observation – as I sat/stood I wrote notes to describe what I had seen, what was going on, and interactions as they occurred.

• Expanded notes made as soon after the observation as possible; after each session, I sat in a quiet area away from the ward and expanded on the notes I had made. These were often based around key themes that already emerged during interviews that I had noted in advance.

• A field work journal to record issues and ideas that arise at each stage of field work; this took the form of a personal diary that I used throughout the data collection process. I carried around a hand help tape recorder which I often used to capture my thoughts.

• A provisional running record of analysis and interpretation; this formed the start of my data analysis and gathered momentum as the analysis process became increasingly large and complex.

Silverman (2001) suggests that this method of systemising field notes increases their reliability. Sandelowski (2002) supports this notion, highlighting the potential difficulties that arise from varied reporting styles, misrepresentation of data and lack of clarity concerning pattern and themes. She suggests that field notes contribute significantly to credibility and dependability because they contain both the immediate thoughts and the researcher’s reflective perceptions later, thereby facilitating the constant comparison of data. Field notes contributed to the process of self-reflection,
and enabled me to explore and reflect on potential influences I may have had on data collection. They were used as a resource to reflect on the research process as a whole.

Below are two examples of field notes:

Field note 1 shows page 1 of a session to observe a ward handover. A concept that emerged from this session focused on interruptions as staff came in to the office to ask advice and to collect equipment.

Field note 2 (described in Vignette 2, Chapter 6.1) again raises the concept of interruptions. The ward manager is repeatedly interrupted by clinical staff as she reviews a patient’s blood results.
“Call yourself a manager” - said to [redacted] who was social worker?

Family not known. Think this was for my benefit??

Observation session 2

Emily McWhirter

Field Notes.

Ward: [redacted]

Date: Wed 27th April.

Time: 1:45 - 3:45 pm.

Background

Observe latest shift handover
Staff shift template
AM: 3x EWA 2x HCA PM: 3x EWA 1x HCA Night: 2x EWA 1x HCA

Observation

WM has been XEA to numbers. Will take an patient this afternoon (8 pts E HCA) - B Grade. Have XEA D grade. This was as ward is clinically heavy.

Central position in ward. From left open

Three place in office. Ward. Is WM’s office, but general staff room, also used for changing room. Very untidy. Scruffy broken furniture.

Post out of date.

Patient 5 - WM gets up to take phone call.

Team carry on to Pt 6, 7, 8 before WM came back.

Questions for later

- Does WM get the into the needs from handover?
- No opportunity to teach. Just read off sheet
- Do staff always know what diagnosis is and treatment plan?

Remember to:

Why do people leave? No privacy in this room. Staff nurse neat/limit

Lack of money and beds. Only place in bed when not there. Is it different? Why?

V. noisy
Field note 2

Vignette 2

6.1

Observation session

Emily McWhirter

Field Notes.

Ward:

Date: 12th May

Background

1st session. 6am ward. Staff presence and formal ward activities. Patient at head of bed next to bed. Good start to day. All staff present. Notes on pills saying only to give if needed.

Observation

Main desk

Very noisy, hurried activity. Can I check patient?

Staff on ward. Ward discussion with patient. Checking blood results. Patient

by J. D., ready to use computer to

view blood results. Can stop conversation?

I don't think it has finished. Talking to J. D.

Get J. D. to walk in - to desk. (Get to 6). Tell J.

for 6, I'm for 6. Go straight up ward. (Interrupt conversation)

Tell J. D. to stop. Why? What is he doing.

Ask where. (25 sec). Never track what I want...

Chair, used, but uninterrupted and give up.

Questions for later

Can you make appointment?

Did I go with relative?

Remember to

Ask if I had times for ward round.

Why do the docs only talk to her?

9:40. Ward round.

Are we ever complete sentences. to conversation.

9:42. Someone tries to get

War's attention. Places.

Failed.
4.7.6 Limitations of Observation

Critics of observational research have argued that researchers in the field are unable to capture and interpret every event as it occurs (Kawulich 2005). The potential therefore exists to observe ONLY what the researcher deems to be relevant, possibly allowing other significant data to go unnoticed. To alleviate this Bernard (1994) advocates that researchers undertaking the observation should be knowledgeable about the subject under scrutiny and sensitive to issues surrounding it. Merriam (1998) adds to this by suggesting that the most important factor in determining what a researcher should observe is the researcher's purpose for conducting the study in the first place. Having experiences in ward nursing I was knowledgeable and informed prior to entering the field. I was also aware of the need to ensure I viewed the field as 'sociologically strange'. As Grounded Theory uses the experiences of the researcher to form part of the data (Glaser and Strauss 1990, Charmaz 2000) it was clear that whilst acknowledging that it is possible to observe what I deemed ‘relevant’, the reasons for thinking it to be so were also significant and therefore formed part of the data. The focus remained on gaining understanding of what was going on during actions and interactions. Whilst it was helpful to determine what to look for, the analysis drove the observation agenda to help focus on specific issues.
DeWalt and DeWalt (2002) have suggested that participant observation is conducted by a biased human who serves as the instrument for data collection. They observed that male and female researchers have access to different information as they have access and react to different people, settings, and bodies of knowledge in different ways. This draws on the need for the researcher to acknowledge these issues within the analysis of the data collection and to demonstrate an understanding of how his/her gender, sexuality, ethnicity, class, and theoretical approach may affect observation, analysis, and interpretation. I was therefore acutely aware of these throughout the observation period and built in a reflective period after each session to review the notes, evaluate my thoughts, and reflect on my interpretation of events. I also spent time after every session with each ward manager reflecting with them on what I had observed. This opened a dialogue where I could test my interpretation of events against their understanding and perception of them. This provided richness to the data that was gathered during the observation sessions.

A further limitation of participant observation particularly relevant in a hospital ward setting is that the observer is only present and observing for part of the time. Hospital wards function twenty-four hours a day with different staff, different shifts and patients that are admitted and discharged continually. It would not be possible to observe activity throughout this entire period. Relevant issues may arise hourly, daily or sometimes rarely, and
many will not occur at all during the duration of the study. To capture the culture of the ward in its entirety is an unrealistic task. Bernard (1994) notes that observers who remain in the field for an extended length of time are better able to obtain information. For the purposes of this study, wards were observed at different times of day and night, when the ward manager was on duty and when other members of staff were in charge. As Grounded Theory requires the researcher to follow lines of enquiry as they emerge through data analysis, the question of what to observe was directed by themes that emerged through interviews and observation sessions of various wards that were carried out concurrently during the periods of fieldwork.

Merriam (1998) encourages the technique of shifting from a ‘wide’ to narrow’ angle perspective focusing on a single activity, person or interaction, then returning to an overall view of the situation as a way to capture the nuances and activity that may occur.

The length of time spent undertaking observation sessions varied. Taylor and Bogden (1984) recommend short sessions at first to prevent the researcher becoming overwhelmed. Initially sessions were 1-2 hours in length but over time these varied. I would attend a ward round, listen to a ward handover, and observe a discharge meeting. At other times I could theoretically sample what it was I was watching, or just sit and watch what was going on.
4.8 Theoretical Sensitivity

Theoretical sensitivity refers to the ability to have insight, to give meaning to data and the ability to recognise and separate out what is relevant. Developing theoretical sensitivity was a significant factor in this study. Throughout the development of Grounded Theory, experts have suggested that the foundations of generating theory stem from the insights of the researcher (Glazer and Strauss 1967, Strauss and Corbin 1998, Schatzman 1991, Charmaz 2000). It is described by Glaser and Strauss (1967) as a process that is in ‘continual development’ (p46). It requires insight into understanding ‘what is being said’ and ‘what is going on’ in the data, in essence being able “to see beneath the obvious to discover the new” (Strauss and Corbin 1990).

It is enhanced by constantly asking what is going on? ...what am I hearing?..and how does this compare with what I know?

Developing theoretical sensitivity involved immersion in the data, which was achieved through a variety of methods: -

- Interview data: Listening to interviews, transcribing interviews, re-listening to the taped-recordings, writing notes, undertaking the coding process, returning to the field to clarify and challenge issues.
• Observation note data: Writing memos, coding. Memos were used throughout the study as a method for keeping track of information and ideas, and refining concepts as data is compared. Glaser (1998) describes them as an instrument for the outflow of ideas, and positioned them as the core stage of grounded theory methodology whilst Charmaz (2006) suggests memo writing is a way to “converse with yourself” (p.72), “explicate and fill out categories” and “serve as the analytic core for subsequent writing” (p72) (see Memos, section 4.11.4)

• Literature: Literature was used throughout the study as part of the data collection process. Its role in developing theoretical sensitivity is twofold. It widens the research field, firstly, by allowing different perspectives of a specific subject to be explored. This contributes significantly to the process of theoretical sampling as it can contribute to developing lines of enquiry and provide case comparisons. Secondly, it provides a strategic view of a subject and enables links to be developed with subjects not directly associated with the subject matter. An example of this occurred when exploring concepts around identity. There was little literature to be found that explored a changing identity amongst senior level nurses but a search through literature directed attention to the airline industry where a study (Hochschild 1983) had raised interesting and relevant points that challenged thinking around the concepts of emotional management in an industry going through change. Parallels could be drawn that
contributed to development of a theory surrounding identity and agency.

- Personal and professional experience: Charmaz (2000) suggests that the experiences of the researcher are key to the development of theoretical sensitivity. My professional experiences had spanned many years. Having started nurse training in 1987, my experiences of ward nursing had occurred during a period of change not only within nurse education but also throughout the NHS as a whole. I had seen at first hand the effects of a changing workforce and had been in charge of wards on many occasions where, for example, conflicting priorities and problems with staffing had been very real issues. These past experiences, whilst personal, were significant. Taking account of them, I incorporated the thoughts and themes they generated into the theoretical sampling process.

4.9 Change in role

For the first 3 years of the study my involvement with the Trust was as an unpaid researcher. In this role I entered and left the field with the purpose of understanding the research questions that had been determined. I spent time in the hospital interviewing staff, observing them at work in clinical areas, and familiarising myself with the contextual backdrop to the study. In September 2007 I joined the Trust as a nurse working in a service modernisation role. My position as an independent research student remained unchanged; all work connected to the study was undertaken in my
own time and continued outside of my employed position. Before joining the Trust as an employee I had undertaken the majority of the data collection. Four further interviews and two sessions observing in the field were subsequently carried out once I had commenced employment and within the first 4 months. However exposure within the Trust and my understanding of the organisation altered significantly once I was working in it.

My position provided opportunities for greater insight into the relevant organisational issues and events that were evolving within the field. This significantly altered the sensitivity to the data and to the development of emerging theory.

Guba and Lincoln (1998) describe sensitivity as the degree to which researchers bring to the research situation their particular paradigms. All aspects of the self, such as perspectives, experience, training and biases become woven into all aspects of the research process. My interest in the role prior to commencing the study had resulted in a degree of sensitivity to the role itself and the generic field in which it was situated. However as the study progressed, my knowledge of the day-to-day operational management of the hospital, its communication methods and its core values and priorities developed. These insights were used to inform the research in multiple ways. Dey (1993) suggests that in order to analyse data effectively researchers draw on accumulated knowledge. Strauss and Corbin (2008) support this by describing how researchers move along in the analysis
process and a constantly growing knowledge and experience enables a greater response to the data. They suggest that backgrounds and experiences provide the mental capacity to respond to and receive the messages contained in data, whilst at the same time keeping in mind that findings are a product of data as well as what the researcher brings to the analysis. Sensitivity is therefore an interplay of researcher and data in which understanding of what the data describes slowly evolves. Corbin (2008) advocates that a greater awareness of subjectivity involved in data analysis provides a greater understanding of how interpretations are influenced.

In addition, Strauss and Corbin (2008) support the view that professional experience enhances sensitivity as it can enable the researcher to understand the significance of events and situations more quickly. During several interviews in the first stages of data collection, ward managers described their frustrations when the hospital management team opened and closed wards at short notice to meet the changing operational needs of the Trust, with little apparent regard for the teams that had been created and built up to work within them. Early analysis of data recognised themes of frustration and lack of continuity, however it was not until later, when working within the Trust, that the depth of these frustrations were truly recognised. The signs that suggested a loss of identity, a lack of self worth and recognition that resulted from the closure of a ward and the disbanding of a team were clearer to recognise when I worked more closely with the team and understood better the organisational issues that had resulted in
the closure. It was only when witnessing at first hand the implications for ward staff when a ward was closed that the significance of the event was fully grasped.

4.10 Data Analysis
The analysis of data, generated from interviews and observation, was undertaken as a continuous process, simultaneously along side data collection and the process of coding. This is consistent with the Grounded Theory method (Glaser and Strauss 1967). The data was analysed manually. Although computer packages exist for data analysis I had no experience of using these in practice, and had been cautioned against their use by colleagues experienced in data analysis of Grounded Theory studies. It was suggested that computer analysis could distance the researcher from the data (Sandelowski 1986). Strauss and Corbin (1998) acknowledge the use of computer software but suggest that it has the potential to alter the quality of the theory. The relationship between researcher and the data is central to the Grounded Theory method and for this reason I chose to avoid the use of data analysis software and examine and analyse the data by hand.
4.11 Coding Process

The coding of data is structured around three stages and whilst the analysis of data as a whole is an iterative process using the technique of constant comparison, the three stages have distinct purposes.

![Fig 2: Demonstration of the stages of the coding process]

- **Stage 1**: Open Coding
  - Recognise concepts
  - Develop filing system
  - Example: Interview data
  - Concepts: Frustration, Dissatisfaction
  - Not listened to, Lost

- **Stage 2**: Axial Coding
  - Reassemble data
  - Categorise related to sub categories
  - Example: Lack of support, Undervalued
  - No role within organisation

- **Stage 3**: Selective Coding
  - Major categories
  - Integration and refinement of major categories
  - Example: Lost Identity
4.11.1 Open Coding

The purpose of coding is two-fold. Firstly to code data so that categories can be recognised and analysed, and secondly to develop a ‘filing system’ or flexible storage system with procedures for retrieving data (Morse and Field 1996). Strauss and Corbin describe Open Coding as similar to “working on a puzzle” (1998 p223). Pieces are sorted and a picture is created by putting the individual pieces back together. During this first phase phenomena that arise from close examination of the data is named and categorised. Initially I transcribed each interview. This was a lengthy and time consuming process but one that enabled me to become absorbed in the interview itself, familiarising myself with its content, questions and responses. The transcribing process slowed down the conversation and enabled me to listen, over and over again to the words that were used. An overall analysis was made following the transcription and from listening several times to the interview in its entirety. ‘Operational notes’ were made as I listened to the interview, which consisted of initial thoughts, questions and impressions:
Following this a line-by-line analysis was undertaken, described as microanalysis (Strauss and Corbin 1990), where data was broken into separate categories, which were compared and examined for similarities and differences. Consistent with Strauss and Corbin’s (1990) method of initial coding, questions were asked of the phenomena based on my own assumptions and those from other sources such as existing literature. From this line-by-line examination of the data a detailed interpretation arose which began to unpick the complexities of the phenomena under scrutiny. Linkages were made between different interviews whereby issues and explanations were connected together. Early concepts were generated which was eventually to form the basis of an emerging theory.

There are different practical ways of developing a coding system. Morse and Field (1996) encourage the researcher to stick with core principles but develop a system that best suits their own methods of working. The system best suited to my visual way of working was to have transcription pages with large margins. Major themes were labelled within each paragraph by writing a category in the margin and highlighting particular words or sentences.
Each labelled paragraph was then cut and glued on to a larger sheet of paper; there was a different sheet for each category. During this initial phase, categories were kept as broad as possible, and were independent of each other, i.e. they did not overlap. Morse and Field (1996) suggest that in the initial coding phase, it is difficult to work with more than ten codes as they lose their distinction. Careful selection of the code subject is therefore imperative. This was achieved by highlighting certain words or phrases that stood out amongst the data as I read it repeatedly, simultaneously using theoretical notes (see Memos) to analyse what is going on.

Core concepts were used to explore construction allowing data analysis to drive subsequent data comparison, then returning to further data analysis / data comparison and coding.
Fig 4. Table to illustrate development of initial concepts.

<table>
<thead>
<tr>
<th>Interview transcription</th>
<th>Initial Concept</th>
<th>Memo</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>WM 1. Talking about being moved from one ward to manage another… “it's like being a jack of all trades and <a href="https://www.example.com">trouble shooter</a> but the trouble is you never get settled and once you start building something up and I've done it here now, (referring to the Ward) and the risk is its all going to go again.</td>
<td>Jack of all trades - not recognised as skilled in specialist field</td>
<td>WM 1 is frustrated about being moved from one ward to another when he is just beginning to build up his team. Because this has happened several times in the past he knows it is a risk on his present ward. He is frustrated that despite being good at ‘trouble shooting’ he is used to resolve management problems and never reaps the long-term benefits of developing a good ward. He does not welcome this position.</td>
<td><a href="https://www.example.com">Frustration</a>, mismatched expectations</td>
</tr>
<tr>
<td></td>
<td>Trouble shooter Unsettled</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of continuity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WM 3. “I ended up here because I was asked to care take a ward because the Ward Manager was actually on long term sick.” …I’ve gone from being specialized in diabetes to general medical care to short stay medical care and it’s different, very different…that's quite frustrating</td>
<td>Ended up</td>
<td>WM 3 was put into a Ward to cover sickness. She had been a skilled diabetic Ward Manager but had been moved to resolve a management problem. No regard was taken of her specialised knowledge, although she recognised it herself.</td>
<td><a href="https://www.example.com">Dissatisfaction</a> Recognised for being able to cope with change and sort management issues but not regarded for specialist knowledge</td>
</tr>
<tr>
<td></td>
<td>Trouble shooter</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frustration – not recognised as skilled in specialist field</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Analytical memo** – what is a reward in specialist knowledge - ? longer term established teams / stability?
As more data was analysed, these major categories were sorted into smaller sub-categories, drawn from the major categories. This is the process of Axial coding.

4.11.2 Axial Coding

Strauss and Corbin (1990) describe Axial Coding as the point at which “the analyst begins to fit the pieces of the data puzzle together” (p229). The purpose of axial coding is to reassemble data that was broken down during the open coding process. Categories are related to their subcategories to form more precise and complete explanations about phenomena. By constantly comparing data, central themes began to emerge. During the process of axial coding categories are related to sub-categories to provide clear explanations of the data.

Throughout the axial coding process my intention was to look for answers to questions such as how? Or why? Strauss and Corbin suggest that by answering these questions it is possible contextualize a phenomenon.
Analytical memo:- What makes them consider agency nurses have low standards? (Reflexive, personal memo: - I was an agency nurse for 2 years and my standards were very high).
4.11.3 Selective Coding

This is the stage of the coding process when major categories are integrated and refined to form the theory. Strauss and Corbin (1990) suggest that the first step in this process is to decide on a central category that represents the main theme of the research. This central category should pull the other categories together to form an explanatory whole. Deciding on a central category with such a huge wealth of data available is difficult. To assist this Strauss and Corbin offer help. They advocate writing the story line, stepping back from the detail within the data to literally tell the reader what is the main issue? What message is repeatedly being said?

See example of a story line below.
Story line 1

Ward manager 1 explained how she was the manager of a diabetic ward. She has specialist training on diabetes and developed a training package for nurses on her ward to learn about diabetes. At the end of a week, out of the blue, the care centre manager came and saw her in the middle of a shift and told her that from Monday her ward was to become a 48-hour short stay ward, pulling patients from A&E, and focusing on rapid diagnostics and rapid discharge. No mention was made of the specialist knowledge of diabetes. Another ward manager recounted a situation when he was asked to move wards and take over the ward management of a haematology ward. This ward manager has no previous experience in haematology, but was an experienced leader with a strong ward team who care for patients following a stroke. Neither ward manager was in a position to dispute the changes. The ward manager who moved to haematology was upset by the move. He had worked on the stroke ward for several years, gathering a good team together who worked well. He described how his old team on the stroke unit struggled without a manager, and over the next year, many left to work elsewhere. A third ward manager described frustrations with the ‘management’ because on 3 occasions in the past six months they had pulled 3 of her nurses and taken them to work for prolonged periods of time because the other wards were short staffed and could not recruit. This left her without the skilled staff that she had come to rely on. Each of these scenarios demonstrate that hospital ‘management’ have little regard for, or value specialist experienced skills, or ward teams, as they move ward staff around the hospital, filling staffing gaps as required. Question: Should ward staff be generic and flexible, able to work on any ward at short notice, or do we need specialist teams with specialist nursing knowledge that we value? Message: Specialist skills are not important – staff unvalued and frustrated.

“You carry your suitcase with you all the time because you never know where you will be working from one day to the next” WM02
4.11.4 Memos

After initial coding of each interview or observation session, extensive memos were written to capture ideas and record recurring themes that were seen in the data. Chenitz and Swanson (1986) describe these as the researchers’ written records of the analytical process that demonstrates the step-by-step process of theory development. Memos provide ways to compare data, to explore ideas about the codes, and to direct further data-gathering. They provide a trail that shows the direction of the research, and should be analytical and conceptual rather than descriptive. They force the researcher to move from working with data to conceptualising (Strauss and Corbin 1990, Charmaz 2000). Charmaz (2006) suggests that memos become progressively more analytical as the data and coding process becomes more familiar.

Memos were hand written or typed on A4 sheets of paper. Some were short memos, especially during the early part of data collection, but others were lengthy and detailed. All memos were kept in a large file, indexed and stored in date order. This meant that individual memos could be found and retrieved easily for sorting and cross-referencing. The memos contained my thoughts about ‘what was going on’ and included questions and comments that could be followed up through theoretical sampling.
Strauss and Corbin (1990) describe three types of memos, throughout the study:

1. **Code note**: - a memo that contains the actual product of the three types of coding (open, axial and selective)

   **Fig 6. Example of a code note**

<table>
<thead>
<tr>
<th>Code note</th>
<th>Participant: WM03</th>
<th>memo no: 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Line:</td>
<td></td>
</tr>
<tr>
<td>&quot;When I first worked here there was only four of us where English was the first language, that has caused major problems&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code note: Feelings around language barrier caused by extensive use of foreign nurses.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Theoretical note**: - a memo that contains a summary of thoughts and ideas. It will direct process of theoretical sampling.

   **Fig 7. Example of a theoretical note**

<table>
<thead>
<tr>
<th>Theoretical note</th>
<th>Participant: WM03</th>
<th>memo no: 22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Ref code note no.14</td>
<td></td>
</tr>
<tr>
<td>What are the language barrier problems caused by staffing wards with nurses from abroad? Are these problems for other Ward Managers or just this one? Does the problem of the language barrier put patient safety at risk. Is it only language issues or are other issues, e.g. different culture cause problems too? What do the patients think about this?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Theoretical sampling from this theoretical note directed a line of enquiry to ask other ward managers to describe their experience of working with nurses with a language barrier. It also directed a search in the literature. During an observation session, I paid particular attention to an interaction
between a ward manager and a nurse (Nurse A) who had a strong foreign accent and was new in her job.

**Fig 8. Example of an observation note (1)**

<table>
<thead>
<tr>
<th>Observation note</th>
<th>Ward 5 WM: 09</th>
<th>Observation memo no: 43</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WM approached Nurse A asking her to prepare a patient for X-ray. Patient had to travel to X-ray in his bed, and needed a nurse escort. The WM asked Nurse A if she wanted to go or would prefer another nurse to take patient instead. Nurse A misunderstood the WM, thinking she was asking her to go on her break rather than take patient to X-ray. Nurse A was confused as she had already taken her break that morning. A 2nd nurse (Nurse B) realising the confusion, came and explained what the WM was saying, and ‘translated’ for the WM. Nurse A took the patient to X-ray, but the WM was clearly frustrated by episode which had taken up more time than was necessary (12 minutes).

Working hypotheses:- Is this about lack of time or culture?

3. **Operational note**: my notes triggered by procedural directions and reminders during transcribing of interviews and after observation sessions

**Fig 9. Example operational note (2)**

<table>
<thead>
<tr>
<th>Analysis note</th>
<th>Participant: WM03</th>
<th>memo no: 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Ref code note no.14</td>
<td>Theoretical: 22</td>
</tr>
</tbody>
</table>

Problems with language/accent of foreign nurses has been appearing as a significant issue for several members of staff. Need to question Matron 03 who has responsibility for foreign nurses employed by Trust. What have been benefits/problems of recruitment programme? Talk to nurses from abroad - what is their perception of language problem +/- other issues. Also refer to RCN documents Fragile future, and Success with foreign nurses. What have been results of national project to recruit from abroad?

Concerns that WM's do not delegate tasks to foreign staff if their language is poor as it takes too long to explain task, therefore quicker to undertake task oneself.
4.12 Saturation

Strauss and Corbin (2008) suggest that the researcher will identify when sufficient sampling has occurred when the major categories show depth, breadth and understanding, relationships to other categories have been made clear, and no new information is gleaned from further theoretical sampling. However they also conclude that total saturation is probably never achieved.

A point came after considerable time spent transcribing an interview and thoroughly immersed in the data that, after re-reading the transcript, it was apparent that no new concepts had emerged. Mindful of the need to avoid premature closure I concluded two further, shorter interviews to close some outstanding lines of enquiry. As no new concepts emerged from these interviews, it was decided that the point of saturation had been reached.

As the study was drawing its conclusions, a significant piece of literature was published by the Royal College of Nursing. Breaking down Barriers, driving up standards: The Role of the Ward Sister and Charge Nurse (RCN Feb 2009). This publication played a valuable part in validating the theories that had been generated from the data analysis and a discussion around this is found in chapter 7. The publication demonstrated that in a field of study that is rapidly changing and, where the spot light constantly refocuses,
Strauss and Corbin’s suggestion that saturation may never be fully achieved is very relevant.

4.13 Conclusion

This chapter has described the methods adopted for this study. It has discussed ethical considerations and described the processes around interviews, observation, sampling and data collection. It has explained how theoretical sensitivity was achieved throughout the study.

Examples of the coding process have been presented to illustrate the development of the methodology.

Key to the coding process was to maintain a robust system that allowed for freedom of enquiry, which in turn captured analytical thoughts. These thoughts (or hypotheses) could then be compared with further data from all sources. The constructivist methods of grounded theory promote a level of data interrogation that ultimately supports the emergence of theory. The following chapter will discuss the findings of this study and discuss the development of an emerging theory.

During the following chapters, text from transcribed interviews, and observation is used to illustrate findings and to generate discussion. Word for word text has been identified using italic script. Each piece of text is
coded. Primary interview notes are recorded by using note WM + number, whilst notes recorded during secondary discussions or during observation sessions are referenced as OBWM + number (Observation note number x). All references to individuals or issues that could betray confidentiality or prevent anonymity have been removed and replaced by codes. Occasionally short vignettes have been included which tell a story taken directly from a narrative or period of observation. These are used to illustrate points and to contextualise emerging discussion.

Discussions around review of relevant literature is a key feature of the following chapter and its integration into the analysis demonstrates how literature contributed to raising awareness of significant concepts. In order to enhance theoretical sensitivity, literature was reviewed and compared with data as it was coded and throughout the process of analysis. This enabled a wider theoretical perspective to be gained of the concepts and relationships that emerged from the data (see section 3.9 Theoretical Sensitivity.)

N.B An analytical note was made as a result of the alphabet and number system adopted to label interviews and observations. I had resisted giving each ward manager a fictional name, preferring instead to allocate them a number. As the emerging theory drew lines of enquiry towards social capital and identity, by dehumanising the conversations and observation sessions with ward managers, I had unintentionally presented a micro case to support an emerging theory.
Chapter 5

Study Site: A Profile

5.0 Introduction

This chapter will commence by describing the setting of the research study. In order to understand the context in which this study took place, it is necessary to provide a rich description of the environment within which the participants of this study worked.

Mindful of the ethical agreement to maintain anonymity for those who took part in the study, and for the organisation as a whole, specific names and events that may direct the reader to the location of the study have been omitted.

5.1 Hospital Profile

The hospital where this research study was based is part of a large acute NHS Trust. The study took place over a period of four years and during that time there were a wealth of changes that occurred within the structure of the organisation. The participants in the study referred to many of these
changes during their interviews and the impact of change could at times be recognised during the sessions spent observing staff at work.

The following section describes the hospital profile and recounts the changes in structure over the past five years that have had an impact on the hospital wards and the staff who work in them.

5.1.2 The Physical Environment

The main building of the hospital was originally built in 1828 and almost the entire original site is still in use. Subsequent new hospital blocks were built in 1977 and 2000, and in 2008 a substantial 10-year redevelopment programme to replace much of the old buildings commenced. There are thirteen acute medical and surgical wards in the hospital, ten of which are situated in the original hospital block. The number of beds in each ward of these original wards varies between 10 and 28. During the 5-year duration of this study events occurred that resulted in the closure and re-opening of wards within this older block despite acknowledgement from the Trust that the building was no longer fit for purpose. Their design and layout is not well suited to modern day hospital care. Some areas have failed to meet requirements for privacy and dignity (DH 2007, 2008) and the heavy traffic of staff, patients and relatives through the wards during both day and night is well known to be problematic. It is hard to maintain single sex accommodation (a key government objective: NHS Plan DH 2000, DH
2007) and due to the age of the building, on-going maintenance is expensive and frequently needed. There is a perception that staff do not consider wards in this building to be popular places to work, due to their lack of modern facilities and an infrastructure that is approximately 180 years old. A key hospital objective is to move all wards out of the original ward block by 2012 and demolish the building.

Transportation of both patients and equipment to and from these wards is time consuming and complex. Key departments, such as Imaging, Pharmacy, Outpatients departments, Theatres and Pathology are situated far away from these wards, and staff and patients alike will often walk considerable distances to other departments, often having to go outside. The wards in this block houses patients from Elderly Care, General Medicine, Short Stay and Stroke (November 2007) but earlier in the duration of this study (April 2003) ENT, urology and orthopaedic surgery wards had also been situated here.

The newer blocks in the Trust are more modern and better designed to manage modern health care. They house many of the organisation’s specialist services such as cardiology, digestive diseases, maternity and intensive care. The wards in these areas are bigger – housing up to 45 beds, but their ‘bay’ design creates natural divisions, which allows them to be managed in smaller units, often divided by clinical specialty or patient dependencies (level of nursing care).
In 2004 a new specialist hospital was built which sits in the centre of the main hospital site. The building project was competed in June 2007. This ‘state of the art’ building, exemplifies modern health care. Its imposing structure has won architectural awards for encompassing modern design with technology and at the same time embracing the concept of the healing and therapeutic environment.

It is surrounded by an ill-defined combination of older permanent and temporary structures and its contrast with the old and out of date buildings around the site is striking. The concept behind the new specialist hospital was to put the users of this specialist service at the centre of all decisions regarding design. This philosophy shines from the building, and staff who work in if frequently speak of their energy and inspiration that has come as a result of working in such a modern and well constructed environment. The old ward buildings that surround this new and creative site give out a very different message and consequently the effects that this has on the workforce within is significant. At first glance the wards look tired and old. They have a dispiriting and demotivating atmosphere that lacks inspiration or pride.

Architect and designer Frank Gehry describes the implications for providing modern services in old and out of date buildings (Isenberg 2009). He suggests that the workforce within them need to work harder to create an atmosphere of inspiration and creativity.
Geographically the hospital is set on a steep hill and much building work over the last three decades has resulted in a complex structure with maze of corridors, paths, stairs and lifts that link different buildings together. Way finding for a patient is problematic, and often a source of complaints.

The hospital is set in the midst of a residential area, with two large schools in close proximity. Parking within the hospital is minimal, and street parking around the area is restricted, limited and expensive. There are no facilities for staff to park on site. Parking and access to the hospital is an ongoing and significant problem for both patients and staff alike.

5.1.3 The Hospital Structure

In 2010 the Trust had approximately 820 beds, and a work force of 6,200 staff across six hospital sites. There have been a number of changes to the organisational structure during the last ten years and many of these have been in response to national developments within healthcare. However the impact of working in a constantly changing organisation was a subject that emerged in many interviews during this study, mostly portrayed negatively and with reservation.

During the period of research the Trust was managed by three different Chief Executives. Each had a unique style of management that filtered through to all levels of the workforce. Each Chief Executive changed the structure of management and reporting lines to reflect their own ways of
working and leadership. Initially in 2003, a cluster of wards was managed as a ‘Care Centre’. Each Care Centre had a clinical and non-clinical manager and ward managers reported directly to the clinical managers. In 2003 the hospital Trust merged with a second acute hospital site approximately fifteen miles away. Emergency and elective surgery was divided, and over the following year, almost all elective surgery was undertaken at the second site. Wards that had been established for many years were disbanded and many staff were relocated – many to the second site.

In 2004 a large Medical School was opened and the Trust became a ‘teaching hospital’. Medical students are taught on the wards and a heavy emphasis on education and learning for students and junior doctors developed as a result.

In 2005, a TV documentary highlighted serious failings in patient care on one specific ward within the organisation. It showed distressing scenes of patient neglect that prompted debate throughout the country. The ward was shut for a period of time, and a substantial review of care followed as a direct result. A new Chief Executive was employed and a restructure followed that changed the Care Centre concept, replacing it with three service divisions: Elective, Emergency and Specialist. These divisions remain and are managed by a clinical director, an associate director of

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4 The effects on morale following this documentary were overwhelming. Staff felt frightened and vulnerable. They felt that their own standards could be questioned and experienced feelings of shame that such low standards had been witnessed in their own workplace.
operations and an associate director of nursing. Ward managers report to
the matrons who work within each division A clinical site team is responsible
for bed management for all divisions and across the entire Trust. The
Director of Operations has overall responsibility for the day-to-day
management of the hospital.

In 2006 the hospital had a £35 million deficit in their budget. The
Department of Health placed them in a financial Turnaround Programme -
(radical programme to rapidly reduce deficit by cost saving and cuts). 300
staff were made redundant and there was freeze on recruitment. Wards
were closed as a result of this financial programme. The Chief Executive left
in June 2007.

A new Chief Executive was appointed in July 2007, bringing with him a new
management team whose purpose and drive was to improve the poor
reputation of the hospital and manage both key government and Trust
objectives\(^1\). Since that time, they have demonstrated a very pro-active style
of management and have been focused on rapid achievement of Trust
objectives. During the period September – November 2007, three wards in
the old hospital block, initially closed as a cost saving initiative, reopened in
order to create additional capacity for patients requiring admission from the
Accident and Emergency department. The new management team now
holds a high profile and a very visible presence throughout the hospital.

\(^1\) National objectives are: 1. No patient should wait in A and E for more than 4 hours 2. All
patients will be treated within 18 weeks. Key Trust Objectives:- Control of infection,
particularly MRSA and C.Difficile 4. Improvement of hospital reputation 5. Financial
stability
has developed clear corporate messages that focus on financial prudence, improving the hospital reputation amongst the local community and achieving government targets particularly around infection rates and waiting times. Its aggressive approach to transformation has had a divided reception. Many employees describe their style as long awaited and necessary, whilst others reportedly find this approach intimidating and undermining. Despite these different opinions, the hospital's performance nationally has improved in the years since July 2007, and the reputation amongst the local community has enhanced. Local press coverage is generally positive.

Ambitious plans for the future are now in development which aims to secure ‘Foundation Trust’ status for the organisation and to rebuild many of the old buildings on the campus, creating a state of the art hospital which will provide tertiary care for cancer, trauma and neurosciences as well as the provision of modern, purpose built facilities for the elderly.

Fig. 4 below illustrates a timeline of the study, showing key national and local events.
Fig 1: Illustrates a summary timeline of key local and national events throughout the study.
The following chapter will present the findings from the data and will provide an account of the themes and concepts that have emerged from the analysis process.

Constant comparative analysis techniques are multidimensional and complex and in order to introduce the findings of this study in a comprehensive and logical order, the chapter will commence by presenting the category that was central throughout the process of analysis. The findings that led to the emergence of this category are woven throughout the data and formed the core from which the three subsequent categories developed. The content of the central category eclipses subsequent emerging themes and in presenting this central category first, it is possible to show how the concepts that lay beneath were unlocked.

Discussions around review of relevant literature are key features of this chapter and its integration into the analysis demonstrates how the literature contributed to the theoretical debate and the development of an emerging theory. In order to enhance theoretical sensitivity, literature was reviewed and compared with data as it was coded and throughout the process of analysis. This enabled a wider theoretical perspective to be gained of the concepts and relationships that emerged from the data.
The Category of ‘The Battlefield’ emerged from the data through the language of metaphors that staff used to describe the culture and the environment in which they worked.

This section will tell the story of the ‘battlefield’. Through the language of conflict and turbulence it discusses the underlying issues that resulted in the emergence of this metaphor as a core category. It examines the reasons why ward managers perceive their role to be one of continual conflict and it will discuss the effects of this perception on a role that strives to maintain its identity and philosophy of care amidst a backdrop they identified as being one of constantly changing priorities and values and disharmony.

5.2 Use of metaphors in research

In order to understand the concept of the “battlefield”, it was necessary to explore the use of metaphorical language in research and identify why participants frequently chose to describe their environment and role using the metaphors of battle and war.

Metaphors have frequently been used in qualitative research to bring a concept to life or to make thoughts more vivid and interesting but Lakoff, a linguist, and Johnson, a philosopher (1980) suggest that they structure our perceptions and understanding. They describe their use as providing us with unfamiliar ways of conceptualising familiar things and familiar ways of
conceptualising unfamiliar things. The choice of metaphor leads to one set of expectations from which reality is defined. These become the symbols of language and meaning. Actions proceed on the basis of these metaphors. From this definition inferences are drawn, goals are set and plans are implemented. A ward manager who describes her team as “foot soldiers” is therefore distinguishing them as the workers who have little say in how their patients are managed and obey orders rather than have respected opinions of their own. Grant and Oswick (1996) describe the power and danger of metaphors such as these that conjure up a reality that may ultimately limit behavior or profoundly shape our view of life in the present and determine life in the future.

When exploring the choice of metaphor, Ortony and Fainsilber (1987) suggest that metaphors are selected for three communicative functions: i) They enable an expression that is difficult or impossible to express by literal use of language, ii) they constitute a compact means of communication, conveying a substantial amount of information in a succinct manner, and iii) they can capture the vividness of experience, painting a richer and more detailed picture of a subjective experience than may be expressed with literal language.

In an attempt to describe feelings of exhaustion, overwhelming despair and loss of control of their ward environment, a ward manager summed this up as ‘surrender’ instantly conveying the image of the end of a battle when an army has given up.
Ortony and Fainsilber (1987) also demonstrated that people are more likely to use metaphors and metaphorical comparisons to describe how they felt rather than what they did when they were experiencing an emotion. They add that metaphorical language is often used to describe intense rather than mild emotional states. A Ward Manager who had been asked to explain an MRSA infection on her ward to the Chief Executive described her anxiety over this as “a lamb to the slaughter”. This metaphor vividly summed up her feelings about her impending task and her assumption that the encounter was not to be an easy one.
CHAPTER 6

The Battlefield

Findings

“The problem in defence is how far you can go without destroying from within what you are trying to defend from without”  - Dwight D. Eisenhower

6.0 Introduction to the Categories

The following chapter will describe and explain the findings from the analysis of data. Three main categories have emerged from concepts and sub categories that have evolved from concepts drawn from the coding process. During the four-year duration of this study, dialogues and discourses between participants in semi-structured interviews and during sessions observing interactions, generated further conversations and deeper exploration of different concepts and themes as the complexity of the role of ward manager emerged. Each narrative was told in a different way but throughout these discussions, common features and themes that emerged from them were plentiful.
6.1 Category 1: The Battlefield

Throughout the periods of time spent observing ward managers at work it was also clear to see that despite their different styles and varying ways of working, their challenges, frustrations and triumphs were similar. They shared common philosophies and were driven by mutual goals. Every member of staff that participated in the study described in some way, their passion for nursing and recognised their responsibility to create environments where their staff could get on with the work of caring for the sick. However, despite these shared values, it was evident that upholding these in practice was difficult. The stark reality of their world was clear. Each ward manager described a role of intense daily conflict. They frequently used the metaphorical terminology of a battleground to explain their
feelings; they spoke of fighting a battle, defending a cause, a struggle and surrender:

‘You fight a battle about something at least once a day’ – WM01

‘It’s such a struggle at times to get anything done – you can quite often feel like just giving up.’ – WM03

‘I used to get really angry….but now I just do what I’m told, because that’s how you become, but if I was coming in to it now I would be really fighting it…There are occasions where sadly you become complacent, you can’t fight every battle quite honestly, and I think I can put my energy into a lot of things where I can get a lot back from, but you won’t get it trying to fight the system. You can challenge it but you can just feel that you are being put down by it – by certain people’ WM08

“Do you know the only book written for ward managers recently is “The Survival Guide? ” WM09

‘It’s a battleground…..’ WM05

The following section depicts the ‘battlefield’ as described through the narratives of ward managers and the nurses who worked for them.
6.1.1 The Enemy

A conflict or ‘battle’ assumes at least two sides in disagreement with each other. Within this subcategory, ‘The Enemy’ was a term used to describe more than one opponent, and was loosely adopted as a description for anyone or any group who appeared to oppose or oppress the ward.

Both the NHS and the nursing profession focus on the care and safety of patients as their priority. But at a ward level, it was evident that the interpretations of these shared values were not in harmony. Whilst the hospital as a whole focused its priorities on financial stability, infection control and achieving government targets (such as 18 weeks from referral to treatment and a maximum 4-hour wait in Accident and Emergency) it was apparent from sessions spent observing ward managers at work that their own professional priorities were not aligned with those of the organisation. They were striving to deliver the standard of care that their patients required and in doing so, it was evident that financial constraints and rigid protocols hampered their ability to provide this. They described the organisational system as ‘The Enemy’.

Their frustrations were plain, and they could articulate them clearly. Lack of time, primarily stemming from a lack of staff, restricted the time that they could spend with their patients and prevented them from providing care in the way that they would like. The ward managers evidently felt the pressure
of this, and focused their frustrations on the inefficiencies of the hospital nurse bank system and the inertia of the recruitment process within the organisation. Significantly, they did not discuss the national shortage of nurses (RCN 2005) and whilst they acknowledged and understood the nationally changing climate of healthcare, the ward managers did not articulate or identify a relationship between national and local healthcare priorities as the cause of their daily conflicts. Their battles remained local, and focused heavily on issues around the day-to-day operations and logistics of running their wards safely. ‘The enemy’ was seen as the organisational machine that rendered them powerless.

“almost every day we have a row about staffing levels. There just isn’t enough staff on this ward, and I told them that, but when I say there are things we can’t do, like get patients down to the discharge lounge early in the morning, because we haven’t got enough nurses, but the argument just carries on…every day…same old battle.”

WM04 ob note 26

“You see, …every day it feels like we have to put on our armour and go out to battle. Sometimes it’s just not worth taking it off – like if you take of your protective suit everything will fall apart – it’s the only thing that holds you together…..we have to fight,…. for everything. I fight for staff, I fight for equipment, we even fight so that patients can have extra pillows or clean pyjamas…”

WM07 ob note 36
6.1.2 Fighting

Conflict exists in many different working environments and is not a new concept within nursing. Issues such as pay reviews, changes in training and working hours have all resulted in unrest amongst the profession as a whole; even leading to threats of industrial action over pay (Mullholland, 2006 Carter 2007). Yet the conflict that the ward managers described was different. Their narratives portrayed battles that appeared to be localised, personal and relentless, with conflict focusing on themselves and the immediate world around them. An example of this emerged from references to the language they used to talk about their exterior resilience. On three occasions, the metaphor of protective clothing was used as a way to intensify the image of protection from enemy fire. They described the need to wear armour (see above OP note 36) and bullet proof vests:-

“Never mind the nurses’ uniform – it’s bullet proof vests we need now – if you’re going to spend your days getting shot at because our ward performance isn’t up to the mark, then you need something to protect yourself.” WM09 ob note 67

This is consistent with Ortony and Fainsilber’s (1987) description of using metaphors to express intense emotions. Here, the metaphors of both ‘armour’ and ‘bullet proof vest’ suggest that the ward managers considered that there was a need to protect themselves from violent attack on a daily
basis. Their need for protection to be part of their uniform highlighted their personal vulnerability and their need to safeguard themselves from harm. Their vulnerability is further emphasized by WM07 who recognised that not only does the armour protect from the outside, it also hides their own internal fragility and prevents it from exposure. This was further observed during the interview process. During each interview, ward managers were invited to describe their role. As these narratives became more detailed and involved the armour and bulletproof vests were metaphorically removed. Towards the end of lengthy interviews or during subsequent meetings, and in many cases after a positive relationship had been established with the researcher, ward managers demonstrated greater vulnerability and fragility than was evident during a first meeting or early part of an interview. They visibly relaxed and reflected more candidly on their role, often disclosing personal and sensitive information. One ward manager described himself as ‘Teflon-coated’ when managing the day to day problems he faced on his ward, yet he was able to leave his ‘coat’ at work each day and become the gentle character he knew was his true self when he returned home to his family after work: -

“When I came into nursing, it was all about care, patient care, at the bed side, you know…washing people, talking to them, listening to their worries and stuff. It is different on my ward now. I put on my Teflon coat each morning, rally the troops and brace ourselves for to take
what is thrown at us. Sometimes it all goes to plan, but you have to be prepared for when it doesn’t….” WM06 ob note 43

Whilst the hospital was described as the battlefield, it was observed that ‘fighting’ occurred on several different fronts. Conflicts were evident between ward managers and matrons, operational teams, cleaning staff and medical teams. The intensity of the fighting varied on the fronts as different personnel; ‘weapons’ and ‘ammunition’ were brought in at various stages.

“.one day you are struggling to get a bank nurse, because you have to cover sickness, then the next day you have to justify to the matron why it was you had to get a bank nurse…. crazy….” WM 08 Ob note 12.

“.We are given our annual budgets – they are always less than the one from the year before. Every year I’ve said it’s not enough, nowhere near enough, and then when it looks like you might overspend, they come down on you like a ton of bricks…even though I told them it wasn’t enough” WM02

Again, these battles and arguments whilst with different hospital teams, were about ward issues and despite clear evidence of unrest at other levels and departments within the organisation and the wider healthcare community, ward managers did not engage in battles other than their own.
There appeared to be little enthusiasm or interest in the wider strategic issues affecting the hospital and no clear reasons for this were identified, however their lack of connection and inward looking behaviour may well have been a manifestation of a role that was all consuming and left little scope for engaging with a wider picture. One ward manager, who had attempted to work with the hospital discharge team to develop an efficient ward discharge process spoke of the risks of raising her head “above the parapet” and either getting “shot down” or being asked to take on additional responsibilities which would impact on the time she spent on her ward.

“You raise you head above the parapet, because you want to change something that isn’t right – that frustrates you, but if you do anything, you either get shot down, or asked to do a whole load of other things. You can’t win, so the best thing is to keep your head down, and just do what you are told. That’s what I do now.” WM07

Ward managers appeared to be torn – on one hand they had a responsibility to uphold the objectives of the hospital, and on the other, they were required to lead a team who recognised that in reality, patient care is a complex matrix that does not fall neatly into fixed lengths of stay, or packages of care. They were increasingly being told how to plan and manage care, particularly around admission and discharge of patients, based on contractual obligations. Patient/staff ratios were pre-determined;
they had no control in setting their annual budgets, and at times little control of how it was spent. At the same time, ward nurses were caring for patients with variable and often high dependency needs, often with inadequate staffing numbers or insufficient levels of nursing experience and at times, both (Ob note 54).

There had been little substantial investment in the professional development of ward nurses for some time. New management structures had resulted in frequent changes in hospital processes that nurses had found difficult to keep on top of. These issues had resulted in a work force who were weary of change and frustrated by a constant struggle to provide a sufficiently high standard of care.

Managing this misalignment appeared to be the root cause of the conflict that ward managers dealt with on a daily basis. Their use of the metaphor of a ‘battlefield’ and the images that were generated by this was clearly their way of describing the intensity of their situation.

Whilst this metaphor may be seen as a dramatic representation of reality, it’s frequent use by ward managers in the study demonstrates not only the need to create a visible image of their reality when describing their role but it also shows that consistently their shared perception of the role is one of fight and conflict.
6.1.3 Defeat

The ward managers in this study were largely experienced, competent professionals perceived by their nursing peers to have reached the higher rungs of hospital nursing’s hierarchical ladder, yet in their narratives they described themselves as disempowered and lacking in unity. They described how the priorities that were set for them were not aligned with their interpretation of their own role or their identity as senior nurses. It emerged that the essence of their conflict arose as ward managers were increasingly forced to manage wards with objectives that were not only unrealistic but at odds with their professional judgment.

“…take ‘Length of Stay’ for example. We have to make sure that every patient is given an estimated date of discharge when they arrive on the ward. We have to work towards getting them home on that day. It’s a really big thing at the moment and it’s not good if we have to change the date…which we do sometimes, just because Mrs. X is just not ready to go that day. You know, bit wobbly on her legs, not that confident, would probably benefit from a day or so longer here, and as an experienced nurse I know she might be more likely to fall over, or not eat, or maybe not take her medicine properly if we send her home too soon, but the notes say Tuesday…so Tuesday it is….and then you feel really bad because you didn't speak up and say what you thought. You know, I've been a nurse for long enough
to know when a patient is ready to go home, but it doesn’t really count for anything now.”WM06

This quote concisely illustrates the perception that their skills and expertise were not valued and at times during periods of observing practice, this concept was tangible and filtered through other tiers of the workforce to the ward nurses and the support workers.

Several of the nurses during the study described themselves and their colleagues as “Foot soldiers” (Ob notes 27, 52, 54). Definition: One who performs necessary but basic, often mundane tasks (On-line dictionary 2008).

This choice of terminology reflected their view of themselves and reiterated their perception of how they were viewed by others. As with ward managers, they felt little regard for their expert nursing skills, professional ability and knowledge and frequently failed to promote the importance of their role. They did not acknowledge their contribution to achieving hospital objectives.

One ward manager described how her ward had ‘suffered huge casualties’ (Ob note 45) as a result of changes over the previous five years. She spoke of teams being split up, anxiety over redundancy and anger that ‘no-one takes any notice (of us) unless we screw up’ (Ob note 45). The theme of disillusionment amongst all the ward managers was consistent throughout the study. They felt they had little influence in the management of the
hospital despite clear nursing structures in place and it was clear that they had remained passive while radical changes in organisational structure had been imposed.

They described how they felt they were no longer trusted to carry out their work. Frequent audits of practice, such as hand washing, documentation and assessment skills occurred and ward managers were asked to complete audits of their own and each other’s practice. One ward manager commented:

“You spend a lot of time checking up in each others work. We all know it’s impossible to get it right all the time, but sometimes as you write up your notes, you can see your friend coming round to check whether you have written them properly.” (WM note67)

The pressure of constant change, heavy workloads and high use of temporary staff and a lack of trust in the organisation, resulted in ‘troops’ on the wards who were ‘weary of fighting’. Over the course of this research, the level of exhaustion observed amongst the ward nurses noticeably increased. When ward staff were asked if this was an accurate observation, it was confirmed without exception and in addition acknowledged by other participants in the study:
“We are always asking them (the nurses) to do things, and quite often asking them feels like a burden, but really it’s the only way to make sure the work gets done.” (Junior doctor note4)

“They do work really hard, and it’s pretty tiring really. They never get breaks and it’s a very heavy ward.” (Physio note7)

Together with an increasingly weary workforce, came visible changes in their patterns of behavior. At times this was demonstrated as defensive, angry and uncooperative, on occasions even rejecting offers of help unless it comes in the form of ‘more staff’. The ward nurses formed strong bonds of friendship together, which appeared to unite them against the ‘enemy’ and shield them from attack. The ‘enemy’ appeared at times to be anyone who did not work directly on the ward, and was not part of the team. This may have contributed to the rejection of agency staff on wards. This closure of ranks in certain areas led to the emergence of micro-cultures which at times even displayed elements of tribal behavior where nurses demonstrated no individual sense of self, or of being an individual separate and distinct from the collective. Behavior was learnt from other members of the group which avoided self-responsibility and gave feelings of protection within the tribal environment. There was evidence of apathy throughout some wards, demonstrated through poorly attended ward meetings, lack of desire to attend training, and higher than average sickness levels.
A nurse summed up her concerns about the lack of training for ward nurses:— “We’re like soldiers who do not have the equipment needed to fight’, (Ob note 52) but it also appeared that ultimately the ward nurses did not know what it was they needed to ask for, or how to ask for it.

The top down management style that had been adopted to achieve centralisation of services had sanitized the personality of the wards, stripping out their individuality and character. Wards where staff had taken care to develop individual ways of working were required to standardise practice. There were examples of this throughout the data:

“We used to bring in cakes for tea on Sundays and have a tea party for patients – they were legendary! We don’t do that any more, there’s not really any time, and I think people thought it was just an excuse for nurses to have a tea break. It’s a shame really - the relatives really liked it, some even bought cakes in too.” (SN obnote17)

“The Ward sister is really good here – she tries to talk to every patient every day – she makes sure they are ok, chats to their relatives, but most of the time these days she has to go to meetings and stuff – I don’t know where, but she doesn’t have the time to chat so much now, which is a shame because I know patients really like talking to her.” (Ward clerk Ob note 2)
Ward managers spoke of times when wards were opened, closed, and altered in specialism with little regard for the skills of the teams that staffed them:

“You carry your suitcase with you all the time because you never know where you will be working from one day to the next” WM02

Less than a decade ago, the Sister in charge of a ward was known by the ward name – for example ‘Sister Lewis’ would be in charge of ‘Lewis Ward’, Sister Vicars in charge of ‘Vicars’ Ward. The wards were named after patrons, or places that bore little meaning to patients but the identity of the ward manager was intrinsically linked with these names. The modern title of ‘Ward Manager’ provides no connection with a specific ward, and more significantly no connection with nursing. The generic term stems from a role that has little identity of its own, and its contemporary use may reflect a significant disconnection between the ‘manager’ and the ‘nurse’.

In response to the battles of almost a decade, it appeared that the nursing management on the wards had run out of steam. The reconstruction of the wards as a result of centralisation had left them without an identity or legitimate power. They were ‘too exhausted to fight’, unable to rise above their poor reputation, lacked identity and were no longer confident in their professional ability. In order to survive, they closed ranks, buried themselves in bunkers and remained silent.
It was clear from analysis of the narratives and from observation, that ward managers were fighting a battle they were struggling to win. Attempts to provide individualised care, and generate opportunities for their staff to develop as individuals are further complicated in a culture driven by targets, ratings and centralized processes. Their battle weary appearance and attitudes contributed to preventing engagement with the wider issues that existed within the hospital and to their feelings of isolation. This was recognized by other participants in the study who witnessed little interaction with the wider hospital teams:-

“It’s hard for them (Ward managers) to get away from the ward really, they don’t have much time to talk, or catch up. Even if they make it to meetings they have to rush back afterwards”. (Matron Ob note 03)
Vignette 1: National nursing leadership perspective

During a discussion a senior member of the nursing profession highlighted the need for ward managers to take control of their environment and drive change to ensure the nursing needs of their patients could be met. She suggested that at times ward managers were too accepting of their position within a hospital culture and needed to be more proactive in raising their profile to ensure their demands were met.

This comment suggested that ward managers required characteristics more typical of a Warrior than a Captain. (Definition: Warrior - One who is engaged aggressively or energetically in an activity, cause, or conflict (on-line dictionary 2008)

Throughout the interviews with ward managers there was little evidence of the traits of a Warrior. One particular ward manager ran a complex and busy ward and was notorious for demanding high standards from her staff. She was observed to have strict and explicit expectations of her team and had a reputation for addressing issues where poor practice has been observed from all quarters. She invested heavily in the education of her staff. Her ward thrived on a successful reputation. Her principles of leadership centred on empowerment of the individual. Her drive and energy was focused on the staff and patients on her ward and she worked on average 14 hours a day. She demonstrated warrior characteristics but her energies were channeled towards protecting her team from the external politics of the Trust and she strongly resisted engagement with management.

A nurse described her as ‘an island’ where she worked from the ‘bunker’. She commented ‘Do what they say and they will leave you alone.’ She represented everything her staff wanted in their leader; she was a role model, a clinical expert, and a leader in the forefront of the ward. However her battle to
protect herself and her team by isolating herself from the ‘control and command’ style of hospital management put her at risk of becoming cut off from the Trust lifelines that would ultimately keep her ward alive. Her warrior attitude was to throw her energies into protecting her environment and those within it, but had she put her energies into generating a nursing model that maintained the high standards and met the wider Trust agenda, she may have had the potential to unite the nursing workforce and the hospital management.

Reflective Memo post interview: 2005

The metaphor of the Battlefield formed the context of the emerging theory. Limited by the boundaries of their environment, the circumstances within which the ward managers found themselves were disempowering and isolating. Their actions and interactions were often observed to be submissive, weary and at times even defeatist. They worked alone in silos that struggled to embrace change at any level.

The consequences of this disturbingly dysfunctional environment on the role of the ward manager are immense. What is the role of a nursing manager if the core identity of the nurse within it is suppressed? It would appear that the connection between role and identity has been broken following prolonged change within an organisation whose priorities have not been in a position to recognise the value or significance of effective nursing management on wards.
Further exploration of this emerging theory led to the generation of a second category. It was evident that ward managers felt under siege and battle weary. Many spoke of fluctuating clinical teams, and difficulties developing the effective ward team they desired. Concepts emerged that focused on insufficient staffing, low morale and problems around the practicalities of managing staff as contributing factors. Issues around staffing featured heavily in interviews, and these formed the foundations of the second category:- “Managing an understaffed ward.”

6.2 Managing an understaffed ward

Fig 2. Category 2

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<th>Subcategory</th>
<th>Category</th>
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<td>Not enough time to ‘manage’ properly</td>
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<td>Being in two places at once</td>
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Understaffing in the NHS, particularly in Nursing is a subject that has received much recent attention (RCN 2007, Johnson, DH 2007, Buchan...
2006), however the focus of this attention is often directed at the wider problems of national and international nursing recruitment programs. How to manage a service that is understaffed on a day-to-day basis is not an issue that has been satisfactorily addressed in nursing literature. From the analysis of data in this study it was evident that ward staffing issues were a cause of huge concern for ward managers, and a problem that they struggled to address.

6.2.1 Working in a supervisory role

From the data it appeared that ‘working in a supervisory role’ was important to the effective management of wards and a role that in some wards did not occur as a matter of course. A ‘supervisory role’ was defined by ward managers to be a day/shift when they did not have a caseload of patients to look after during their shift on duty and were not allocated responsibility for a particular patient or group of patients. The opportunities to maintain supervisory status varied between wards. On some wards, the ward managers never allocated themselves a caseload of patients, and on other wards they always did. Many ward managers appeared to adopt a flexible approach to this, taking patients when staffing levels demanded it, or when they chose to work with staff or students as part of clinical assessment. In all cases, ward managers identified problems with managing the ward when they were directly providing bedside care for patients at the same time. The determining factor for adopting a supervisory role appeared to be the levels and skill mix of staff.
The RCN report on the role of the Ward Sister and Charge Nurse (2009) described that their most significant finding was the pressure placed on ward sisters from looking after and nursing a group of allocated patients on every working shift, in addition to their ward leadership responsibilities: -

“This has made it impossible for them to appropriately lead, manage and supervise clinical practice and the ward environment. This is not acceptable to the RCN and needs to be swiftly remedied.” P5

Despite the RCN’s clear stance, in 2011, ward managers in the hospital were still allocating themselves a group of patients and struggling to maintain their managerial duties. Their reasons for this focused on lack of staff within the ward.

Wilmott (1998) who describes the ‘confusion’ of clinical and non-clinical ward management as a prohibitive fact in allowing ward managers to fulfill the potential of the role. This element of confusion may in part be attributed to the interpretation of the terms used.

McGowan and McCormack (2003) carried out a study to assess nurses understanding of ‘supernumerary (supervisory) status’. Whilst this study was carried out in an Intensive Care setting, it emerged that the need for clarity over the exact definition of ‘supernumerary’ was important. From observations made during the course of this study there were times when supernumerary meant different things.
Ward managers used it to mean that they were co-coordinating the ward and did not allocate a patient caseload for themselves. This was a consistent view taken by all ward managers but when referring to student nurses in a supernumerary role, they meant that students were additional to the establishment numbers. Clarity may be required for other members of the hospital workforce. Understanding that ‘supernumerary’ does not mean ‘additional to the required establishment’ may encourage sensitivity from other areas of the workforce around the need to leave the ward to attend meetings, manage ward rounds and ‘be in two places at once’.

‘Not enough staff ’ was an issue that was raised by many of the ward managers and other participants who took part in the study. This is reflected as an on-going anxiety amongst the nursing profession (Royal College of Nursing 2004, Royal College of Nursing 2007) who focus largely with problems with recruitment and retention of nurses nationally.

Ward managers gave clear examples of times where the lack of staff was a problem:-

“I've been saying I need more staff – I need more senior staff in order for the ward to run as they expect it to...I was told I had to go out and find out about like wards and see what their establishment was like..”

(WM1)
“My biggest thing is to increase the establishment. There just isn’t enough of us here…” (WM3)

“If you had to think what would be the single most important factor as a ward manager that you could do for a ward what would it be?” (Researcher)

“It would be to increase the staffing levels…” (WM4)

This was echoed by the other participants in the study who acknowledged that the ward nurses were often stretched and under resourced:-

“They (the nurses) don’t really have much time to spend with the patients, it’s sometimes hard to find someone to help you” (Junior doctor Obnote12)

“There used to be six of us here, and we each worked with a nurse. We would really work as a team to sort the patients out in the mornings. Now there’s never more than 3 nurses, so we don’t get to work like that any longer. The nurses are so stretched and we have to do all the sorting out by ourselves.” (Health-care assistant, Obnote 09)

The issues that surround staffing levels and the ward establishment are complex. Nationally work has been undertaken to understand the issues
around staffing, yet the solutions to a chronic shortage of nurses in the NHS are far reaching.

In the NHS Plan, (DH 2000) the Department of Health committed to investing in 20,000 extra nurses by 2004 and whilst the number of nurses in the UK has increased, recruiting and retaining nurses to work on in-patient wards has remained a problem. There are no standard formats for calculating staffing establishments and therefore budgets are set at local level according to judgment and cost constraints. In 2005 the Healthcare Commission carried out an acute hospital portfolio review of ward staffing (Healthcare Commission 2005) which acknowledged the complexity of managing staffing levels across different clinical environments as establishment needs differed depending on specialty and skill mix. The review highlighted that higher use of temporary staff was strongly linked to low levels of patient satisfaction, and as the use of bank and agency staff is strongly related to high levels of vacancies, this demonstrated the clinical impact of staff shortages. Their review also showed that patient satisfaction and improved clinical outcomes were linked to Trusts spending more money per member of staff, rather than just by employing more staff. This would suggest that wards who invest in experienced and skilled staff, rather than merely employing more staff may have a more positive influence on the effectiveness of the team as a whole and the experience of the patient.
This was echoed during an interview with a ward manager who suggested that adequate staffing levels enabled a delegation of care delivery, created shared experience and provided a sense of belonging:

“..if you manage your staff and you are sure your staff feel part of something, AND have the right skills then your patients will be looked after.” (WM 1)

Throughout the duration of this study, the hospital was in financial deficit and for a period of time a recruitment freeze for all ‘non-essential’ staff had been imposed. The Healthcare Commission review suggested that ‘freezing’ of vacancies makes it more difficult to attain low levels of vacancies and because temporary staff are likely to be used to fill these vacancies, cost benefits are not seen (Healthcare Commission 2007). During the first 2 years of the study (2002-4) the hospital depended heavily on temporary and bank nursing staff to cover unfilled vacancies but financial pressures and an imposed Turnaround programme (see Section 4.2) forced the hospital management to reduce the use of temporary staff, only permitting it if there was no other way of managing the workload. An example of this demonstrated a resigned attitude to understaffing:

“ You haven’t got the staff and they are not in a position to close beds so therefore you just work without the staff” (WM 2)
In 2007 the new management team set a target to increase the size of the nurse bank from approximately 100 to 600 by April 2008 in an attempt to avoid the use of more expensive agency staff altogether.

When discussing staffing levels during the study, ward managers were asked how the actual required levels of staffing had been calculated. Responses varied from ‘historical’, ‘inherited workforce’, ‘don’t know’ to a more calculated process tool that analyzed patient dependency. These local inconsistencies in assessing skill mix were mirrored across the country in the Healthcare Commission’s review (2007). Although ward managers appeared at times to feel that they did not have enough staff, it was not always clear what the required staffing levels needed to be. The review emphasized the need for the Department of Health to undertake new research into ward skill mix. Five years earlier, in 2002 they had commissioned a review of literature surrounding methods for estimating the size and mix of nursing teams (Hurst 2002). They analyzed five methods for calculating the number of nurses required daily, on the basis of patient dependency but this did not examine tools for calculating the core establishment.

‘Not enough time to manage properly’ was a concept that evolved through both interviews and from observations of ward managers at work. It was clearly a source of immense frustration. All ward managers who took part in the study were contracted to work 37 ½ hours per week. With the exception
of one, all acknowledged that they worked on average many more than this:

“How many hours do you actually work a week?” (Researcher)
“I try and stick to my thirty seven and a half.....try.” (laughing) (WM1)

“Ward managers are trying to be as supernumerary as possible, therefore you can probably manage your hours better, but I would probably say that still, on average, well… I came in at six yesterday morning and I didn’t go home till half past four so I probably do somewhere between an extra 5 or 10 hours a week, yes. (WM3)”

(This was an under estimation. During observation sessions on the ward, it was evident that this ward manager actually worked from 6am till approximately 5pm five shifts a week, total hours on duty were approximately 55, or 18 ½ additional hours: Field note 16WM3)

“I do at least a sixty hour week here, most weeks. I need to be in work at the start of the day (7.30) but then it’s really hard to leave later and there isn’t any one else to take over, so I just stay.” (WM7)

“I don’t add them (hours) up any more – what’s the point? You can’t just leave.” (WM 8)
These comments not only highlighted the additional time ward managers spent at work, but they again demonstrated their resigned attitude to working long hours. It was part of their identity, and an accepted part of their role.

The impact of long working hours for nurses and having too many patients to care for has been well documented as a serious risk to patients’ safety and has implications for morale, health and work – life balance (Allen 2001). During discussions, several of the ward managers appeared resigned to their long working days and when observed in the clinical field made no attempt to leave at the end of their scheduled ‘shift’. It was clear that those who held supernumerary status were better able to organize their day but still worked considerably more than a 7 ½ hour working day. When ward managers had a case load of patients, they were frequently observed to hand over the care of their patients at the end of their scheduled shift and then take on the management duties that had not been dealt with during the day, such as answering emails, planning rotas and staff appraisals.

In 2001 Allen conducted a report for the Policy Studies Institute to investigate stress amongst Ward Sisters and Charge Nurses. Allen highlighted that ward sisters and charge nurses did not recognize the effect of long hours on their personal lives. “The extent to which these sisters had made sacrifices within their home lives often appeared to be lost on them” Allen 2001 p39.
One ward manager described his exhaustion when he got home:

“…it impacts a lot on my family. When I’ve got the patience I can sit and talk to anybody, but when I get home I can flip which is not a healthy attitude really”. (WM3)

The European working time directive (EWTD) was introduced into the National Health Service hospitals for doctors in training in August 2004 in response to mounting evidence that showed that fatigue in doctors contributed to adverse events in patients. Doctors’ hours were reduced and they are no longer permitted to work more than 48 hours per week. Many nursing staff showed a resigned attitude to working long hours, particularly demonstrated by ward managers. Whilst this may indicate an acceptance that long hours are part of the role, potentially it may penetrate deeper than this. Psychologist, Doyle (2002) examined reasons why many managers in many organisations (not specifically healthcare) work long hours when others in similar roles do not. The obvious reason for this was that there was too much work to do in the allocated time, however Doyle reports more complex reasons, such as an inability to hand responsibility to others, lack of confidence that other staff can manage without direction and the need to remain in control. Comparing Doyle’s report with findings in this study, similarities can be drawn. Specifically with issues around control, it was apparent that ward managers were uneasy with delegating work and responsibility to more junior colleagues, and gave this as a reason for
working extended hours. This demonstrated a lack of trust in the team's ability to continue in the absence of the ward manager.

'Being in two places at once' was a concept that emerged frequently and was seen as detrimental to both patient care and ward management. Ward managers spoke of how they were pulled in all directions.

For example:-

“...we just seem to get more and more things coming at us....pulling us in different directions..... you can’t manage a ward, that is be the coordinator, look after patients, supervise the students, supervise the trained members of staff – you can’t do all that in one go – you have to divide it up to do it when you can. “(WM2)

“Everyone wants a piece of me”. (WM7)

Vignette 2
During a session observing a ward, the ward manager was talking to a dietician about a patient’s feeding regime at the main ward desk. A junior doctor interrupted to enquire about a patient’s blood test results. The ward manager stopped her conversation and spoke to the doctor. Meanwhile 6 doctors walked on to the ward to commence a ward round. They immediately interrupted the ward manager. A relative walked up to the desk appearing as
if she wanted to ask a question. No one spoke to her. After 25 seconds she moved away. The ward manager continued to talk to the doctors on the ward round – she did not return to the conversation with the dietician. She did not complete her conversation about blood tests. She (nor anyone else) spoke to the relative.

After the session I questioned the ward manager about this episode. She was aware that she had not completed two conversations and was frustrated by this. Her response was:-

“...It happens all the time. You start doing one thing and then someone asks you a question – you get distracted, then it's too late to go back. It happens so often, sometimes I think we hardly even notice it’s going on…but it is – all the time.”(WM7)

Being in two places at once became a problem for ward managers when they were called away from the ward to meetings. This was more complicated to manage when not in a supernumerary role.

“It’s difficult to manage when you have to go off the ward for meetings –so many meetings now. They always have them at times when we are trying to handover or sort out a difficult patient. I had three in one day last week so I was hardly on the ward at all.” (WM6)
The difficulties in physically leaving the ward were compounded by concerns over delegating responsibility to junior staff. Again, this reiterated the lack of trust on the ward workforce.

The fragmentation of the ward manager’s role has resulted in the introduction of many different disciplines involved in patient care. In order to communicate together across different disciplines, these groups meet. Regular meetings occur to discuss multidisciplinary issues, governance, standards, infection control etc.

Examples of these that involve ward managers on a regular basis are:

- Delayed discharges from hospitals (Weekly – 1 hour)
- Infection control (Weekly 1 hour)
- Clinical Governance review (fortnightly 1 – 2 hours)
- Patient safety (fortnightly 1 – 2 hours)
- Ward managers meeting (monthly – an afternoon)
- Multidisciplinary team meeting (weekly)
- Ward meeting (varies – when time permitted)
- Consultant team meeting (weekly 1 hour)
- Divisional meeting (weekly 1-2 hours)
- Budget meeting (2 hours monthly)

In order to attend these meetings, ward managers were spending a considerable time away from the ward. If they chose not to attend the meetings they missed the opportunity to discuss important aspects of
service delivery or voice their opinions and communicate with other members of the work force. Solutions to overcome this problem were not forthcoming, but the frustrations surrounding the frequent periods of time spent away from their wards was clearly evident. Meetings that appeared unproductive caused the most dissatisfaction. This highlighted the clear conflicts between the strategic and the operational elements of the job, each pulling the ward manager in different directions.

There was evidence of a miss matched expectations as ward managers were compelled to fulfill the management team requirements, yet retained responsibility for the clinical needs of their patients.
Vignette 3

I attended a multidisciplinary meeting led by the site management team to discuss delayed hospital discharges. This weekly meeting with ward managers and Social Workers was to discuss patients who had been in hospital for longer than ten days, referred to as Delayed Transfers of Care (DTOC). The meeting lasted approximately two hours. Ward managers presented a synopsis of each patient from their ward who had an extended length of stay. Each case was then discussed with the social workers team, with the aim of developing suitable plans for timely discharge. In practice, problems were rarely solved as ‘waiting for a bed’ ‘waiting for assessment’ ‘waiting for a package of care’ were often the causes of the delay which in many instances were beyond the control of any of the team members present at the meeting. Ward managers knew this information before attending the meeting and were clearly frustrated at the need to present it:

“All I do is read off my list all the patients who have stayed longer than they should have done – that’s nearly every patient on my ward. I could email that. It’s such a waste of time, and not just my time. We had a ward meeting with our social worker yesterday and we discussed everybody then. Why do we need to do it again? It doesn’t achieve anything…” (WM4)

“I didn’t go to the Tuesday meeting last week, and I got rung up to ask why I wasn’t there. I was trying to sort out a sick patient who had just come back from theatre but I think they thought that was just an excuse.” (WM7)
Challenging the purpose or productivity of meetings was not observed. Whilst ward managers talked freely about their frustrations of attending ineffective meetings, they continued to attend them despite their anxieties and reluctance to leave their clinical areas unsupervised. When asked why they continued to attend meetings of little value, away from their ward their responses were varied:

“*My matron tells me I have to attend – it’s part of my role…apparently.*” (WM07)

“*I don’t really know – I suppose I worry a bit that I might miss something – they change the rules around discharging patients so often that I think if I don’t go, I might miss something important.*”(WM09)

Many of the anxieties around understaffing highlighted a lack of confidence in the ward workforce. Fears around leaving a ward unattended by a senior nurse for both short and long periods of time, and an inability to delegate responsibility to colleagues led to the exploration of the issues around recruitment and retention of staff. The issues that emerged were significant and led to the development of a subcategory of their own.
6.2.2 Recruitment and retention of staff

Recruitment and retention of staff has been the focus of much attention both within the Nursing Profession and politically (see Chapter 2). It was a subject that was frequently discussed both by ward managers and management staff during the study. Often referred to as one subject, 'recruitment and retention' are words that in reality may in fact be better addressed as two very separate issues. In this study data surrounding issues of recruitment suggested that it was seen as a hospital-wide issue:

“There was a hospital recruitment drive to get more staff,” (WM01)

“A recruitment programme for newly qualified nurses.”(WM04)

Ward managers appeared to take little responsibility for recruitment issues, and this was reinforced by strong direction from the Human Resources department.

Retention of staff on the other hand was discussed at length by ward managers and clearly a responsibility that was felt to be part of their role.

Since 1998 the hospital had encountered difficulties recruiting nurses, and consistent with national trends within the profession (Buchan and Seccombe 2006), many nurses were leaving. The close proximity to London and the addition of London weighting to nurses’ salaries was anecdotally considered one of the reasons why nurses left. The hospital’s use of agency nurses
was high and it was not uncommon to observe 3 or 4 agency nurses on a ward at any one time. Over the 4-year period of this study the dynamics of the nursing workforce in the hospital changed. At the start of data collection, the hospital’s use of agency nurses was extremely high, but as the costs of this soared, their use was prohibited unless no other arrangements for essential cover could be made. In 2007 it was rare to see agency nurses on the wards. The new management structure developed a strategy to grow the Nurse Bank and offered incentives to encourage bank work amongst the existing workforce.

Despite changes in workforce dynamics however, there were many issues, both positive and negative, that arose from discussions about recruitment and retention in relation to the ward manager’s role.

6.2.2.1 Issues with nurses recruited from overseas

Between 1999 and 2000 the Trust recruited more than 100 nurses from the Philippines and 25 from South Africa. The nurses had to go through a three-month induction course to adapt their qualifications to the UK nursing requirements. They were given accommodation in a nurse’s home and were managed by an Adaptation Manager whose role it was to support them.

Both the Royal College of Nursing (RCN 2003) and the Government gave immense support to internationally recruited nurses. Good practice guidance for employers recognised the crucial role that foreign nurses played in contributing to the UK workforce when it was under pressure, and
issues of cultural stereotypes and language were addressed. However, in practice at ward level, it appeared that there were concerns with language and culture that generated considerable strength of feeling and difficulties in day-to-day management.

“…the frustrations are many..., we can’t recruit effectively and retention of staff is a big issue...when I first came here there were only four of us where English was the first language, that has caused MAJOR problems. Nursing, I think personally has gone down the pan in that respect. Nothing against foreign nurses...but the impact that it’s had after x number of years is...complaints for example, the general public, and it would be the same in any other country, the general public don’t understand that somebody can’t actually speak to them. They complain and it’s a big issue that we’re having to deal with”.(WM03)

“Is it the accents that are sometimes difficult to understand?” (Researcher))

“Oh, absolutely, for an 85 year old who is confused or you know, it’s very very hard. That’s why I think the whole system, whether it’s the governments’ fault or nursing per say to go down that road it was probably – if you think back recruitment has always been an issue, but it seemed like another knee jerk reaction to go off to a foreign land and bring back ten’s of thousands of nurses, because if they
suddenly all went back home, …because now the issue is that we are depriving third world countries of their own health care needs, the health service would just collapse – it would implode, you know, if all mine went back I would probably be left with about six people, so the future of nursing as such…the average age of a nurse is well into their forties, coming up to retiring age and there isn’t any coming up from below.” (WM 2)

This ward manager had been asked to run a ward where the current ward manager had left. 60% of the ward establishment was made up of nurses from the Philippines who had recently been recruited to work in the UK. It was evident from observing these nurses at work on the wards, that the quality and standards of their practical work was very high. At no time did the ward manager question their knowledge or skills. However, due to local dialects and different use of language and terminology, understanding what they said was very difficult. The RCN (2003), in its guidance for UK staff acknowledged this problem but offered no practical solution:

“Initial problems with understanding local dialects and terminology can also be an area of friction and staff need to be aware that an IRN’s (internationally recruited nurse) language skills may take time to adapt.” (RCN 2003, p11).
This language barrier was observed to result in a breakdown in communication at several levels. Firstly interactions with patients were seen to focus on giving instructions, or asking questions such as ‘do you have pain?’ but ‘chat’ between patients and nurses was not observed. The nurses spoke together and talked to each other but these conversations were not held in English. When observing a handover session, it was difficult on occasions to understand details of what was being said.

Communications with medical staff were not observed as frequently with nursing staff from the Philippines. Two reasons were identified for this. One nurse who had been recruited from the Philippines told me:

“In hospitals in my country (The Philippines) junior nurses do not speak to the doctors very much. We tell our managers of things and they tell the doctors.”(Nurse 23, 02)

Secondly, it was observed that doctors did not question foreign nurses and engage them in conversations. Reasons for this were unclear and when two medical staff were questioned regarding this, neither acknowledged that it was the case. A ward manager had recognised this however and was frustrated by it:-
“There is an assertiveness issue – certain cultures are not assertive. Things like “did you ask the doctor about this?” …..Do you know what I mean?” (WM 5)

Effective communication at all levels is a key part of a nurse’s role. Poor communication between patients and nurses, nurses and medical staff, and between the ward team can clearly have implications for patient safety, effective team management and morale.

It appears that whilst there is an understanding of the issues around communication and foreign nurses, and recognition of cultural differences, little practical support has ever been given to ward managers to help them overcome difficulties caused by this on a daily basis. Increased complaints about poor communication and divisions within the teams were reported but ward managers appeared unable to implement strategies to address these. They recognised that it was a short term solution to a large national problem:-

“Inevitably if you employ people from abroad they will go home, and you are back with the problem that you had in the first place.” (WM 2)

“We need to put our house in order before going elsewhere. We solved a problem very short term”. (WM7)
In 2006 the government (Warner 2006) announced that the NHS should no longer recruit nurses from abroad as an expanded training programme and better conditions had meant that the supply of nurses was healthy and the manpower shortage had eased. This move was attacked by the Royal College of Nursing who argued that it would not be possible to replace the 150,000 nurses due for retirement in the next five to ten years with nurses trained in the UK alone (Malone 2006). Debate continued around the need to invest and train UK staff, the Government acknowledging that large-scale nurse recruitment across the NHS was only intended to be a short-term measure. The Royal College of Nursing argued that this short-sighted measure was using foreign nurses as scapegoats for the financial deficits in many hospital trusts. At local level, ward managers had recognised the implication of this debate but were unsupported and unadvised as to how to manage the day to day problems that occurred not only as a result of shortages in nursing staff, but by filling the vacancies with nurses from abroad:

“I think we’ve actually done the wrong thing by recruiting from overseas. I think we’ve actually shot ourselves in the foot. What we should have done is promoted the role of the nurse here and made it much more lucrative and attractive to people here to apply and do nursing. I know we live in a multicultural society but I think it’s very difficult sometimes to communicate within a hospital. Not so much the young patients, but the majority of our patients are older and they
might have visual impairment, they might have hearing difficulties and the communication is not the same” (WM01).

There was little doubt that ward managers struggled with issues surrounding ward communication. In a role where the identity of a ward manager is conjoined with skilful communication it was apparent that failures in these interactions were deeply problematic and difficult to solve in wards with poor levels of staff retention, difficulties recruiting and language and cultural differences. This highlighted further the significance of identity and the frustrations that were articulated when there was an organisational failure to recognise its importance in effective ward management.

The problems faced by ward managers as a result of poor recruitment and retention were compounded further by the use of large numbers of temporary nurses. These issues were widespread and led to the development of a further sub-category.

6.2.2.2 Difficulties working with temporary nurses

Temporary nurses (agency and bank staff) have been an integral part of the nursing workforce for many years (see Chapter 2). Their part in the delivery of care on hospital wards has been the subject of discussions throughout government and the nursing profession (Audit Commission 2001) Few recent studies have been undertaken to explore the use of agency nurses
on wards in the NHS, and much of the literature focuses on the cost of agency labour and how to reduce use of it. Manias et al (2003) conducted a study to explore the perceptions of hospital managers and agency providers. Two main themes emerged from this piece of work and were echoed in the data gathered from this study. Firstly, in planning for the ward allocation, hospital managers were primarily concerned with maintaining adequate numbers of nursing staff in the ward settings, whereas ward managers expressed anxieties about managing a ward using nurses whose level of competency was unknown. This introduced a conflict between hospital management and ward managers:–

“We have to justify using any agency nurses now, and explain why we need them. The problem is we are only allowed them when we are really desperate, and then we really need a good one – you know, someone who can just get on with the work. We don't always get that”. - (WM7)

“I always allocate the easier patients to the agency nurses. That means that my permanent staff can often get a heavy workload of sick people to look after. They know the agency rates so it seems a bit unfair that the agency nurse gets paid more”. (WM4)
Vignette 4 : Reflective memo

Being assessed for skill and competency as an agency nurse was an issue that I had personal experience of, having spent two years as an agency nurse working in this Trust at night during 2000-2002. The agency for which I worked had checked my employment references and my nursing registration. I had been deemed competent to work in the Trust. They were aware of my levels of experience and skills and had discussed them at length during an interview. Most of my previous clinical experience had been in medical and surgical ward environments. Soon after joining the agency, I was allocated my first shift. I was asked to work a night shift in the Accident and Emergency department. This was an area that I had never worked in and had very little experience of. A short time later I was offered a shift in Intensive Care - again not an area where I had experience or clinical expertise. I was a competent general medical and surgical nurse, with 17 years experience working in the NHS. I had declined the shift in Intensive Care – deeming myself as lacking technological and specialised skills to care for patients in this area. I did accept the shift in Accident and Emergency however and struggled to give high quality care in a very unfamiliar and specialized setting. This experience illustrated to me that neither the agency nor the hospital management was concerned with ensuring that the skills of the agency nurse were suitable for the area of work to which they were assigned. Priority was given to filling the gaps in staffing. (23/05/07)

The effects of this were demonstrated in the emerging data. Ward managers were concerned with addressing the issues of competency when
in fact it could be that more careful placement of nurses, and greater care in understanding the spheres of experience of agency staff by the agency itself and by hospital management could result in a more positive experience for all.

The second issue that has emerged during data analysis involved the need to defend any request for additional temporary nurses. Ward managers alone were not permitted to book agency staff; instead, they had to justify their need to managers (usually the matron) who would sanction or refuse the request. This withdrawal of autonomy was particularly incongruent when payment for additional staff came from the ward manager’s budget, for which they were accountable. One ward manager spoke of his frustrations at having to justify the need for an agency nurse to cover sickness. This resulted in an overspend of his monthly budget. He then had to defend this overspend to his manager (Ob note 53 WM02).

A second ward manager described her intense frustration with the issues surrounding agency nursing. She managed a ward where the divisional directors had decided to cohort a new group of patients following complex surgery. She had not been included in the decision process and was not in favour of it. She did not feel her nurses were sufficiently skilled to nurse this patient group in the absence of any specific training. The patients were sent to the ward and needed 1:1 nursing care post operatively. She requested agency nurses to increase her staffing levels during this time. The poor
condition of several of the patients meant that a high nurse: patient ratio continued for some time. The ward budget overspend during this month was fifteen thousand pounds. She was chastised for this:

“They said that they were going to allocate 4 beds to max fax surgery – we don’t have patients from max fax here, and they have big operations with difficult nursing care afterwards. I said that we didn’t have the right skills on the ward, or enough staff to give them 1 to 1 care. They came anyway and we sorted out some training, but I had to backfill the ward to free up 3 of the band 5 nurses to concentrate on looking after them. Obviously my agency spend went up by quite a lot – about £15,000. I had to go and defend this to the matron who basically told me off for spending the money – what was I supposed to do? It really was very frustrating.” (WM09)

These examples illustrate how ward managers have little control or influence over not only their patient case mix, but also the staffing levels that are needed to support it. All ward managers recognised and understood the issues surrounding ward staffing and ordering agency staff. Despite feeling that they had little or no control over managing the issues, they were held to account for them.

Control over one’s own environment is described by White (2008) as a significant factor in the determination and recognition of one’s own identity.
Repeatedly, ward managers described a loss of control within the ward, associated with unclear roles, responsibilities and isolation from their peers. Jenkins (2008) suggests that being in control is a critical part in creating a picture of who we are and how we are perceived. Where people display a lack of control, they, and others will start to question their purpose, identity and value within that environment.

6.2.2.3 Keeping good staff

A significant finding amidst this category was that whilst ward managers described how they felt unvalued, without exception, they discussed the need to help their staff to develop professionally and recognised the need to invest in them both professionally and emotionally in order to achieve a more effective workforce, better teamwork and a low staff turnover. They recognised their difficulties in keeping good staff and acknowledged the need to support and promote their ward workforce. They accepted that their teams were fragmented and understood that the lack of social capital within teams manifested itself in poor staff retention and high use of agency staff.

For example:-

“My concern now is that the breadth of knowledge that the staff need is so wide that something is going to get missed on the way. So that’s my next obstacle: to teach. I don’t want them in situations where they don’t know what to do.” (WM01)
“I took over from a ward sister who had gone off on long term sick. A lot of good staff had left because they weren’t motivated or encouraged. There wasn’t a very good team.” (WM05)

One ward in the hospital was observed to have a very low turnover of staff. When questioned about how this had been achieved the ward manager described how she and her team had developed a mentor approach that reflected a strong nurturing support network with fortnightly team meetings. Nursing staff on this ward were actively encouraged to enhance their skills and were given management responsibilities. There was a strong ethos of disciplined learning and an obvious respect and admiration for the ward manager.

“Staff don’t seem to want to leave - I hope that’s because they are happy here” WM07

Ward ‘X’ was a model for ‘keeping good staff’. Other ward managers recognised that Ward X kept good staff and could articulate many suggestions as to why. They recognised the experience of the ward manager and her focus on high quality patient care. They recognised her team approach to managing her workforce and her investment in creating a model of working that maintained social capital. It was also suggested that it was a ward that had maintained a high profile within the Trust and was
renowned for good performance and high standards. However, despite this it appeared that this model, whilst widely known and admired, had not been replicated in other areas.

On deeper interrogation of the data it was perceived that the high rates of staff retention on this particular ward were due to a combination of reasons. All staff questioned on this ward (six in total) were happy at work. They articulated that they felt valued, both professionally and as part of a wide and supportive team. Two nurses, in conversation described how they were proud of the reputation that the ward had throughout the Trust, and despite being one of the largest and busiest wards, they both recognised that they learnt skills and had specific responsibilities that their friends on other wards had not experienced. When asked why this was so, both acknowledged the skills of ward manager to be the factor that gave the ward its 'special identity' (memo 48).

6.2.3 Managing a team

The third sub-category, 'managing a team' grew from a group of concepts that illuminated areas where the ward manager's skills in team building and effective team management were challenged.

6.2.3.1 Working with a multidisciplinary team

Working with a multidisciplinary team from different agencies, departments and specialties had provided patients with care from a team of experts in
their own field. Traditionally the ward manager and the nursing team carried out many of the duties now undertaken by specialist teams, such as dietary advice and discharge plans (section 2.11). The use of multidisciplinary team approach to care is well established in this hospital. Social workers, physiotherapists, occupational therapist, speech and language therapists etc are allocated to specific wards where they see and treat the patients, whilst specialist nurses work along side medical teams and see patients when required. The relationships between these groups and the wards were largely positive and comments were made to support this during interviews:

‘The specialist nurse used to be the ward sister here- she obviously knows how the ward is run. We have a very good relationship with her” (WM6)

“They (specialist nurses) are absolutely essential to helping me see things in a completely different light” WM3

“I have no hesitation in going to them (diabetic nurse) for advice because that’s what they do, every single day of their life.”(WM2)

These comments, whilst being examples of support for different departments demonstrate that this support is based on the benefits they bring to the ward manager and the nursing team. Their relationship with the ward manager was a critical factor. Comments such as – “helping me”,

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“going to them for advice” indicated that ward managers actively sought support from other disciplines for themselves. This was reinforced by comments where support was not so forthcoming:-

“A lot of specialists we see are people who come in and out because we’ve got one particular patient needing that specialism. It’s not so close. Maybe we see them for a fleeting glimpse.” WM6

“They (Occupational Therapy) have had a lot of staff changes recently and we haven’t had one of our own for a while…” WM3

This comment highlights a desire to develop the identity of a unit – ‘our own’ suggesting the need to belong to the ward, and enhance its social capital. It reinforces the positive support gained from developing a strong multidisciplinary team, yet also suggests that the ward managers had little opportunity to control the development of such a team.
Vignette 5

On a ward where the input from a social worker was observed to lack direction and pace, the relationship broke down. The ward team appeared to struggle to manage patient discharge into community care, and were reprimanded by the operational management team for delays in discharging their patients. Whilst this reprimand may have been as a result of poor input from the social work department, nothing was done to address this. When questioned, the manager stated that she recognised this ward had patients with complex discharge needs but did not acknowledge the need for effective social work input in resolving the problem. The social worker remained unchallenged and the problems of delayed discharge were not resolved. (Memo 44 WM02)

It appeared from scrutiny of the data that specialist nurses had a more positive relationship with ward managers than other disciplines.

A survey carried out for the RCN (Ball 2005) examined the role of specialist nurses. It demonstrated that a key activity within their role was to provide specialist advice to other health professionals.

Schuetze (2004) examined the role of the hospital social worker. Her report identified the need for social workers to be part of a multidisciplinary team, but did not identify the need to support or advise the ward manager, focusing their support on the patient. The ‘team’ referred to the individuals who were involved in the care of a particular patient, rather than a ward
team. She suggested that the social workers’ role was more than finding resources and planning discharge but in many hospitals was only used as such.

A discussion with an occupational therapist working on a ward revealed that her role was centred around 1:1 relationships with patients. Although recognising her part in a multidisciplinary team, consistent with Schuetze, she described this as a team who looked after individual patients. Her interpretation of a multi-disciplinary team was focused “around the patient.” (Memo23WM4).

This is in contrast to a ward manager’s interpretation of a multidisciplinary ward team who suggested that nurses, including specialist nurses, view the term “multidisciplinary team” differently to other hospital staff. The focus here is on the ward rather than the patient. It was suggested by the specialist nurse, that the relationship between ward managers and specialist nurses was often positive because their expectations of the relationship were the same.

This was not seen to be the case with staff from other departments, whose expectations of teamwork were different. Her comment was supported in a separate discussion with a different ward manager, talking about her multidisciplinary team:-
“We have a great physio here – he’s a really important part of the team- he used to be a nurse” (WM7)

It appeared that the common thread uniting these two scenarios stemmed from the concept of a nursing identity. Both the specialist nurse and the physiotherapist appeared to share a common identity with the ward manager that was easily recognisable despite both undertaking different roles and crossing disciplines. The physiotherapist was interviewed and asked about his experience of teamwork. His perceptive response illustrated that he understood the benefits to his patients that occurred as a result of his position within the team: -

“The ward manager here sees you as a very important part of the ward team – what do you think? (Researcher)

“Well, I am not sure it would be right to go in and out of a ward, do your job and not be part of the team. You have to get in there. They need to trust you, and that works both ways. I need to know that if a patient needs something special, like a specific way of getting out of bed, that it happens when I’m not there. The nurses will only do that if they understand why it’s important and take on board what I say. It’s taken a while to be part of the team though. It’s a big ward here and you have to get to know everyone really. I try and turn up and do my share of other things, help out – like if a patient hasn’t finished lunch I will help them and clear away the tray - little
stuff like that, but the nurses notice that, and it helps them out - then they help you! It’s a good ward this one, other people know that, and we all really raise our game to keep up the reputation, it’s really important to all of us.” (Physio1).

6.2.3.2 Morale amongst staff

It is well known that morale amongst the nursing profession has been low, and this has been reflected in the number of nurses who have left the profession during the last decade (Healthcare Commission 2007). The RCN investigation into ward sisters and charge nurses (2009) highlighted the low level of morale nationally amongst this level of ward staff, attributing their demoralisation to feeling undervalued, frustrated at trying to achieve simultaneous high quality standards in a wide range of areas, and lack of clarity about their role.

Ward managers in this study have clearly felt the impact of low morale on their workforce and voiced concerns about the effects that this had on the management of the ward.

“The crew that I worked with on a previous ward, now all but one have left…..13 people have said that’s enough – they’ve just had enough of this organisation… most people making these decisions don’t really know what’s going on at root level” (WM3)
Ward managers knew the causes of low morale amongst the profession and recognized it in areas of their own sphere of practice. Many had experience of managing issues of long-term sickness, increased complaints and sustained pressure to achieve targets; all recognized causes of low morale (McKenna 1998, RCN 2009). There were elements of low morale seen amongst the Ward managers themselves in the study:-

“You have this little cloud that hovers over you – if I haven’t done this by such and such a time someone’s going to come and tell me off…”(WM3)

“I wouldn’t have any hesitation about giving up…
“You can be struggling and people see you struggling and won’t offer you the help”(WM2)

“I just really wish that we could …give something back to the workforce rather than take all the time and take it for granted that you can just take it…” (IWM2)

Nurses are by nature ‘problem solvers’ (Gordon 2005, Allen 2001) and it was evident that the ward managers interviewed were frustrated by their inability to resolve issues surrounding staff morale. Low morale was witnessed throughout all staff disciplines: -
“It’s becoming more and more of a difficult job, without the resources, and the apathy does run through other levels of management”

(WM4)

A long-standing employment survey carried out by the Healthcare Commission (Ball 2007) demonstrated that morale within the nursing workforce was at an all time low. Nurses felt insecure with employment, felt they lacked work opportunities and did not consider their employer to be supportive in their development. Whilst this view was evident amongst the ward managers, many of them highlighted during interviews that a key element of their role was to support their ward staff to develop.

“I want to help my staff to get where they want to be.” (WM2)

“It’s important that my staff are encouraged to grow – that’s really important” (WM7)

“Every Band 5 nurse who works for me will get to do the HDU course. It’s a really big part of their development” (WM8)

It was evident that ward managers had identified the connection between staff development and higher morale, and spoke of their commitment to staff development yet despite the very clear desire to support and encourage staff, many ward nurses were not enrolled on courses, had study leave cancelled due to lack of ward cover and did not feel that they were
developing professional expertise. These nurses appeared resigned to the situation and ‘blamed’ the hospital management or matron rather than the ward manager for lack of staff development. This was a pattern that was seen during different discussions and worthy of further investigation. Ward nurses frequently maintained a loyalty towards their ward manager and rarely questioned their authority, instead focusing their frustrations and often despair over lack of staff and inefficiencies, on the managers of the hospital. In turn, ward managers directed their frustration at the hospital management, and perceived that low morale was widespread and out of their direct control.

Ward managers in this study were capable of managing effective wards. They believed that the development of their permanent team was critical to their notion of managing a ward, yet external factors outside of their control blocked their ability to achieve this. They considered that their lack of influence and authority rendered them powerless. For the majority of ward managers, this perception has become the reality.

The analysis of data in this category produced an emerging substantive theory that required deeper investigation and further exploration in different areas. Whilst ward managers have provided much of the data for this category: managing an understaffed ward, the direction of enquiry needed to explore other views and different perspectives in order to make strong connections between the categories, which felt insecure. Grounded theory
ensures that the path of data collection is directed by emerging theory and a
need emerged to understand how and why ward managers perceive that
they have no control over factors that prevent them from running efficient
wards. There was a requirement to explore the relationships between
professionalism, managerialism and policy, and to engage in discourses
surrounding this with individuals who work in these areas.

Analysis of data has shown that ward managers understand their role and
recognise that there are obstacles preventing them from achieving success.
However, they consider that they are powerless to remove these obstacles
and key to the development of a substantive theory is to discover why they
think this.

6.3 Support for Ward Managers

Using theoretical sampling to drive data collection, further data was then
gathered from not only ward managers but from those who they perceive
obstruct the success of their role. This led to analysis of findings that
explored the support for the role that existed throughout the organisation
and beyond. The data from this analysis led to the establishment of a further
category that explored the relationships that ward managers formed beyond
the ward, and their position within the organisation and levels of
accountability.
### Fig 3. Category 3

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#### 6.3.1 Relationship with Matron
Throughout the study, the ‘relationship with Matron’ was frequently referenced. They were the line-managers for the ward managers and had a responsibility for their development, appraisal and on-going support.

When Alan Milburn (Secretary of State for Health 1998-2003) re-introduced the role of Matron in the NHS Plan (DH 2001) it was welcomed throughout not only the nursing and medical professions, but amongst the public. Milburn described the matron as an experienced leader, and someone who was intended to “play a key role in the Health Service, putting power back into the hands of frontline staff.” (Milburn 2001).
Christine Hancock, then general secretary of the Royal College of Nursing, said she welcomed the idea of a modern matron. In a press release she stated “Patients have been crying out for someone they know to be in charge on hospital wards. The idea of modern matron recognises that strong nursing leadership leads to better care and that when things go wrong, there is someone with the authority to put them right.” (RCN 2001 in The Telegraph, April 5 2001)

Matron as the ‘leader’ was a feature of many discussions with participants throughout the study. Since 2000, when The NHS Plan pledged to develop the role of the modern matron, the role of the matron within this Trust has increased and is now well established and well recognised throughout the organisation. Matrons have responsibility for specific clinical areas, and wards and are accountable to the Associate Director of Nursing in each hospital division (Emergency, Elective and Specialist). In May 2009 there were six matrons in the Emergency division. Their roles vary considerably depending on their clinical area, but a key part of their job was to enhance the flow of patients through the hospital, focusing particularly on patient discharge, and key Government and Trust objectives which include the 4-hour A&E target and infection control. Different views of the matron’s role emerged from the data and demonstrated that at times, the relationships with matrons were not always easy ones:
“…Matron – I’m not sure it’s a tier of management that we really needed” (WM2)

“..we always really need experts, and they really should be the Matrons” (WM8)

I see it as her job to support the role of the ward sister, listen to what she wants to do and maybe help her with things like … cleaning contractors.” (WM1)

..most of his job is business…policies…you know, he’s not actually out on the floor with the nurses…and that’s what people want to see really… (WM8)

It was evident from the data that ward managers viewed the matron’s role as one that should provide a daily visible support on the wards, and in all cases, this was what they wanted from their matrons. When it was first introduced by the Government as part of the NHS Plan, the role of the matron was to be visible, accessible and supportive to patients and front-line staff (see section 2.10) These are clearly the very elements of the role that were highlighted by the ward managers as essential. In reality, however, it was apparent throughout the study that few ward managers received the level of support from their matron that they not only expected,
but also badly needed. It was also clear that the matrons’ essential and heavy daily operational work load, (such as attendance at bed management meeting four times a day, addressing staffing issues, patient complaints (Ob note 34) left little time to provide that support. This suggests that their actual role was very different from that which had been outlined in the NHS Plan (DH 2001).

The huge variability in implementation of the matron’s role across the UK was recognised in a study carried out by the University of Sheffield and the Royal College of Nursing (Read et al 2004). In a thorough review of the role of matrons across the country, key messages from the study highlighted the need for clarity around roles and responsibilities and line management, and the need for matrons to have manageable workloads to enable them to focus on their 10 key responsibilities (Matron’s Charter DH 2004). The study emphasized the role that matrons play in maintaining standards, particularly in cleanliness, and improving the patient’s experience, but it did not directly highlight the need to develop a strong supportive relationship with ward managers, despite line managing them. Whilst this may not have been a key objective for this modern role, its success may well depend on this element being in place. In part, this was recognised in January 2008 when the Prime Minister, Gordon Brown provided further government funding through the Strategic Health Authorities to increase the number of matrons from 2,000 to 5,000 in an attempt to tackle not only MRSA but C-Difficille. In his comments to the BBC about the new posts the Prime Minister said
“Ward sisters will have new powers...Everybody has a right to expect, when you go into hospital, you are not just treated as a person and not a number, but it is going to be clean, it is going to be safe, it is going to be secure. I want to reassure people that we are taking every step possible to do it.”

Gordon Brown’s remarks echoed those by Alan Milburn (Secretary of State for Health) at the RCN Conference in April 2007: “Ward sisters and charge nurses are the lynchpin of our hospital system but for far too long they have had responsibilities without power.” In their comments, both Milburn and Brown highlighted the importance of the ward sisters when they were discussing the introduction of the modern matron and acknowledged the significance of the matron’s support to ward management, however in defining the role of the new matron, they failed to clearly identify how this should work in reality. Their comments highlighted confusion in the differing identities of both matron and ward manager, which has served only to further blur the boundaries between the roles. Their use of the title ward ‘Sister’ when in reality, the vast majority are referred to as ward ‘Manager’ highlighted a perception that suggested the identity of the role differed from the reality of it.

As a direct result of Gordon Brown’s action, in February 2008, five further matron posts were created at the hospital. Two of these focused on a relief role, to cover existing matron absences, and two were established to concentrate on hospital discharge, with their own patient caseloads. Only one post emphasised the need to provide professional development and
support for ward managers as a key part of its role. The decision to use matron posts in largely operational roles clearly reflected the needs of the hospital at the time. There were heavy demands on beds, and difficulties achieving government targets around levels of hospital acquired infections. The matrons were heavily involved with resolving difficulties with discharging patients with complex continuing care needs, and managing the flow of patients in and out of the hospital. Whilst these issues required management from highly skilled and experienced nurses they were roles that focused on very different priorities than that of the modern matron introduced by the NHS Plan.

There is little doubt that in a hospital of this size, there is a need for experienced nurses to carry out both roles, but whether it is possible for both roles to be undertaken effectively in a combined post of matron, is questionable. Data drawn from this study demonstrated that at times the modern matron role fell short in meeting the expectations of other staff.

“...It’s a surprise when they talk to you. I never know when my matron’s going to turn up, I don’t have a regular 1:1, and haven’t had for the last eighteen months, I’ve not had an appraisal” WM8

…the majority of matrons don’t know one of the patients in their area, or any of the problems. They know very few of the staff, they know a few of the staff but they don’t know the staff. They have never had a
conversation with half of the staff, and they worry about beds and discharges and breaches, and that sort of thing." WM7

It was clear from discussions with matrons that they too felt that the demands of their jobs and the different focus of priorities prevented them from supporting ward staff to the extent that they felt was necessary. One matron, working a minimum of ten hours a day, spoke of the frustrations of an operational role, which allowed very little time to speak to either staff or patients on their wards unless there were complex problems or complaints to resolve.

Matron :-

“Sometimes they (the ward managers) ask us to do things for them that they probably should be doing themselves. When we suggest that, I think they sometimes feel we’re not supporting them. …if we’re not on their ward then I think they forget that we are somewhere else, we cover a lot of different areas now, and go to the bed meeting three times a day, sometimes more.

...actually, you know which ward managers will be ok if you are caught up and can’t get to the wards, the ones that can cope. And you know the ones who can’t.

Researcher : How do you manage those?
Matron: You just try and get there when you can, or phone them. But sometimes it's hard, really hard and you feel bad for not being there. But, I do say, they are Band 7's, so should be able to cope with most things really...should.” (Matron 2)

Before the modern matron role had been introduced in the hospital, clinical departments were divided by specialty into Care Centres. Each Care Centre was managed by a senior nurse who was accountable for many of the operational duties such as bed management, staffing levels, cleaning contractors, supplies etc. A re-structure in 2004 removed these positions, and replaced the senior nurses with matrons. Several senior nurses took on the new role of the matron. It may be that this was the point at which the two jobs merged into a hybrid role that did not truly reflect the new matron role that had been introduced by the Government. There has been much publicity surrounding the role of the modern matron, both within the profession and through media. The public has been made aware of their role and their part in dealing with hospital infections and hospital nutrition at ward level. If the public perception of a matron is one that does not reflect the current role then it cannot be a surprise that many ward managers in the study did not feel that the support they or their patients received from their matron met their expectations.

During an observation session on a ward, a matron visited. His purpose was to check the number of patients planned for discharge that afternoon. The ward manager talked through the caseloads. There was a query over
whether a patient could go home or would stay to wait for a scan. The ward manager was unsure, as the Doctor had not visited the patient that day.

WM: “I’ve tried to chase it up, but the Doctor said he will see her (the patient) when he gets up. I think she’ll probably need to stay, even if she doesn’t have the scan - she’s not that well really.”

Matron: “Ok, can you chase it again, before the bed meeting? We’re going to need that bed later.” (Ob note 30)

The matron was working in his operational role, on the front line. He had to find beds for patients waiting in the Accident and Emergency department and had to report any potential free beds to the bed management team at an operational meeting that took place three times a day. His focus of attention was not on the condition and well-being of the patients on the ward, nor did he appear to acknowledge the judgement of the ward manager. (The patient did remain on the ward and was not discharged). This short interaction demonstrated that at that time, the matron’s operational responsibilities were a greater priority than the ward responsibilities. This was clearly an issue that was observed frequently throughout the hospital since the arrival of the new management team in July 2007. The new team were focused on achieving the Government’s target for Accident and Emergency waiting times. All attention was directed to meeting these targets and individuals were often publicly held to account for any failures. Two matrons reported that they often had to justify
discharges late in the day, or push hard for beds on the wards to become available. They were under considerable pressure from the operational management team, and both these matrons when questioned felt the operational function of their role often overshadowed the role that they had taken on as a modern matron.

This is consistent with the literature surrounding the matron role. When Reed et al (2004) evaluated the role of the modern matron, it showed that nationally, matrons in the role were undertaking a vast and varied range of tasks, many of which did not fit with Department of Health’s definition of a modern matron (see Chapter 2, section 2.9).

When exploring the relationship between ward manager and matron it was evident from the data that in many instances, ward managers wanted matrons to provide a physical support on the ward by being available and present to discuss issues:

“…the whole idea of having a Matron is that they lead…” (WM7).

However, this was at times inconsistent and at odds with their desire to manage and lead their own wards without having to justify their actions to their matron.

“People like matrons or that sort of level are frustrated because you are not doing your bit in moving the process along, but actually they
don't really understand what the issues are. The matrons don't spend enough time in the clinical environment, not in this Trust anyway. If you look at what Tony Blair wanted to do with his matrons which was to get things back to standard in the clinical area…. and it hasn't happened… (WM8)

This comment is significant. The ward manager identifies that she does not require support from her matron, suggesting that the matron may not understand the issues she faces. However, she also acknowledged that standards in clinical areas have not been raised. On the one hand she does not require matron’s support, yet on the other she is suggesting that current low standards are the result of a government plan that has not delivered its intentions. At no point did she consider that as the manager of the ward, standards were her responsibility.

This again demonstrates the lack of clarity around ward accountability and responsibility that has emerged as a result of the introduction of the modern matron and reinforces confusion over identity and role recognition.

6.3.2 Working in isolation

There were many times during data collection and during observation sessions when it was clear that ward managers worked in isolation. In many cases this was recognised by participants and was perceived as a reason
for feeling unsupported and at times powerless, in their role. Working in isolation emerged as a sub-category

“…if ward managers really worked together, stuck together, we could be extremely powerful within the NHS. But I think for some reason we don’t and I don’t think nurses stick together… as a united force we could be really strong…” (WM1)

“we are really a very powerful group, but have never really stuck together well, despite having hundreds of sisters essentially they still work very individually and allow the organizations to make all the decisions without any consultation.”(WM3)

“I suppose you could say there is someone at the end of a phone, but in my role, I would only use those people [matrons] if I was really struggling with something and I knew it really wasn’t worth me bothering, I might as well just try and solve it or resolve it or whatever, myself really and take the risk. Those of us who think we can, will take a reasonable risk and it’s usually ok. You know from experience that you can do it and that’s it. And whether it’s a clinical or non-clinical decision, you make that at the time and you go with it and carry the responsibility, and that’s the way it has to be really.” (WM2)

Allen (2001) highlighted the lack of peer support, combined with limited opportunities to share ideas and discuss common problems as a major
contribution to stress amongst ward managers. Her study, undertaken to explore reasons for stress amongst ward sisters and charge nurses, recognised that as a professional group they were ‘detached’ both in management and educational terms, and found few opportunities for peer-group support. Her report concluded that there was an urgent need to establish effective support networks and open lines of communication in order to meet the modernization agenda of the NHS Plan (DH2001).

Every ward manager that took part in the study discussed the lack of peer support and was immensely frustrated by it. There were clearly times when they recognised that implementing change could have been made easier if a network system had existed for ward managers throughout the hospital. Why this did not occur was unclear. Formal meetings for ward managers occurred three times a year, three ward managers reported that they did not always attend them due to conflicting work commitments. Whilst they recognised the value of peer support, no one had initiated a formal process for this. When asked why, a range of responses were given: -

“Not enough time” (WM4)

“Too short of staff” (WM7)

“No-one would come” (WM5)

“Too busy too leave the ward”(WM9)
It appeared from this that whilst ward managers described feelings of isolation at work, and were outwardly attempting to create social capital, feelings of belonging and mutual support, they made little effort to create a support network for themselves or others. Even when meetings were held that brought them together, they did not always show a commitment to attend.

As the ward managers talked about their roles at length, it became apparent that at times their isolation acted as a protection mechanism from the complexities of the hospital. Showing an interest in other clinical areas and supporting other Ward Managers raised their profile within the hospital, which had the potential to create extra work, which was not always welcome.

“If you are seen to do something well, you get given loads more things to do so the best thing is just to keep quiet and get on with your own work” (WM8.)

This was a concept that was observed throughout the study. By keeping a low profile, ward managers could avoid being asked to pilot specific projects or take on additional workloads. This enabled them to focus their time on their own ward with fewer distractions.

Three of the ward managers in the study recounted times when they had been moved from their own successful wards to manage struggling wards in different specialties because they were deemed ‘competent managers.’
They had not wanted to move to different wards but had felt unable to say no. The new roles had been challenging and difficult and they had each felt unsupported.

Vignette 6

A particular ward manager described himself as a “Jack of all trades” and a “trouble shooter...you carry a bag with you all the time because you never know how long you are going to be in one place.” He had been moved to different wards on four separate occasions, which had led to frustrations, as he never felt settled or saw the long-term benefits of an established team. His identity within the organisation as someone who solved temporary staffing problems was significant. He did not welcome the ‘label’, and expressed feelings of dissatisfaction at being frequently moved. He did not recognise that his value to the Trust was enormous, and that the hospital managers considered his efforts to be ‘heroic’. (Ob note 60) Instead he felt used, unsettled and tired of constant change. The first issue that this raised was around his feelings of being used merely to solve a Trust problem of staffing. He was clearly experienced and skilled at the trouble-shooting role he had undertaken and yet had either not been recognised for his skills or had not acknowledged the recognition. He had not had an appraisal for three years, despite moving from one ward to another at short notice. His expressed frustration at a system that appeared to care only for a solution and not for the people who made a solution possible. As he described his current role, he talked about how his position had changed over time. He used to bring in a toolbox at the weekends to fix broken equipment, such as a locker or a leaking tap. He was no longer allowed to do this, and yet he could not get the estates department to repair lockers, repair
or mend taps, as they were considered low priority repairs. He spoke of his increasing lack of control over his ward budget, and his concerns that any over spend regardless of cause had to be justified to the management. His weariness of battling the system at every point was overwhelming.

“I've noticed you do take work home with you, or you have this little cloud that hovers over you – if you haven't done this by such and such a time then someone’s going to come and tell me off. You don't want to live under that cloud – you should be trying to make life easier in very difficult times, there’s still this, you must do this….So I wouldn’t have any hesitation about giving up, equally I still come in and do it. …..It's becoming more and more of a difficult job, without the resources.” (WM2)

This section has highlighted the feelings of support that ward managers experienced. Worthy of note is the limited references to support from the medical teams. Support from medical colleagues rarely feature in the data gathered from interviews, and when questioned about relationships with medical colleagues it was evident that support from this section of the workforce was neither sought nor offered. It is difficult to understand the reasons for this, but it gave strength to the theory that for the most part, nurses work alone, seeking little help or support from their peers. There may be a perception that staff work together, in a multidisciplinary-shared working environment and this may be consistent with medical teams, or allied health professionals, but within the ward staff in this study, it was clear that this was not the case. Consistent with the work of Allen (2001) the
isolation they spoke of may well have contributed to feelings of weariness and frustration.

Consequently, it is possible that the feelings of lack of support that many ward managers articulated were perceptions that stemmed from working in isolation, “just getting on with it” and failing to ask for support when it was needed. This may well have been because asking for support suggested an inability to cope, and many requests for help and support in the past had gone unheard.

### 6.3.3 Position within the organisation

In 1996 MacLeod described how ward sisters acted as a ‘lynch pin’ between the wider hospital organisation and the ward. She spoke of their duty to provide a role model for the practical functions of her nursing team. “Practicing nursing incorporates “noticing, understanding and acting” (Macleod 1994 p361). It was clear from observation sessions in the field, that the ward managers spent much of their working day in an office, rarely able to notice or understand the detailed needs of either their patients or their nursing team. Whilst they attempted to be a role model, they were rarely seen as such by the ward team.

All too often older nurses said to me “Nursing isn’t what it used to be”. As the modern day ward manager grappled with non-clinical but essential operational and administrative issues, it was clear that they were spending
more and more time away from the clinical environment, their patients and their staff. Consequently they were no longer in a position to direct and dictate the standards of nursing care on the wards that were referred to by older nurses when they talked about the ‘good old days’.

Whilst the memories of ward sisters in immaculate uniforms and starched aprons, managing ward rounds with doctors in white coats, portray an identity of ward leadership that is surrounded in discipline and cleanliness it is also known that hospital care has moved forward, and memories of former decades do not necessarily convey a rounded and accurate picture. The ‘good old days’ of nursing were far from perfect. Patients waited months, sometimes years for routine operations, care was regimented and choices were limited.

This research has shown that whilst many of these operational issues have been addressed, the focus for ward managers has become centered on the inward delivery of the metrics that support the hospital objectives rather than looking outwards to their patients by providing nursing expertise and clinical leadership.

Whilst their core nursing values are embedded in the values surrounding healing, recovery from illness and comfort, they no longer have the support or time to develop new ways of working that reflect the complex needs of the sick patient and uphold these values. As the hospital focuses on centralisation as a means to improve efficiency, speed up patient
throughput, budgets and externally imposed targets, ward managers have struggled to foster and maintain a culture on their wards that allows the patient time to recover and heal from illness.

These values are articulated by the American sociologist Arthur Frank (2007). He describes the traditional idea of hospital care as something that offers more than treatment. That is staffed by people who’s true and uncompromising vocation is to care for the sick “that welcomes the sick person without qualification.”, inviting them “to feel less stigmatised and isolated” (Frank 2007 p2). He describes this as medical generosity in an environment where the focus is about the ability to promote both the physical and psychological aspects of healing. He explores the meaning of ‘care’, enacted in gestures that can console far beyond what they accomplish as practical components of treatment:-

“Touch must be generous, seeking contract with a person as much as it seeks to effect some task. Generosity is the resonance of touch, endowing the act with a capacity to give beyond its practical significance. There is no reason why the skilled touch cannot be generous. On the contrary, true skill has to include generosity…..In generosity of spirit comes healing” Frank (2007) p6
Frank has highlighted that in order for patients to ‘heal’, hospital care must focus beyond efficient processes and deeply address the psychological barriers to healing and health. Weinberg (2003) describes the effects of this in her study of the outcomes on nursing following the merger of the Beth Israel Hospital and the Deaconess Hospital in Boston in the late 1990’s. The Beth Israel Hospital invested its resources in employing predominantly degree-trained nurses who worked to a model based on Primary nursing. The same nurse cared for a patient from admission to discharge, and through subsequent admissions. The nurse to patient ratios were high and the hospital was heralded as the best example of nursing care in the USA. The focus of attention from not only nursing, but medical staff and management was based on healing and care. Beth Israel demonstrated to the United States that good nursing took experience, education and skill, but it also took money. The priceless relationship that was fostered between the nurses and the patients came at a huge cost and at the time of merger with the Deaconess Hospital it was losing $1 million a week.

The Deaconess Hospital provided a high standard of care but through a different model to that provided by the Beth Israel. It relied on skilled technicians to provide much of the routine care, and based its model on task allocation and lean efficiency.

The merger brought about a new focus on process redesign to improve efficiency, increase patient turnover and reduce length of stay. (Weinberg 2003, Gordon 2005, Nelson and Gordon 2005). At the same time, the high standard of nursing care that had been provided at the Beth Israel could not
be transposed into a new way of working and standards of care in the new merged hospital fell dramatically.

The experiences of the Beth Israel and Deaconess Hospitals in Boston are not unique. Their need to save costs required a change in organisational direction that became dominated by saving money. This has occurred locally. This research has shown that as the hospital has become a business, fighting for financial stability, the focus has become dominated by developing efficient processes, care pathways and achieving targets that will support financial security. Whilst these have described under the umbrella statements of ‘patient centered care’, and ‘putting patients first’ it is clear that at ward level, the priorities centre around getting patients home as quickly as possible, reducing staffing levels to a minimum and cutting costs. Within this, ward managers are unable to create an environment where the true spirit of generosity and healing is permitted to flourish. This is not because they lack the competence to do so, more that they are battered with a workload that feeds the organisational machine and in doing so, has removed them from the patient’s bedside and prevented them from being a constant presence of experience and advice for the ward staff. It is clear that the organization has not recognised the need and benefits of having the most experienced, highest paid member of the ward workforce working clinically at all times.

By removing the ward manager from the ‘shop floor’ their skills and credibility as the clinical expert have diminished. Instead, specialist nurses
are called in to take over care of the sickest patients, or to advise and plan specific pathways of care. Outreach nurses, vascular nurses, wound care, stoma specialists, diabetic nurses etc, all working closely with the medical teams, have become the clinical experts on the wards, a role that the ward manager once occupied.

The introduction of the modern matron has served to further devolve responsibility for ward care away from the ward manager. This new role has created a tier of nursing management whose remit and responsibilities are varied and unclear. In many areas they have assumed responsibility for ward cleanliness, house keeping and staffing levels – all duties that until their arrival were the responsibility of the ward managers.

This loss of responsibility for many issues within the ward has resulted in a striking loss of legitimate power and identity, particularly prominent in ward managers who had been in their jobs for some time. For a role that was once considered to be at the top of the professional ladder, the fall to a job that at times requires no more than a competent administrator (for example: - undertaking staff duty rotas, developing job advertisements, monitoring performance) has been severe. Traditionally the role of ward manager was one that had a very clear identity and authority within nursing. Patients, the public, medics and hospital managers alike understood the role and what was expected of it. Now its position of authority has been reduced. They are less visible to the public, and as they become less present as the clinical
expert on the ward, their involvement with the medical teams has decreased. Hospital management now demands far more from them than ever before, expecting their skills as business administrators to meet with their ever-increasing demands. As their role has changed, it appears that the skills as the traditional ward leader are no longer valued or even at times, required by the organization. The results of this are clear – as they have become unable to fight the organizational machine to demonstrate the true worth of their role, their inability to deliver care to their patients or support their staff in the ways that they consider necessary, has resulted in experiencing a huge sense of failure.

“The whole essence of our job is about patient care and this has been stripped away from us”. – WM4

During the study, ward managers recognised the need for clinical expertise and leadership. Senior managers also identified this as a key requirement, yet in reality the importance of these components of the role was far from evident. Leadership training was offered infrequently and there was no evidence to suggest that it explored leadership issues within the context of the hospital culture.

There are three aspects to this role that have emerged from this study: -
i. Expectations of the role – grown from the traditional and historical images and perceptions of the ward sister. It is the scaffold of their identity as ward managers.

ii. Role expected by the hospital – This is the role that ward managers have to undertake in order to deliver the hospital objectives at ward level. It focuses heavily on measuring performance, targets, financial scrutiny and standardisation.

iii. Reality of the role - ward managers are struggling to meet the hospital’s expectations. The business management skills required to understand finances, monitor activity and develop local strategies have never been formally taught. Yet the demands are such that they have no choice but to react and respond to management demands. The immediacy of these requests leaves little time to spend with patients, developing and supporting staff and fulfilling their identity as ward leader and clinical expert. In many cases this responsibility is devolved down to the junior sisters (Band 6) and the specialist nurses. Ward managers are no longer able to be the ward leader in the way that want to be, and that others expect of them. As a consequence ward managers in this study have become deeply unsatisfied, disillusioned and consistently unhappy in their role. Their lost identity has resulted in feelings of isolation and loneliness, which in turn has given them little voice within the hospital.
This misalignment between perception and reality is vast. Those ward managers who give everything to succeed work extraordinarily long hours, but even these describe themselves as struggling, even “drowning”. They compare their daily life to that of a battleground. One ward manager (WM07) created an urgent ‘to do’ list following a week of annual leave. 68 separate items featured - not one of them was regarding the clinical care of any of the 32 patients on the ward (From WM interview, July 2006).

There is no single reason why this misalignment has occurred. At the onset of this study I believed that the role of ward manager had evolved throughout the last two decades, resulting in a complex, demanding and multifaceted position. It is only by studying this role in detail within the culture of the organisation and the context of contemporary health care provision that it is clear this is not so. An evolutionary process suggests that the role should have developed, progressed and advanced and yet there is little evidence to suggest that this has occurred.

Studies carried out by Fretwell (1982), Ogier (1982) and Orton (1981) explored the role of the ward managers as a clinical educator, creating an environment and culture for ward learning. There was limited evidence to suggest that on the wards today that despite the presence of both nursing and medical students, education was a priority. In reality, financial constraints had forced the restrictions of training, and ward based teaching sessions were rare. Although students worked with mentors on many
occasions, there appeared to be little formalized agenda for ward learning and teaching had been delegated to others.

Willmott (1998), Wade (1998) and Savage (2004) studied the leadership role of ward managers at a time when leadership training was high on the nursing agenda (Cunningham 1999). Some ward managers who had been in post for over 5 years had seen the benefits of leadership training earlier in their careers, but all reported that it had fallen short of providing guidance for issues that were relevant to business administration and management duties. Many had received no leadership training or professional development to help them develop in their roles. Developing a team of expert leaders, whilst clearly necessary was not a feature of the hospital objectives and the initial drive to offer training some years earlier had not been sustained. One senior hospital manager stated that ward leadership was intuitive and inbuilt, and not something that could be taught – a statement that failed to recognise that effective leadership stems from more than intuition and requires expertise along side a deep understanding of the organization and the cultures within it (Fineman 1993, Handy 1999). McLeod (1994) showed that ward leadership requires the skill to be able to sit by a patient’s bed and comfort, to enable the healing process, to have a therapeutic presence that inspires confidence and safety. Pembury (1980) also demonstrated that it requires a person who can lead by example, creating the model that all ward staff adhere to, aspire to and learn from. This hospital particularly needs ward leaders who can inspire those who are
weary and disillusioned. Critical to the ward manager’s role is the ability to ensure that their staff are sufficiently skilled and capable to provide the nursing that is required of them when they are at work, and to notice when standards of care fail to meet the standards expected. These points highlight the importance of the seminal work of Fretwell (1982) (Chapter 2) who demonstrated the significant benefits to patient care by providing wards where students and staff were inspired to learn from role models and leaders who provided an environment where clinical learning could thrive.

It was clear that over the last two decades, priorities for ward managers have changed. The focus is no longer on developing leaders or clinical experts and thus the role has not evolved, instead it has radically changed direction. Ward managers now need to be astute in business and finance and competent to manage complex human resources issues. The hospital demands that they develop efficient processes for ward activities, adopt centralized ways of working, and remain open to frequent and often poorly managed change. These factors were never part of the remit of ward managers in the past but are critical factors in the success of the contemporary role. It seems that as hospital care has evolved and moved forward, growing and changing at a rapid pace, the role has not grown or developed along side it. Ward managers in this study were fighting to stay in a role that in its present form appeared to be difficult to sustain and of questionable value to the organisation. Consequently those who attempt to manage their wards both as a traditional ward manager, and at the same time attempt to meet the demands of the organisation are clearly struggling
to cope, Physically, the challenging work load left them exhausted and disillusioned, and emotionally their altered identity appeared to leave them with little social agency or status.

The job in this current form, without training and support, asks for more than the ward managers interviewed in this study were able to deliver. Nationally, evidence shows that few nurses seek to take on the role; it is no longer considered a desirable job, and is not a role that nurses progressing up the professional ranks aspire to take on (RCN 2009).

Traditionally one of the more identified and desired roles within nursing has become a role struggling to survive. For the ward managers interviewed in this study, the personal cost has been high, as the role has demanded more of people than they can deliver. This is consistent with evidence nationally that showed ward managers as a group had low morale, were reported to feel under valued and frustrated with a role whose remit and responsibilities were at times very unclear (RCN 2009).

Exhausted from long days trying to achieve all that is expected of them, under siege and desperately frustrated with lack of time to spend with their patients and staff, ward managers are no longer able to deliver all that is required of them.

The heavy demands put upon ward managers from the hospital management require knowledge and skills that many have never been taught. Many struggle with budget sheets, complex human resources issues
and financial issues. As a consequence of this, the organisational requirements of the wards are rarely embraced sufficiently.

Ward nurses and students no longer have the security and continuity of their ward manager to teach them the skills of a highly experienced nurse leader and role model despite the evidence provided by Pembury, Fretwell, Ogier and Orton in the 1980’s.

Whilst healthcare and medical treatment have moved forward with great pace, nursing the sick remains an art and science that requires expertise, experience and clinical leadership (Frank 1995). Creating a ward environment that can adapt to the changing science and technology that surround disease and treatment, whilst at the same recognise the need for time, compassion, understanding and support are the skills that are required of clinical leaders. Ward managers in this study had these skills but were rarely in a position to use them well and did not have the support to do so. These findings are consistent with literature from both the US (Gordon 2005, Buresh and Gordon 2006) and Canada (Rankin and Campbell 2006) who all describe similar levels of disillusionment, isolation and lack of social agency.

Hospital delivery of healthcare has changed. The NHS Plan (DH 2000) promised radical new ways of working and in many ways has delivered on its promises. Darzi’s report (DH 2008) further recognised the need to
address both the physical and emotional needs of patients, and understand the patients’ experience of hospital care in order to provide an agenda of healthcare based on quality.

Ward management does not appear to have embraced changes to enhance standards and meet the agenda set by Darzi. Instead, the ‘battlegrounds’ create conflict and disillusionment where staff are unable to embrace new ways of working or challenge and confront the organisation that struggles to recognise the value of those who are at the forefront of care delivery and the importance of the intimately close connection between the nurse and the patient.

6.4 Introduction to the central category

The data from this study has demonstrated that the role of the contemporary ward manager is complex, diverse and dynamic. Its historical and traditional anchors have provided it with a scaffold through which the modern methods of delivering health care in hospitals have infiltrated. Through this research ward managers have revealed the difficulties that they face in meeting the expectations of others, particularly hospital management, and those who are involved with the day-to-day operational delivery of the service. Within these disclosures, they have described their loss of power and the frustrations and feelings of helplessness and despair.
Through the development and understanding of the issues surrounding the three categories in this analysis, a central category is formed. This leads the focus of the study towards an emerging theoretical framework that will underpin the multifaceted role of the ward manager.

<table>
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<tr>
<th>Categories</th>
<th>Central Category</th>
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<tbody>
<tr>
<td>The Battlefield</td>
<td></td>
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<tr>
<td>Managing an understaffed ward</td>
<td>Social agency</td>
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<tr>
<td>Support for Ward Managers</td>
<td>Erosion of power</td>
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<td></td>
<td>Emotional management</td>
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![Diagram to show formation of central category](image)

**Fig 4. Diagram to show formation of central category**

The following chapter will explore and discuss the emerging theoretical underpinnings that have led to the development of this central category. It will examine the psychological and emotional explanations for the behavior that has been described and observed. It will position these explanations within the field of organisational culture, specifically that of healthcare.
Combined with the current social reality of nursing, conclusions will then be drawn that generate a theoretical explanation for this contemporary role.
CHAPTER 7

The Central Category

“Our lives begin to end the day we become silent about things that matter”

Martin Luther King, Jr

7.1 Introduction

This chapter explores the overwhelming theme that emerged from the analysis of the data in this study and it discusses the issues of organisational culture and emotional labour that underpin the substantive theory.

7.2 Emotional Management

Significant issues arise from the findings of this study that demonstrate the misalignment between the values of the senior operational management within the hospital and those of the experienced ward managers. During the period of data collection, the hospital as a whole spoke of its commitment to providing the highest available quality of healthcare (Trust Core Values
yet within the descriptions of their daily work, ward managers gave frequent accounts of times when care fell short of meeting this pledge. It was evident that this discordance extended beyond the hospital itself. The government rhetoric that promised an NHS ‘designed around the patient’ (NHS Plan DH 2000) made little connection with the values of the ward managers who spoke of their struggle to provide sufficiently safe levels of staffing, or who had little influence over timings of admission and discharge, length of stay and other issues that had a profound effect on the patients experience. Their frustrations lay in their responsibility to deliver the NHS message and the objectives of their organization, whilst at the same time recognising that there were frequent situations when organizational constraints prevented them from being able to ‘practice what they preached’.

The ability to create a public face for the benefit of others, which differs from the emotions that are felt inwardly, is described by both Hochschild (1983) and Fineman (1993) as “Emotional Management”.

Hochschild (1983, p7) defines emotional management as “the management of feeling to create a publicly observable facial and bodily display”. Managing one’s own emotions in public is learnt throughout childhood. Within nursing itself, learning to hide ones feelings, appearing calm during times of emergency, or when dealing with stressful situations is part of any nurse’s daily working life. Hochschild describes it as “labour that requires
one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others…” (Hochschild 1983 p7). The purpose of emotional labour is for organizations to promote a positive organisational image. Organisations “subvert the worker’s ‘true self’ by reinterpreting the emotions they naturally feel in work situations” Theodosius (2008 p 22). Hochschild suggests that healthcare organizations exploit the commercial value of this principle, essentially by paying nurses to ‘care’.

“Emotional labour is sold for a wage and therefore has exchange value” (Hochschild 1983 p7). It is controlled by the employers, whose motivation for exploiting emotional labour is for profit. Undertaking emotional labour draws on the individuals’ sense of self. It stems from individuality as it is developed from memories, personal relationships and personal experiences. Hochschild argues that organizations who utilize emotional labour teach employees new ‘rules’ around feelings and emotions. Employees adopt these prescriptive emotions, which results in the suppression of their own true emotions. This ultimately serves to divide the individuals sense of self, creating a true self and a false self. As a consequence of this, employees become alienated from their own sense of self. The emotions that are portrayed to the public, to their colleagues and even to themselves are not the genuine feelings of the individual, but those determined by the organization. This concept supports the work of Goffman (1959) who developed the concept of ‘front stage – back stage’. The
organizational front stage is where the performance is carried out – scripted and planned by the performing actor, who is skillful at concealment and adopting socially acceptable masks (Fineman 1993). Hochschild suggests that society as a whole perceives the emotions of individuals within an organization to be genuine, as they are performed within the arena of the ‘front stage’. By undermining the ‘true self’, organizations deny employees their own feelings. The public perceives that the individuals within the organization emotionally support it, and through the combination of these factors, the emotions within the individual’s true self cease to be valid.

Staff have to learn to control their own feelings and emotions, and as a result, Hochschild suggests that the burn out, disengagement and alienation of individuals within an organization is the cost of emotional labour. Hochschild’s research focused on the airline industry. She recognised that as the industry grew, offering cheaper airfares for many more passengers, their profits were generated by a high turnover of passengers rather than by providing a reputation for offering a high quality of service. The significance of emotional labour as a way to generate money decreased. Staff were still expected to provide effective emotional labour but the change in emphasis from the organization had a significant impact on the staff’s sense of self.

Some members of staff were unable to differentiate between their own identity and that of the organization. They over-identified with their work, and were unable to separate themselves from their job. Hochschild
recognised these employees were at risk of high levels of stress and burnout. Other staff were able to distinguish themselves from their roles but described feeling guilty at the insincerity and dishonesty of doing this. They became alienated from their work. A third group of staff were unable to act towards passengers in the ways that was expected of them, believing that they were giving false impressions. This group became cynical and estranged from their own sense of self as well as from their jobs.

Hochschild concluded that an organization who uses emotional labour to generate profit will lose the sense of self, individualism and genuine expression of feelings and emotions from its employees, which will inevitably result in a disaffected and isolated workforce.

Although Hochschild’s work focused on one specific industry, the transferability of the concepts that she discussed can be applied to other areas and organizations, including that of healthcare (Fineman 1993, Smith 1992). Fineman (1993) explores the similarities between emotional labour within Hochschild’s arena of research and that of nursing. Similarly to Hochschild’s workers, Fineman acknowledges that nurses are in effect paid for their emotional management, adapting their behavior and emotions in their care of their patients. He describes a ‘benign detachment’ that occurs in order to disguise private thoughts that may interfere with a professional relationship.
Theodosius (2008) explores this viewpoint in more detail, and drawing on the work of Smith (1992) discusses the need to teach emotional labour to nurses in order to meet the public expectation of a role that is identified by its inherently caring characteristics. This is supported by the Nursing and Midwifery Council Code of Conduct which stipulates the nurse’s role as patient advocate (NMC 2008).

Smith (1992) explains that the vocational and altruistic image of a nurse is vital to the nursing profession as it provides a scaffold to recruit potentially suitable students. Focusing on emotional qualities such as empathy, friendliness and caring, suitable candidates can be selected who demonstrate these characteristics. Theodosius suggests that throughout nurse training, “this expression of self identity is moulded and developed into that of a professional, dedicated nurse” (Theodosius 2008 p31).

She draws on work by Bolton (2000) who suggests that nurses demonstrate emotional ‘work’ rather than emotional labour. Emotional labour requires an exchange between individuals, but Bolton describes nursing as emotional work because the emotions are given to patients with little or any expectation that they will be returned. She describes emotional work as being given freely, as a gift. Theodosius disputes this and reflects on the work of Hochschild who suggests that people “manage their emotions by understanding and recognising the degree of emotion they owe to one another” (Theodosius 2008 p34). The role of emotional labour in nursing is
clearly a critical part of the therapeutic relationship between the nurse and
the patient, and this is enhanced by the public image of a nurse. This image
provides the patient with a belief that nurses are naturally caring and can be
trusted to carry out intimate and personal tasks as part of their nursing care
with a depth of emotional exchange usually only shared between family
members. Emotional labour in nursing therefore involves an interactive
exchange between the nurse, the patient and their family. This differs from
Hochschild’s view that emotional management is a scripted and carefully
controlled one-way process.

Theodosius (2008) suggests that nurses are motivated to carry out their
roles because they inherently care about their work, rather than by being
driven by financial incentives. Because of this, their care for patients is
perceived to be genuine. Theodosius argues that this links the meaning of
care to personal identity: “..it suggests that it is an important and
underpinning ideal type through which both nurses and society defines,
understands and judges the meaning of care and actions relating to it”
(p37).

Emotional labour is the vessel through which nurses’ values and caring
attitudes are demonstrated, and represents their own and the publics’
understanding of who they are.
Throughout this study, during their observed activities on their wards, ward managers not only articulated but also demonstrated that key to their role was to provide care that was rich in emotional labour. Establishing an environment that could provide this, where their staff could flourish, was paramount. In reality, however, there were many obstacles that prevented them from achieving this.

They all recognised their role in motivating and supporting their ‘battle weary’ workforce, and understanding the emotions of their ward teams was described as integral to their role as ward leaders. They wholly recognised the demands that were placed on the team, and the emotional impact that occurred as a result of working in environments where there were staff shortages, dependence on temporary staff, and difficult and demanding patients. The ward manager’s ‘front stage’ supported their staff in different ways. They displaced emotional labour from the therapeutic relationship with patients to caring for their battle weary ward team. Working long hours to ensure their presence in the environment, often juggling office based duties with clinical responsibilities, and positively promoting the messages sent out by the hospital management to the wards. ‘Back stage’ however their professional values were often clearly at odds with the realities of delivering fast patient throughput and standardization. Their anchors to their traditional roots had held them in an era where their presence on the ward and being recognised as the lynch pin of hospital care were seen as the key to their success. Since the inception of the NHS Plan (DH 2000) their move
away from clinical expertise towards a role more focused on managerialism has resulted in a challenge to this traditional role. Without the security of a clear identity, it was evident that ward managers in this study had become emotionally wounded.

Whilst the work of Theodosius explores the consequences for nurses when emotional labour is challenged, there is a need to expand on the issues she raises around role identity within emotional labour in order to understand the theoretical significance for ward managers when their values and beliefs are contested.

Moland (2006) has explored the issues surrounding identity and integrity within nursing, and highlights the relatively straightforward connectivity between who we are and what we do. “When a person acts according to the norms of her identity, there is a consistency between her self-understanding and her actions. Acting to one’s self-understanding, in other words, is one source of integrity” (Moland 2006, p52).

Eraut (2003) believes that professional identity is sustained by the preferred ideals of a profession and is therefore influenced by cultural assumptions. The traditional image of a ward sister is one that is familiar to all as embodying empathetic virtues, guiding leadership and altruism - a calling that reflects the individual’s moral merit (Eraut 2003). This strong identification of the role through history has provided ward managers with a
source of moral strength and purpose. This study has shown that the contemporary role of ward manager bears little resemblance to that of its traditional counterparts and as ward managers have had to come to terms with the practical changes and the altered responsibilities of their changing role, they have also needed to adapt to a changing identity.

There are two components of this changing identity that require consideration. Firstly, that whilst ward managers have recognised their changing identity, there remain significant differences between internal and external perceptions of the role. Internally, ward managers acknowledged that their clinical role no longer exists in the way that it used to. Priorities to achieve financial stability, and manage complex staffing and human resources issues have taken over and they are less involved with direct patient care at the bedside. This change has not been recognised by the public, who still view the role in its more traditional image, expecting to see the ward manager on the ward, working as the clinical expert and leading their team from the front. This viewpoint is not one that is exclusive to patients. During the study it was clear that medical teams and hospital managers also viewed the ward manager in the traditional role. They expected ward managers to have an in-depth knowledge of all patients on a ward at any one time, assumed and often demanded that they were available to undertake ward rounds, and managers, whilst demanding data, reports, and accountability for budget statements and levels of staffing, also
expected that ward managers would teach students, support struggling staff and care for critically ill patients and their families.

The second issue of identity explores how ward managers have not embraced or welcomed their changing image. Their reluctance to move away from a clinical role is highly evident. Throughout discussions they spoke of their frustrations and distress with a system that required them to be away from their patients, placing them in a managerial instead of service role. This prevented them from being able to provide emotional labour and the impact of this had a dramatic affect on their moral and professional values. They managed this cognitive dissonance by attempting to balance both roles, managing the ward from the office, whilst maintaining a clinical presence on the ward. This was clearly not feasible within the normal 37 ½ hour working week, but such was their desire to ensure that patients received good care, it had become ‘normal’ for the ward managers to work an hugely extended day, often spending the evening hours back on the wards, with their patients and relatives. The inevitable consequences of working long hours under pressure resulted in the exhausted and ‘battle weary’ role described in Chapter 6. Too weary to challenge or question their role, they demonstrated the behaviour of passive compliance in a cycle of despair where they merely continued to work in the same way, but harder and for longer. It was clear that they put up with the controlling and commanding styles of hospital management for the sake of their patients and the infrequent pockets of time when they were able to offer and deliver
emotional work. The roots of their professional identity, embodied in the need to offer emotional labour remained the driving force that kept them motivated to come to work. However it also left them professionally compromised, demoralized, and exhausted, with little voice and low self-esteem – all characteristics of varying degrees of burnout. Traditionally seen as healers and carers, it appeared during this study that they had become the wounded storytellers.

Nelson and Gordon (2006) have explored the power of the ‘virtue script’ within nursing. They use this term to describe the reliance on the traditional caring discourse that describes the trusting, compassionate figure of a nurse. They suggest that whilst this not only fails to recognise the knowledge and skills that nurses require in order to provide expert care in a modern day setting, it also sentimentalises and trivializes the highly skilled and complex work that nurses undertake. Frank (2004) however offers an opposing argument. He discusses the significance of providing an environment for healing where the relationship between caregiver and receiver is paramount. He calls for a renewal of generosity and a reciprocal increase in gratitude in order to create the therapeutic relationship that is required for healing to occur. He identifies with Hochschild’s’ principles of emotional labour, describing it as an act of generosity. He acknowledges the two way process involved, yet at the same time recognising that it is not an equally shared process:-
“Generosity transcends any expectation for what the gift may bring back in reciprocity. Generosity implies the host’s trust in the renewable capacity to give; the generous person feels no need to measure what is given against what is received. Generosity does not plan for the giver’s own future. It responds to the guest’s need.”
Frank (2004) p2

Frank’s work explores the healing connections between mind and body, and the psychological need to permit and accept the healing process (Frank 1992). The emotional labour provided by skilled and experienced nurses forms part of this process, and defines the emotional identity of many of the experienced nurses at work. There is a danger that by removing the virtue script, as described by Nelson and Gordon, from the agenda of the ward manager’s role, there would be nothing remaining that they value or that defined them as their ‘true-selves’.

As the custodian of emotional management, the hospital culture has the ability to manipulate this. Yet its command and controlling style of management has failed to understand the significance of emotional labour, and convert this knowledge into achieving higher levels of patient safety and patient satisfaction, both issues of which feature highly on the hospital agenda.
There is a wealth of evidence from the United States and Canada to suggest that levels of patient safety are much higher when nurses are valued (Institute of Medicine 1996, 1998, 2001, 2003, Rankin and Campbell 2006) and yet it appears that in the UK we have been unable to capture the true essence of the nursing identity and translate this into supporting a workforce that is able to combine both the academic and emotional aspects of care that are required to deliver modern healthcare safely.

There is no doubt that this study has recognised that our hospital wards need experienced, competent and creative leaders and the Royal College of Nursing and the Department of Health have recognised this (RCN 2009, DH 2009). But it has also shown that as our health service has modernised and transformed, it has imposed the disciplines and responsibilities of managing finance, data reporting and staffing at ward level. Ward managers have always been a pivotal role of the National Health Service. They have a huge responsibility to guide and support their staff to move forward, and to inspire the workforce of the future (RCN 2009). In their recent report: Breaking Down Barriers, Driving up Standards: The role of the Ward Sister and Charge Nurse, (RCN 2009) the Royal College of Nursing has wholly recognised the significance of the role and acknowledged that for many ward managers, their role is unclear. It focuses on their lack of authority, lack of training and the difficulties and consequences of balancing roles. Whilst it recognises that this has been a neglected tier of the nursing workforce, it does not identify the essence and lifeblood of the role.
Their role has changed dramatically, leaving them undervalued, exhausted, and consequently questioning not only their sense of purpose but also their whole essence of identity as human beings.

This has led me to conclude that there is an incompatible conflict between the ward manager’s desire to provide emotional labour and the perception of their identity both within the organization and without.

It is clear from this study that there are ward managers who are prepared to work extraordinarily hard to maintain high standards of care despite the systems and processes in place that suppress their ability to provide emotional work. They are willing to find moments in their chaotic working day that allow them time to provide the care for their patients that they believe makes a difference. The NHS is in serious danger of losing these nurses if we do not address the real identity of ward managers and place a value upon the emotional labour that they and their teams provide.
CHAPTER 8

The loss of negotiated order

“It is not the consciousness of men that determines their existence, but their social existence that determines their consciousness.”

Karl Marx

8.1 Introduction

Within the perspective of symbolic interactionism, identity is defined as the construction of one’s own sense of self. Identities are forged by the social situation in which a person finds themselves and how interactions with others relates to that person’s self-concept (including self esteem, self image and self evaluation). A process of negotiation, bargaining and reciprocity takes place for identities to be formed, changed or maintained and people will present themselves and act in particular ways during social encounters in order to create or win the most socially situated and desired identity available to them.
8.2 Perception versus Reality

During the process of data analysis, significant evidence emerged that demonstrated a disconnection between what was expected of the role of the ward manager and what the ward managers perceived to be their role. This misalignment led to a discussion that explored the contributing factors to this concept. Within this debate it emerged that ward managers situated themselves in a reality that was frequently at odds with the culture, values and priorities of the hospital management. The organisational demands that focused on standardisation, reducing length of stay and financial stability were not contested yet the execution of these demands at ward level placed ward managers in a seemingly helpless situation. Their locus of control appeared destabilised by their apparent frustrations and at times despair with a system that they perceived failed to place significant value on their core identity. Their ability to manage this cognitive dissonance was thwarted by a lack of time to reflect or to evaluate their situation, or more significantly to plan a strategy to manage it.

It was apparent that their perceived responsibilities of a ‘Ward Manager’ bore little resemblance to the realities of the role (see Fig 1). This came as no surprise to the ward managers, who were clear in articulating the misalignment between their own perceived responsibilities and values and
those of the organisation. Yet whilst they acknowledged the reality of their
situation, they showed no motivation to realign their role with the
organisation, or to redefine their values and situate themselves within the
construct of the contemporary role. They failed to identify the common
ground with the organisation’s core values which was an overarching goal to
provide good care for patients.

The table below shows a summary of the actual and perceived
responsibilities of an NHS Ward Manager (taken from NHS job descriptions
(blue print) and data generated from interviews with ward managers (green
print). These are taken from actual NHS job description, and the
conceptualization of core themes from data collected during the interviews
with ward managers.
Fig 1: Table to show roles and responsibilities of an NHS ward manager

In 1963, Strauss et al carried out a study to explore models for studying hospitals. They describe this overarching goal metaphorically as the “symbolic cement that holds the organisation together” (In Friedson, ed
Varied personnel within the organisation hold different interpretations of how this goal is achieved. This results in negotiations and bargaining. Strauss et al describe the rules that exist round negotiation. Professional experience, relationships with patients and personal assumptions creates ‘conditions’ within which negotiations occur. They call this a ‘negotiated order’. Ward negotiations with other professionals, such as hospital doctors and managers are typically carried out by the senior nurse on the ward, who in turn negotiates with her own team to carry out care for patients. Established teams develop agreements, understandings and contracts that determine ‘the way things are done’. Strauss et al demonstrated that high performing hospital teams have clear agreements and an established hierarchy of negotiating order. This in turn provides identity, and social agency.

In contrast, a breakdown in the ability to negotiate causes conflict, helplessness and betrayal. Contracts become broken and agreements are revoked. Breakdowns are caused by organisational change, workplace conflict, a transient or temporary workforce, and conflicting agendas. Within the context of this study, it was evident that the organisation has been, and continues to be exposed to all these issues.

The three categories that emerged from this study demonstrated that ward managers have lost their interface for negotiations and their negotiating order. Away from their patients, poorly supported and in continuous conflict,
their bargaining power was significantly reduced. Without this their professional identity was compromised.

Cote and Levine (2002) acknowledge that the concept of identity is core to an individual, group, or organization. In determining one's identity, fundamental and potentially profound questions can be triggered that can produce both deep insight and ambiguity.

Charmaz (2009) further describes identity as the way an individual defines, locates and differentiates their ‘self’ from others. Consistent with the symbolic interactionist perspective, the concept of identity implicitly takes into account the way people wish to define themselves. Identities bring with them commitments and responsibilities and in turn how individuals define these commitments and responsibilities in relation to other people deeply affects their identity decisions.

It was apparent that ward managers had failed to define their concept of ‘self’ within the modern role and had failed to live up to the demands that it put upon them. In order to maintain any degree of self-worth, they blamed the organisation for imposing unreasonable demands on them, and used these as excuses for under performing. Their lack of identity enabled them to protect themselves by being weak and exposing themselves as victims in battle rather than warriors.
They made identity trade-offs at certain points or even lowered their identity goals to match their reduced role. At other times they raised their hopes and increased their identity goals when they met with success. These raised and lowered identity goals formed an implicit identity hierarchy created to deal with the loss and changes in their role.

Their lack of identity was not shared amongst their peer group. Whilst all ward managers in the study identified their isolation they did not share this with each other. Instead they talked about the advantages of getting together, sharing ideas and support but when opportunities arose for these, they failed to make them valuable and did not pursue them. This resulted in undernourishment in network support and unity, and demonstrates their inability to create social capital.

In contrast to this was the role of the specialist nurse, who, whilst welcomed as part of the ward team, was also envied for the ability to step away from the confusion of roles and responsibilities and carve a clearly defined and valued role within the organisation as a whole. The specialist nurse role reinforced the perceptions of the organisational identity that favoured higher skilled and educated nurses. Consistent with the perceptions of the nursing profession as a whole, the hospital’s desire to increase the academic status of nursing was seen at times to place less value on nurses who had no desire to achieve post graduate qualification. Many used the example of the enrolled nurse to demonstrate this view.
They suggested that enrolled nurses had once been the backbone of ward nursing and their demise had left a hole in the workforce that had not been replaced by a similar grade of nurse. Tasks previously undertaken by enrolled nurses were now managed by health care assistants. This was at odds with their argument that highlighted the complexities of bedside care and their desire for a highly trained and skilled ward workforce. The conflicting argument was a further example of how they appeared to be unclear about the connection between nursing qualifications, hierarchy and the identity of the bedside nurse.

Cox and Levine (2002) describe how over decades, psychological and sociological approaches to identity have constituted independent frameworks, operating in isolation. The psychologists’ view will therefore address the ward manager view of identity as mental and personal, taking into account perception, whereas the sociologist perspective explores their identity within social structures and related behaviours.

In formulating a theory to explain the role of the ward manager, an interdisciplinary, multidimensional theory of identity from both the perspective of social structure and that of personality are explored.

The psychological formation of identity falls in to two parts. The transition to adulthood and the ability to maintain one’s identity of self. Erikson (1980) describes three elements that enable people to maintain their identities in interactive contexts: -
i) The subjective / psychological dimension (Who am I?)

ii) The personal dilemma (How I behave)

iii) Social dimension (My role)

Erikson describes the ‘identity crisis’ that occurs if these three elements fail to connect. This crisis is characterized by identity confusion, behavior disarray and a lack of commitment to a role.

The sociologist’s concept of identity is based on the ontological assumption that humans create social reality by attaching names and meanings during interactions. These ongoing processes create and modify identities.

Cote and Levine (2009) recognise that in order to understand an individual personal identity:

“one needs to know more about a person than his or her constructions, and sociohistoric location and opportunities – one needs to know about the emergent interpersonal circumstances affecting his or her behavior”

Cote and Levine (2009) p46

The specific social identity of being a ward manager is challenged by uncertainty produced by rapid change and cultural contact. Jenkins (2009) describes this as a reflection on the fact that our social maps no longer fit our social landscapes. Without frameworks for defining social identity there is no potential to relate to others in meaningful or consistent ways. Mishler
(1999) explains how encounters with others whose identity and nature is not clear contribute to identity confusion and crisis. Identity is seen as being a construct of reference and comparison as we are defined with reference to others, not merely with reference to oneself.

A key finding of this study was the lack of clarity around the purpose and expectations of roles associated with the ward manager. The relationship between the ward manager and the matron was one such example. Confusion regarding the role of the modern matron resulted in anxieties about their own role and identity.

Giddens (1991) argues that self identity is a process within which individuals can reflexively construct a personal narrative which allows them to understand themselves as in control of their lives and futures.

Plummer (2001) has placed this search for identity within a post-modern context, suggesting that:

a) Traditional communities are kinship bound

b) Modern societies are bureaucratised, with people being defined by their membership of social groups such as nurses

c) People in post-modern communities suffer from a lack of certainty about which groups they belong to, and thus have to create an identity for themselves. This premise would assume that the ward managers within this study are no longer defined by their status as
nurses, but have to work hard at presenting other identities within the organisation.

Ward managers displayed varying degrees of ‘identity crisis’ as a result of role confusion, low self esteem and flagging morale. Their inability to construct clarity around who they were and what they did dominated their ability to function effectively, and their loss of negotiating order and power was fundamental to their sense of worth.
Fig 2. demonstrates the relationship between the real and the ideal identity of the Ward Manager within the context of the hospital.

Ideal

- Career
- Generosity of Spirit
- Educator
- Clinical leader
- Pinnacle of job/identity
- Lynch pin
- Responsibility
- Managing emotional labour
- Strong social capital
- Modern NHS Agenda
- Delivery of targets
- Management of ward and staff
- Maintain face of organisation

Personal

- Low Social capital
- Exhuastion
- Disempowerment
- Low resilience
- Inability to move with changing circumstances

Organisational

- New roles of support
- Fragmented teams
- Mismatched expectations
- Battleground

Ward Manager Identity

Real

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CHAPTER 9

Summary and reflections

9.1 Summary
This study was undertaken to understand the role of the contemporary ward manager. Using a constructivist Grounded Theory methodology, ward managers and those who worked with them, were interviewed and observed at work. Data from narratives, observation sessions and memos were collected and analysed. Coding processes were adopted to develop themes which were challenged using constant comparison techniques. At the onset of this study, three questions were asked.

i) What is the contemporary role of the ward manager?

ii) What are the contextual factors that influence the ward manager's ability to undertake their role?

iii) What are the implications of a changing identity on the role of the ward manager?

Conclusions were drawn that provided explanations and interpretations of the contemporary role. The findings showed that ward managers have a complex and varied role and struggle to maintain their identity in an environment that no longer values their skills and professional position.
Managerialism and changing political priorities within the NHS have forced the role to embrace complex management tasks that have pulled them away from clinical and educational responsibilities. This has resulted in feelings of isolation, role confusion and loss of identity and power. The erosion of negotiated order has contributed to a role that is now disillusioned, disempowered, and battle weary. As a consequence of this, ward managers are struggling to deliver the service that is required of them.

![Diagram](image)

**Fig. 1** Theoretical evolution of the role of the Ward Manager
9.2 Reflections

The motivation for this thesis stemmed from the poor care that my Great Aunt received whilst she sat with my Great Uncle following his stroke. Both have since died. Now, as I conclude this study, I have once again had cause to be ashamed at the low standard of nursing care on a ward that was shown to a member of my family. Today a relative was admitted to hospital. I was with her. I asked a nurse five times to give her some analgesia as she cried in pain. An hour and a half later someone came to help her. She was cold and no-one gave her a blanket. I asked to talk to the ward manager but was told that she was in a meeting.

I arrived home tonight to find two articles sent to me by different members of my family, both who know my interest and passion for nursing. The first, Daily Telegraph, 4 May 2010 titled “I want a nurse, not a ward manager” (Judith Woods)

I'm not a client, or a customer or a consumer, I'm a patient, which I'm telling you now, is a lot needier. I don't want my care to be overseen by a number-crunching manager calculating my bed days and turfing me out into the car park in my open-backed nightie, still attached to my drip.

I want a proper ward sister on my side. An old-fashioned figure of authority, a Hattie Jacques to see off James Robertson Justice, who is firm, fair – and always washes her hands”
And the second

“It is clear that patients want care, kindness and compassion. It is also clear that many nurses are struggling to provide it. It is also evident that providing care and compassion generates a two way process of good will, tolerance and understanding. In essence, patients will put up with a lot if nurses are gentle, kind and take the time to explain what is going on.” (Maurice 2011)

These accounts come as no surprise. They suggest that societal expectations match those of ward managers in hospital. As Woods recognises the identity of the traditional role, she confirms a view that the managerialism of the NHS has corrupted the system and created environments where old fashioned care and compassion is stifled and is struggling to survive.

Despite decades of advances in treatment and far greater understanding around healing and health, there is little doubt that McLeod’s research in 1984 “It’s the little things that count” still holds true. Navigating through the complex and confusing pathways that have formed the road maps for clinical care requires skill, leadership and experience. Thirty years ago, this was undisputedly the responsibility of the ward sister, and recognised by hospitals as an important and valued part of their role. The priorities facing the contemporary role remain focused on providing first class health care, however it appears that in this hospital the organisational machine, in its attempt to provide an efficient and modern service have overlooked the
importance of the intimately close connection between the nurse and the patient and the elements of care that matter the most. As a consequence, ward managers are disillusioned, disempowered and rarely in a position to challenge, stand their ground or defend their ill defined domain.

Throughout this process, I have learnt many things that have shaped my thinking and developed my understanding.

I undertook this study because I believed that the role of ward manager has changed significantly since my experience of it as a junior ward nurse, and I wanted to understand it better. It was once a role that I held in high esteem, and as a student nurse, it was my ambition to become one. It is clear to me that the role has struggled to maintain its traditional identity and despite the crucial part it plays in the delivery of high quality nursing care on wards, it has been neglected and misunderstood.

My initial thoughts expected the study to show that the contemporary role of the ward manager would be determined by leadership skills and training. However, the narratives of those who undertake the modern role revealed a more complex picture, shrouded in low morale, disillusionment and sadness which permeated throughout their story telling. Their unanimous commitment to tell their stories was encouraging and it was plain that despite their obvious frustrations with their role, their core values were never far beneath the surface. They spoke of a desire to provide a good environment for their staff, the need for compassion, empathy, clinical expertise and generosity of spirit, but they had been beaten down by a
system that failed to recognise their potential or place a value on their expertise.

In addition to my personal reasons for undertaking this study, there is a political driver for this research. The NHS has gone through many periods of change, and recent developments towards GP commissioning and decentralisation will once again destabilise the pathways for patients. The complexities of care are such that it is becoming increasingly difficult for patients to navigate through the systems without expertise and support. Throughout the history of nursing, ward sisters in various roles have provided a constant, identifiable and trustworthy character to which patients can identify. My personal frustrations, consistent with those of Judith Woods (Daily Telegraph March 4, 2011) were focused on the fact that my Great Aunt never saw a ward manager, and wanted to. Ms Woods described her desire for an authoritarian figure on the ward who she could trust. In the chaos and confusion that all too often can surround illness in hospital, I believe that this role is vital to navigate, support and provide a role model to others that imbues good nursing practice and leadership.

The third purpose of this study has been to contribute to knowledge. At the onset of this research little was known of the modern role of the ward manager and the issues that have affected its ability to thrive had not been identified. During the process of research, other works were published, both nationally and internationally that raised the profile of the subject and acknowledged the need to single out the role for close scrutiny. These
works, including the significant investigation into the role of the sister and charge nurse by the RCN in 2009, and the report by the Welsh Government in 2008, Free to Lead - Free to Care (2008) have provided different angles and different interpretations of the role, yet all, including mine, have provided the profession with insight, explanation and interpretation of a role that deserves attention and understanding. The government reports examined the roles and responsibilities of ward managers, highlighting the importance and significance of the role itself; however, they fell short of providing detailed insight into the changing role over time. By providing a theoretical explanation to demonstrate why the role has changed, this study has contributed to the wider body of knowledge that can now move forward to develop strategies for change.

The table below show themes that were common in all 3 documents and highlights differing levels of discussion that evolved from each.
<table>
<thead>
<tr>
<th><strong>Common themes</strong></th>
<th><strong>Breaking down barriers, driving up standards. The role of the ward sister and charge nurse (2009)</strong></th>
<th><strong>Free to Lead - Free to Care (2008)</strong></th>
<th><strong>The Changing Role and Identity of the Contemporary Ward Manager (2011)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fundamental to the organisation and delivery of hospital nursing</strong></td>
<td>Clear responsibilities for ward decision making and operational issues (e.g. visiting times.)</td>
<td>Pivotal role within hospital care</td>
<td></td>
</tr>
<tr>
<td><strong>Responsible for standards of care within wards</strong></td>
<td>Delegation of domestic duties with day to day accountability</td>
<td>Misalignment with management expectations and clinical responsibilities</td>
<td></td>
</tr>
<tr>
<td><strong>Absence of agreed role definitions</strong></td>
<td>Authority to decide placement of patients</td>
<td>Blurred senior nursing roles mean exact role is unclear</td>
<td></td>
</tr>
<tr>
<td><strong>Role conflict – balancing different aspects of the role</strong></td>
<td>Period of preceptorship for all newly appointed ward sisters / charge nurses</td>
<td>Often challenging relationship with modern matron as reporting structures unclear</td>
<td></td>
</tr>
<tr>
<td><strong>Lack of morale</strong></td>
<td>Development of a ward sister / charge nurse forum in every NHS Trust</td>
<td>Lack of identity and value</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Contrasting themes</strong></th>
<th><strong>Breaking down barriers, driving up standards. The role of the ward sister and charge nurse (2009)</strong></th>
<th><strong>Free to Lead - Free to Care (2008)</strong></th>
<th><strong>The Changing Role and Identity of the Contemporary Ward Manager (2011)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of formal preparation and skills development for those in post</strong></td>
<td>Empowerment and development programme to be implemented</td>
<td>No relevant training or recognition of specialist skills</td>
<td></td>
</tr>
<tr>
<td><strong>Lack of authority to assure responsibility for key issues underpinning nursing standards</strong></td>
<td>Development of ‘dress code’ to maintain high standards of appearance</td>
<td>Identity as ward leader not always apparent Loss of domain and erosion of power</td>
<td></td>
</tr>
<tr>
<td><strong>Role rendered ‘almost impossible’ due to pressures and competing priorities</strong></td>
<td>Managerial and clinical supervision for all ward sisters/charge nurses</td>
<td>No clarity around role. Public perception and actual role no longer the same</td>
<td></td>
</tr>
<tr>
<td><strong>Inability to provide care for a group of allocated patients whilst co-ordinating ward activities</strong></td>
<td>Audit tools to ensure standards are met</td>
<td>Battle weary workforce struggling to cope</td>
<td></td>
</tr>
</tbody>
</table>

**Fig 2.** Table to demonstrate consistencies and contrasts between recent publications and this study.
I hope that this study will enable those responsible for supporting and developing the role to create a sustainable model for ward management that provides a role model for expert patient care and opportunities to educate and develop the ward managers of the future. I hope that ward managers who read this study will identify with the issues and discussions it has raised. By articulating the difficulties they face at work in their complex and frustrating roles I hope that their authentic voice has been heard by those who can support them. Through support and empowerment they need to find the strength to take control of the role, and in doing so develop its identity and status to provide the leadership and inspiration that is needed in modern hospital wards.

9.3 Summary points and Implications

This study has highlighted many issues that prevent the contemporary ward manager from thriving. Whilst this research does not seek to provide a case for change, the points below summarize the implications of this work and explain how the knowledge gained from this study will contribute to the knowledge that is needed to negotiate and recreate a role that supports patient care, learning, and authority at ward level.

Summary Point 1

This study has shown that the role of the ward manager is unsustainable in its current form. The erosion of negotiated order, combined with the loss of
identity has resulted in a dysfunctional role that does not meet the needs of the organisation or its staff.

The organisation requires dynamic and innovative leaders at ward level, to support fast throughput, reduce hospital infection rates and manage lean and efficient processes and yet it is clear that ward managers have little authority or status to enable them to function in this way. Their lack of positive engagement with the operational management of the organisation prevents them from developing relationships that would enhance their position, and a lack of clarity around accountability for the services they provide have contributed to a disengagement with responsibility over time.

With the lack of a role model within wards, and the development of specialist roles that have greater professional status, identity and financial reward, there is a concern that ward managers of the future will not have the skills and motivation required to fulfill the role.

**Summary Point 2**

This study has demonstrated that the identity and definition of a ward manager has had little recognition from both within the hospital and externally. Internally, it has also exposed a distinction between the organisation and those who live the role.

Whilst there have been positive steps to enhance ward leadership, and develop visible senior nursing presence within hospitals, the role itself has not been clearly defined. Literature around the definition of a ward manager
is inconsistent, and whilst encouraging developments highlight what the role ‘should’ be, there has been little discussion about the reality of the contemporary role or the societal perception of it. The addition of the modern matron has confused the boundaries of this role still further, creating a tier of nursing that has displaced the definition and identity of ward managers. Without clear definition and clarity it is hard to see how this role in its current form can evolve or develop in a positive and dynamic way.

**Summary Point 3**

This study has demonstrated that ward managers require specialist knowledge in order to be effective in their role.

The need for expert clinical knowledge to care for acutely sick patients in wards is clearly essential and the ability to teach skills to ward staff and students is critical to the safety of patients. Specialist nursing roles enter and leave the ward at the invitation of medical or nursing staff but are not part of the ward establishment. There is an expectation that the role of the clinical expert falls to the ward manager; however, within the organisation ward managers felt that there was little recognition or respect for this clinical expertise. Ward managers are moved from one ward to another with little regard for specialist knowledge, and wards change specialty with little notice in order to accommodate changes in bed requirements, patient flow and throughput. Consequently the significance of the individual’s clinical expertise and experience has become diluted and replaced by the need for a dynamic hybrid role that can trouble shoot, be flexible and support a team
to adapt to change at short notice. This has contributed to stripping away
the traditional role identity of individual ward managers. Without a clearly
defined domain (structure) and the erosion of their role identity (agency) the
ward managers have gradually lost their capacity to negotiate the order
within their units of ‘power’. As a consequence of this process they have
become relatively ‘powerless’, charged with the task to develop a high
performing unit, but with teams that are frequently or regularly
reconstructed and dispersed. Their working lives have become one of
negotiation breakdown resulting in continual conflict being the norm. This
has an emotional cost to which the participants in this study gave testimony.

Summary Point 4
As the role has evolved, ward managers have taken on complex
administrative and managerial tasks. Whilst these are varied, including
budget management responsibilities, HR issues such as recruitment and
disciplinary procedures, and managing investigations and complaints there
is little support or training to undertake these tasks efficiently. Ward
managers discussed the potential value of senior administrative support
within the ward, and recognised that it would enable greater time to be
spent in the clinical environment. Because they felt the lack the authority
and power to develop new ways of working, they were unable to develop
this concept further. Their requests for administrative assistance often went
unheard despite evidence that they were at times managing in excess of
fifty members of staff. In reality, the organisation has given ward managers
potentially unrealistic management responsibilities, without providing them with the tools and support to carry them out. As ward managers have felt more disempowered they have gradually lost the ability and energy to demand support.

**Summary Point 5**

It was clear from this study that ward managers work in isolation, with little structured peer support. They gained comfort from personal friendships, but lacked the ability to formally unite together to share practice or problems. They did not demonstrate resilience to cope with dynamic change. As a result, their lack of identity, compounded by a perceived lack of recognition or value to the organisation revealed that ward managers in this study were in varying degrees of burn-out.

If this role is to be sustained and developed to manage the increasing complexities of hospital ward care the role incumbents must be given the legitimate power to enable them to exercise accountability, responsibility and to take charge.
9.4 Implications for future study

In its scrutiny of the role of the ward manager, this study has explored the complex interactions and relationships that surround the role in the context of the modern hospital ward.

At the beginning of the thesis (Chapter 2) the concept of the ‘ward’ was discussed. The history of the hospital ward was not examined in detail, but literature that explored the history of the ward sister, suggested that patients have been cohorted in wards since the beginning of hospital care outside of the Poor House (Abel Smith 1960). This study has assumed that the physical ‘ward’ is an established environment for the care of patients and has not challenged this concept.

This study has shown that both leadership and management of modern wards is challenging and has focused on the role of the ward manager as a vessel to develop efficient and effective care within them. It has not explored the potential to cohort patients in a different way and as such, create an opportunity to radically change the requirements of inpatient nursing care. In recognising that the role of the ward manager is unsustainable in its present form, there would be significant benefit in understanding the implications for the role of developing an infrastructure that demanded very different skills and responsibilities.
New hospitals are required to be built with a high proportion of patients accommodated in single rooms. With this comes an opportunity to explore new ways of working and potentially new roles that would challenge the traditions of ward nursing care. There is little research to show how the contemporary role of the ward manager can be aligned with innovative hospital design and better inpatient care and using the findings of this study to develop further knowledge would have the potential to significantly benefit hospital care in the future.
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Appendix 1

Consent Form for Ward Managers

PLEASE MAKE SURE YOU HAVE READ AND UNDERSTOOD THE INFORMATION SHEET BEFORE YOU SIGN THIS FORM. SIGNING THIS FORM GIVES YOUR CONSENT TO PARTICIPATE IN THIS RESEARCH STUDY

Title of the Study: The Role of the Ward Manager.

Researcher’s Name: Emily McWhirter (Research Student, Centre for Nursing and Midwifery Research, University of Brighton – Tel 01273 600900).

1. I confirm that I have read and understand the information sheet (version 0.1 Dated 26 October 2004) for the above study and have had the opportunity to ask questions.

2. I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I understand that all personal data will be anonymous. Any comments that I make will be anonymous and non-attributable and used only for the purposes of this research study.

4. I agree to take part in the above study.

Name of Ward Manager ___________________ Date ___________ Signature ____________________

Researcher ___________________ Date ___________ Signature ____________________

I copy for Ward Manager, 1 for researcher.
Appendix 2

Information sheet for Ward Managers

PLEASE MAKE SURE YOU HAVE READ AND UNDERSTOOD THIS BEFORE YOU SIGN THE FORM GIVING YOUR CONSENT TO PARTICIPATE IN THIS RESEARCH STUDY

Title of the Study: The Role of the Ward Manager.

Researcher's Name: Emily McWhirter (Research Student, Centre for Nursing and Midwifery Research, University of Brighton – Tel 01273 600900, Mobile 07739 804515).

PURPOSE

You have been asked to take part in a research study. The aim of this study is to understand the contemporary role of the Medical /Surgical Ward Manager. This role was last examined in the 1980’s. Since then much has changed within the National Health Service and this may have had an impact on the way you are able to do your job. The purpose of this research is to learn as much as possible about your role, by hearing your experiences as a ward sister, and by watching you at work. By understanding your role, the aim is to clearly identify a career pathway to address educational knowledge and skills for Ward Managers of the future.

PROCEDURES

If you agree to take part in the study, you will be invited to an interview with the researcher. With your consent this will be tape recorded, and you will be offered a full transcription of the interview. It is estimated that this interview will take approximately 1 hour, and take place in a suitable location of your choice, such as your office, or a quiet room in the hospital, at a time that is suitable to you. This interview will be very informal, and will include discussions about any aspects of your role that you feel are relevant to this research.

The second part of the study will involve the researcher shadowing you whilst you are on duty to capture the range of activities that you are engaged in during your time at work. This will take place 3-4 times for 2- hour sessions at varying times in the shift. You will be offered copies of observation notes for verification within 28 days.

In addition to this I would like to talk to other members of the multidisciplinary team that work with you in order to gauge the impact that these professionals have on the Ward Manager’s role. Clinical Nurse Specialists and Hospital Matrons will also be invited to take part in the study, particularly those who regularly work with you.

2-3 patients from your ward will also be invited to be interviewed, for about 20-30 minutes at their bedside. They will be asked questions about their nursing care, their interactions with you and the expectations that they have of the role

CONFIDENTIALITY

With your consent, a recorded copy of the interview will be made in order to provide an accurate written account of details provided. All references to your name and any personal information given will be removed from the transcripts and form no part of the research. Any comments that you make
about your work, other members of staff, or the Hospital itself will be anonymous and used only for the purpose of this research project. All data will be safely stored and destroyed after 10 years.

RIGHT TO REFUSE OR WITHDRAW

You may refuse to participate in this study and you have the right to withdraw at any time. Please let the researcher know in writing if at any stage you decide to withdraw from the study.

QUESTIONS

If you have any questions about this research project please contact Emily McWhirter, who will be happy to answer them. Please write to: Mrs Emily McWhirter, Centre for Nursing and Midwifery Research, Mayfield House, Falmer Campus, University of Brighton, Falmer BN1 9PH.

Thank you very much indeed for taking the trouble to read this form.