Learning From Failure: An Exploratory Study of What Makes a Successful Nursing Service

A thesis submitted to Cardiff University in the fulfilment of requirements of candidature for the degree of Doctor of Health Studies.

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Contents

DECLARATION

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

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ACKNOWLEDGEMENTS

Summary

The research study aspired to ascertain what, if any key factors can be identified by the Senior Nurses in Wales to improve the quality and safety of the service delivered by the nursing service.

Numerous reports with recommendations for improvement have been published following significant service failures in the nursing service. Despite these reports, failures continue. This thesis details the methodology and findings of a research study undertaken with Senior Nurses in Wales, to ascertain their views on what factors are needed to have a successful nursing service. It explores what needs to be in place in the nursing service to prevent failure and deliver high quality, safe care to patients. A mixed-method research approach was used which comprised three stages. Stage one analysed secondary qualitative data in the form of case study inquiry reports into service failures. The second stage comprised semi-structured elite interviews with nine Senior Nurses in Wales. The final stage, which was used to prioritise and validate the results from stages one and two, was a questionnaire sent to 65 Senior Nurses in Wales, with 41 returned. From the analysis of the above research, a Senior Nurses' Framework covering 6 main themes and containing 35 key factors was developed, which if implemented could potentially lead to a successful nursing service. In addition the thesis explores why Senior Nurses find it difficult to implement such actions, their lack of empowerment and how it is important for their voices to be heard if failure is to be prevented in the future. The main findings of this study have been published in a peer review journal (Andrews-Evans 2012), which can be found at Appendix 7.

Chapter 1

Introduction

The focus of the research study is the delivery of the Nursing Service within the context of how it ensures patient safety and service quality. It also considers the influence the organisation in which the nursing service is located has on the success or failure of the nursing service. The research study explores what needs to be in place in the nursing service to prevent failure, whilst aspiring to ascertain what if any key factors can be identified by the Senior Nurses in Wales to rectify these failures and improve the delivery and safety of the nursing service in whatever setting it is delivered. In addition it explores, using a critical nursing science approach, why these factors are difficult to implement for the Senior Nurses at ward or Board level. It subsequently identifies methods that the Senior Nurses can employ, whether working in acute, maternity, mental health or community services, to facilitate the changes necessary to implement the key factors and deliver a high performing service.

High media profile is given to the Health Service, particularly when matters go badly wrong. In addition, a considerable number of health service inquiries have been published over many decades following incidents of service failure. These range from the first inquiry in 1969 into Ely Hospital, Cardiff (Parliamentary Report 1969), to present day investigations, such as the inquiry into patient deaths at Mid-Staffordshire Foundation Trust (Healthcare Commission 2009). But why do things go wrong?

Clearly since the nursing service provides a high proportion of direct patient care and makes up 52% of the total workforce (Welsh Government 2009), it is reasonable to conclude that nursing might make a significant contribution to both a good and a bad Health Service. Gaps in knowledge currently exist over the extent of the role nurses play in patient safety improvements (Richardson and Storr 2010). For example, West (2001) suggests, that there are no high quality studies of the relationship between hospital organisation including the nursing service and patient care outcomes. In addition, although there is evidence to suggest that nursing work is integral to the everyday organisation of health services (e.g. Allen 2001, 2002, Latimer 2000, Procter 2000, Rafferty 2001, Rudge 2003) these studies emphasise how this organising work can remain invisible at the strategic level (Procter 2000) and from other non-nursing members of the healthcare team. Questions arise therefore over

the relationship between the nursing service at an organisational level and quality of service delivery, particularly in the context of patient safety and service failures.

Aim and Research Objectives

The overarching aim of the research study was to explore factors of a quality nursing service that can assist Nurse Directors and Senior Nurses in helping to prevent failures and promote a successful service to patients. This was achieved through enabling a better understanding of the relationship between patient safety, quality of care and the place of the nursing service in the overall organisation of patient care. The research study therefore identified the features and characteristics of a good nursing service that can facilitate the provision of a safe, high quality service.

Specifically, the research study explored what key factors are missing from the nursing service when things go wrong. By exploring these factors the thesis developed a framework that needs to be in place in the nursing service for it to be successful in ensuring patient safety and service quality.

The study's objectives were as follows:

- To explore nursing service failures, or 'disasters', from a service level perspective.

- To identify what positive actions could be taken to prevent such failures in the future.

- To identify key factors for a successful nursing service and ascertain whether these factors are of equal weighting or whether some are more important than others.

- To develop a framework for Senior Nurses to use to ensure they have the positive actions in place to prevent failure and are able to deliver a successful nursing service.

- To explore the influence on the nursing service of NHS organisational issues.

- To contribute to nursing practice knowledge in order to improve outcomes for patients.

The final step in the process will be the successful implementation of the findings from this study. This goes beyond this thesis, but it is hoped that those Senior Nurses that participated in this work will take on the responsibilities of implementing these findings. In addition the research study has identified wider implications for similar research to be undertaken outside Wales and makes recommendations for further research studies.

Background of the Research Study

Why did the research focus on failure? As an experienced Nurse Director in Wales with a key role of monitoring when things go wrong in the health service, I was frustrated that despite reading numerous reports and recommendations about failures, they still continue to happen. While conditions for failure in the nursing service have been identified (Healthcare Commission 2004, 2005, 2006, 2007, 2009; Healthcare Inspectorate Wales 2007, 2009), these reports do not examine if there were specific combinations of failures in the nursing service, neither do they examine if there is any relationship between the failures identified and the totality of the circumstances, or 'conditions', that lead to a poor quality, unsafe service. From my own experience of working with health service staff I considered that it was not just important to monitor failures, but to also ensure that they do not happen again. I considered that there had to be other underlying reasons for failure, something fundamental about how the nursing service was organised and it's systems worked, which when these factors were combined together, lead to the service failing. Specifically, I wanted to explore whether there was some relationship between the lack of involvement of nurses at the strategic level, poor quality services and failures in patient safety.

Making the nursing service a central focus in the context of health services failures in relation to patient safety and quality means that there are certain practices that distinguish nursing from other healthcare disciplines (Procter 2000, Sandelowski 2003, Allen 2004, Allen 2007). What distinguishes nursing from other professions is sometimes thought of in terms of how nurses have a different training to other healthcare professions, and are governed by different laws (Nurses, Midwives and Health Visitors Act 1997), or in terms of 'the purpose of nursing' (Royal College of Nursing 2003, World Health Organisation 1991, International Council of Nursing 2002, Nightingale 1859). Within these perspectives nursing practice is usually

understood to be about individual nurses' expert ability to care, protect, encourage, comfort, maintain and support individual patients (Smith 2006). Further Allen (2004) describes eight bundles of activities that comprise the nurses' role, which include both direct patient care, as well as the management of the system in which the patient's care is provided. These aspects of nurses' practices do not make the service they provide distinctive in such a way as to account for the impact the nursing service has on the healthcare system (Styles 2005). Critically, nursing is unique in that it not only undertakes specific nursing activities *vis à vis* individual patients, but nursing has the 24 hour responsibility for the patient's wellbeing (Procter 2000), the co-ordination of their care (Allen 2004) and the management of the environment in which care is delivered (Dennis and Prescott 1985).

For example, Latimer's study (2000) helps us to see that nurses do not just focus on individual patient care, but also orchestrate the organisation of patient care services, such as wards, operating theatres, accident and emergency departments, outpatient clinics and homecare. The orchestration of services does not just include the co-ordination of other professions and resources, but also how a service fulfils those system requirements that impinge on individual patient care, such as availability of beds, and access to services, as well as movement of patients through the system (Hillman 2008).   In her work, Latimer (2000) argues, nurses are having to continuously juggle what are sometimes complementary, sometimes competing organisational and professional agendas and objectives, with the nursing service continuously working in a complex environment (Procter 2000, Latimer 2002).

One might argue that because the health service environment is chaotic (Girlin 1999), nursing is continuously in a state of response and adaption; evolving with the changing demands of the health service. This is not necessarily negative but rather can be of positive benefit to the delivery of the health service, and one aspect of the dynamic, flexible and constantly evolving role that nurses play (Procter 2000, Allen 2002). It has however been noted that associated with this dynamic organisational context (Faulkner 2002) comes the opportunity for success and also the risk of failure.

Critically for nurses to adapt and evolve in ways that protect patient safety and ensure quality care delivery, they require particular skills, experience and knowledge that are vital to the health service, but at the same time this often goes unrecognised (Procter 2000, Allen 2004, and Allen 2007). If nurses do not discharge the

responsibility of being in-charge (Nightingale 1859), so ensuring everyone (not just nurses) do what is needed in the best interest of the patient as well as the service, then there is an increased risk of 'disasters' occurring to the patients, either individually or as a group (Dixon-Woods 2010).

The nursing service thus occupies a unique and pivotal place in the health service and when it fails there can be severe consequences. A key question that needed to be addressed in this thesis was the relationship between the 'health' of the nursing service, and the dynamics of the nursing system, including how the activities of nurses are understood, valued and supported, or not, as well as their effect on patient safety and service quality.

An Organisational or Systems Perspective

The current research study builds an approach which examined failure and poor service not from the point of view of the individual nurse delivering care, but from an organisational or systems perspective that examines nursing and patient safety in terms of a nursing service. This means that nursing and failures in patient safety can be understood not just as matters of individual accountability, or of the motivation, goals and needs of the organisation's members and leaders (Faulkner 2002). Rather, nursing and patient safety can be understood in terms of the relationships between how things are done 'on the ground', organisation structures and systems management.

These structures and systems may include organisational features such as the formal allocation of work, administrative mechanisms to control and organise work activities and the identification of the role members play in the system (Faulkner 2002). In addition, an organisation perspective allows exploration of how a nursing service and the organisation in which it exists, is influenced by the environment in which it operates, such as economic and political constraints, the development of technology and the size and complexity of the organisation (Procter 2000, Squires 2009).

The diagram below (Figure 1) helps locate the nursing service in the health system in Wales (2010). The Welsh Assembly has devolved powers from the UK parliament and has total control over the running of the National Health Service (NHS) in Wales. The funding of the service comes to the Welsh Assembly as part of the total funding

for Wales, and it is for the Welsh Assembly members to determine how much of this resource is allocated to the NHS in Wales.

Figure 1.   **A Diagram of the Healthcare System in Wales**
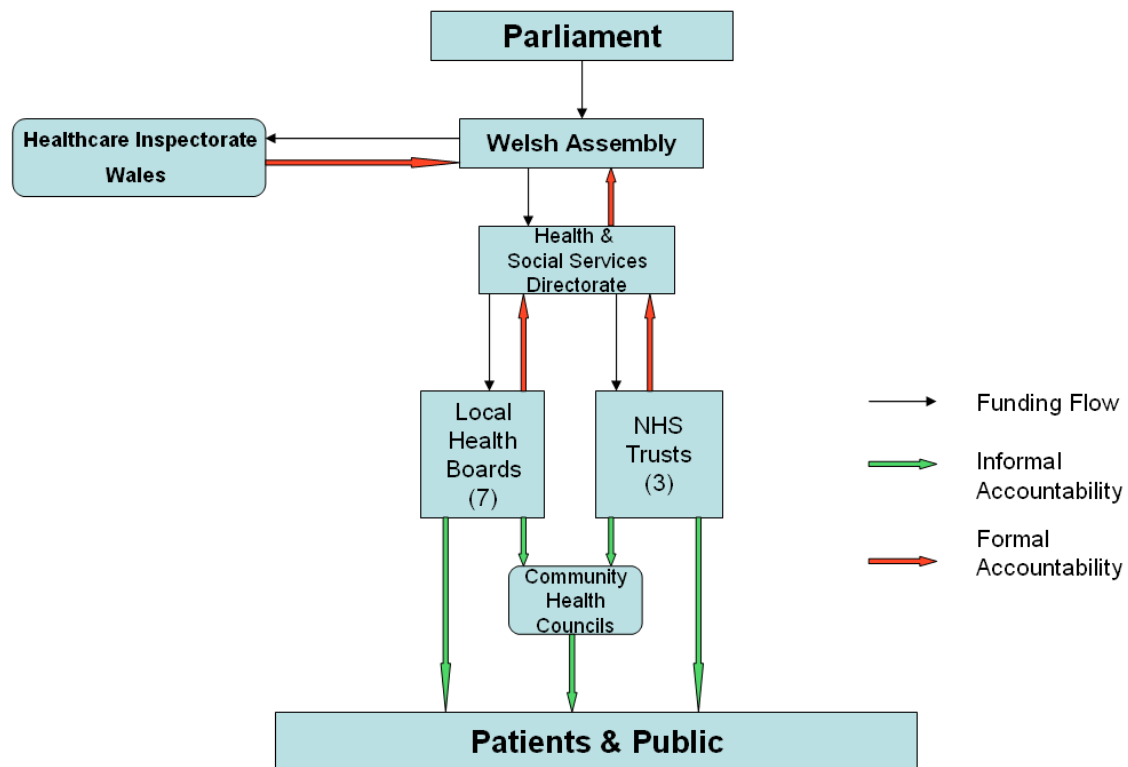
The Minister for Health and Social Services sets the policy direction for the NHS, and through the staff in the Health and Social Services Directorate of the Welsh Government, acts to ensure the services delivered by the NHS are in line with the policy and strategy set by the Assembly and its Ministers. To support this role there is an independent inspectorate, Healthcare Inspectorate Wales, which periodically inspects and reviews the NHS in Wales and reports to the Minister and the Assembly on its findings.

The NHS in Wales is delivered by seven Local Health Boards (LHBs), who are responsible for providing the full range of healthcare including primary care, community services, acute hospital services and mental health services for a defined population in Wales. In addition there are also three specialist NHS Trusts. These ten organisations are not only accountable to the Minister but also to their local

population who are represented through the Community Health Councils (CHC). The CHCs can challenge organisations and raise concerns on behalf of service users.

The nursing service system as discussed in this research forms a sub-system of the service provider's organisation (yellow boxes), the LHBs and Trusts. This is outlined in the figure 2 below:

Figure 2   **A diagram showing the position of the Nursing Service in the NHS organisation system**
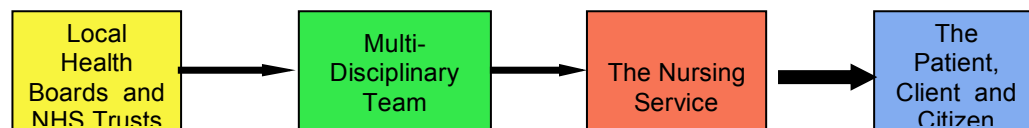
Understanding where the nursing service fitted within an NHS organisation and where that organisation fitted within the NHS in Wales, helps to identify the potential influences on the nursing service as it provides care to the patients.

The model described by Williams (2006), focuses on the components found in a nursing service, it makes no assumptions as to the value of these components or what influence they have on the nursing service. Rather, it is descriptive and provides the reader with insight into the inner workings of the nursing service which can be considered when reading the thesis.

In the dissertation by Williams (2006), she proposes a conceptual model of 'Nursing Best Practice'. This contains her suggestion that this system has the emergent properties of a complex adaptive health care delivery system. The properties of the system's behaviour are hard to measure by traditional methods as usually you would break the parts down into manageable pieces, but the Nursing Best Practice system has to be seen as a whole as there is such close interdependency of its component parts (Kernick 2003).

Williams proposed model of 'Nursing Best Practice' is shown in figure 3:

Figure 3

A Diagram showing the Nursing Best Practice System (Williams 2006)
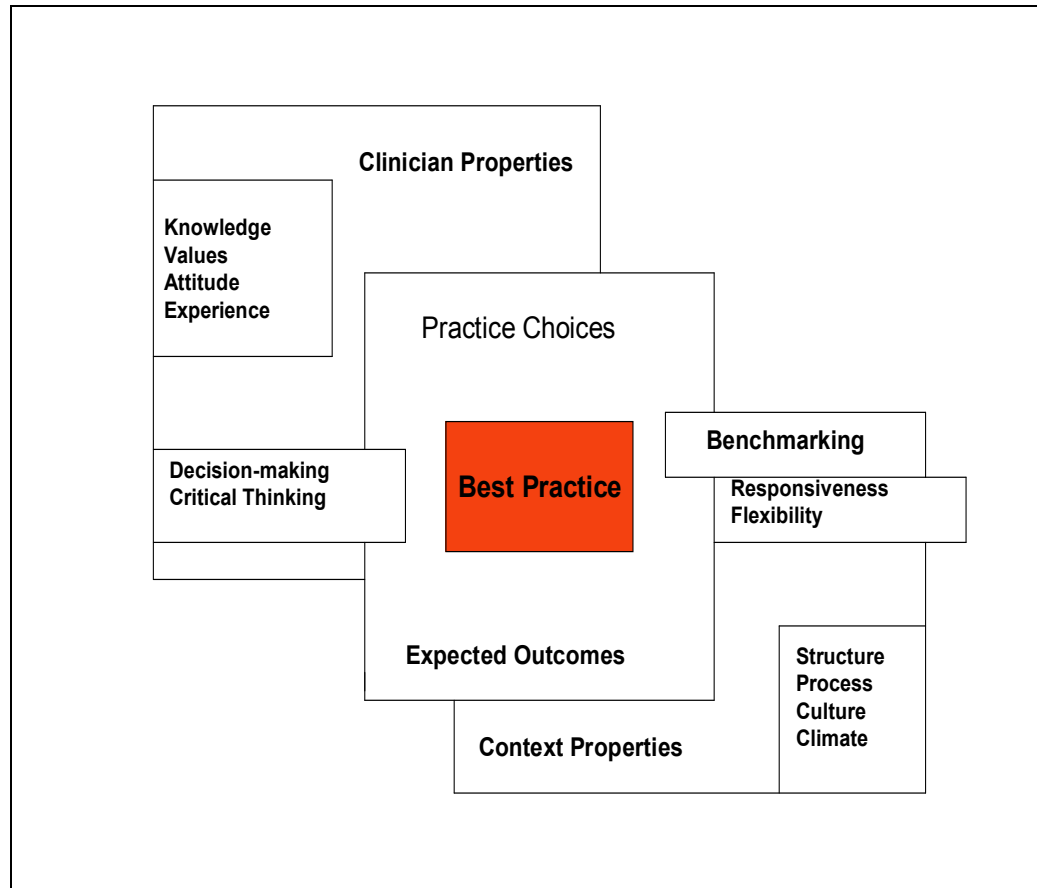
Further, Squires (2009), in her presentation on the nursing workforce in Mexico identifies the external influences on the nursing system and the pull between the outcomes for the healthcare system against the professional-based outcomes of the nursing system.

This is shown in figure 4 below:

Figure 4

A diagram to show the external influences on the nursing system (Squires 2009)
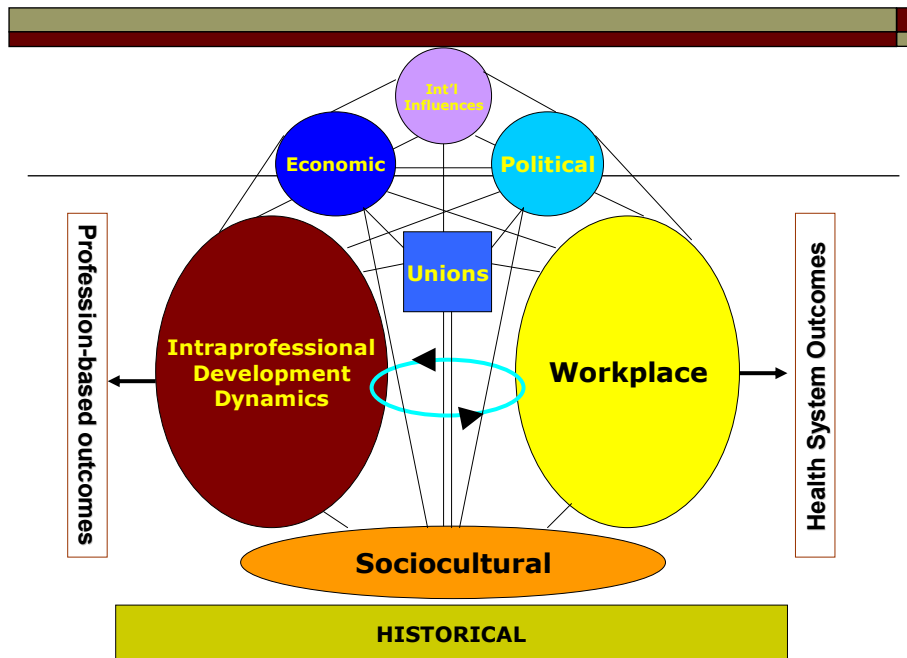
The combination of these two systems acts to demonstrate both the internal workings of the nursing system and the external influences which when taken together create the dynamic and responsive nursing system we see in today's health service. The above diagrams set the context of the nursing service, showing both the internal functions and factors that constitute the nursing service, as described by Williams (2006) along with the external factors (Squires 2009). The components of these diagrams are further considered throughout the research and are examined in the analysis of results. They provide a direction to the development of the factors in the Senior Nurses' Framework.

Conclusion

This chapter has outlined the background for the research, the on-going failure to deliver safe quality nursing services to the patients. It sets out the aims and objectives that if achieved, have the potential to produce a framework of key factors that can be used by Senior Nurses to improve the delivery of the nursing service in

their organisation. It further gives an overview of the different models representing the NHS, the nursing service within it, the components that make up the nursing service and the environment in which it operates. This provides the reader with an understanding of where the nursing service fits into the NHS and the internal and external influences on it. A summary of the main findings and a sample of the Framework have been published in a peer review journal (Andrews-Evans 2012), a copy of which can be found at Appendix 7.

The rest of the chapters are organized as follows:
Chapter 2 outlines a review of literature, including both nursing and non-nursing literature, the majority of which has been written in the context of the delivery of a healthcare service. The two types of literature were selected as it was found that the general literature did not provide sufficient focus on nursing, its failures and successes. It was essential that the contributory elements of nursing were explored further. Following the literature review a conclusion was reached that much had been written about why the health service and in particular the nursing service succeeds or fails, with explanations as to what action could be taken to improve services in specific cases. The question was therefore posed as to why undertake the research, when there is already a volume of literature written about the nursing service. But the nursing service continues to fail, so critically it can be concluded that the literature written so far has not addressed all the issues in a robust way, which actually describes and recognises all the conditions underpinning service failures. Since the previous research had not fully identified the real reason for the problems that lead to failure, it was anticipated that the research could add to what is already known. By achieving this aim it could provide not just an understanding as to why the nursing service fails but also what can be done to have success.

Chapter 3 details the methodology used. The theoretical framework for the research was a mixed methodology, where qualitative methods were reinforced by the use of a quantitative method to priorities the results of the semi-structured interviews. Both stages 2 and 3 were undertaken following a pilot process. The semi-structured interviews were undertaken using a critical nursing science (CNS) approach, to enable the Senior Nurses to describe the factors affecting service delivery. The CNS approach was used as it allowed the participants and the researcher to reflect and consider the social situation in which the nursing service operates. They were able to explore alternative ways of viewing the nursing service and its place in the organisation and society. The final stage in the research, the questionnaire, was

undertaken to enable prioritisation of the key factors identified by the first two stages and provide validity and generalisabilty of the findings.

Chapter 4 presents results and is divided into three sections. The first is the examination of published reports by inspection bodies. By analysing the themes from these documents, a graphical representation of the themes was produced of what the key features of failure were in the organisations reviewed.

The second results section provides a detailed analysis of the nine semi-structured interviews undertaken with Senior Nurses in Wales and presents what they perceived to be the reasons for a failing nursing service and what could be done to put it right.

The final section on results presented the findings from the use of a questionnaire distributed to all Senior Nurses across Wales. The aim of this part of the research was to ascertain the views of a wide range of Senior Nurses as to the prioritisation of the factors detailed from the interviews at stage 2. This also provided validation of the interviewees' opinions, as the questionnaire respondents made a large number of comments, which confirmed the original list of factors to be reliable and generalisable.

Chapter 5 has two main sections. The first being the analysis of the results, clarifying the factors which would be contained in the final framework for the Senior Nurses to use. The second section offers a general discussion of the results in terms of their sociological antecedence and their significance for nursing in today's health service.

Chapter 6 provides a chart showing the thirty-five key factors of the Senior Nurses' Framework. It further describes the factors in the 'Framework' in detail, which provides the background for Senior Nurses to assist them in understanding the provenance of each factor and so support them in using the 'Framework' to deliver a successful nursing service.

Chapter 7 summarises the thesis of the research study, considering the underlying and fundamental reason for the nursing service's failure and how this could be addressed. This chapter provides a professional debate, which, through a critical nursing science perspective, explores what the profession can do to empower itself. Through this approach it is anticipated that Senior Nurses can implement the

framework of factors and make the difference needed in the nursing service to prevent failure and improve the quality of care.

 Chapter 8 explores the limitations of the research and considers the next stages in the implementation process. This involves working with the Senior Nurses in Wales to implement and evaluate the Senior Nurses' Framework and whether they consider it enables them to deliver a high quality and safe nursing service. The chapter further outlines opportunities the current study presents for further research work in the area of improving the delivery of the nursing service. In particular it suggests repeating the study in other countries to explore if the factors may be different.

Chapter 2
Literature Review

Purpose

The review considers literature which examines the failures in the health service. Since the focus of the thesis is to ascertain what, if any key factors can be identified by the Senior Nurses to improve the delivery and safety of the nursing service and also what could have been in place to prevent them. The literature review considers firstly the role of nursing in the health service, followed by a discussion on failure and success in the health service and why these might happen. Literature written from both a general management and nursing perspective which examines the organisation and leadership of the Nursing Service is then reviewed. The review does not examine literature written in relation to the delivery of clinical patient care by nurses. There are several reasons for excluding this, in particular that the study is looking at the nursing service from an organisational perspective rather than at the level of patient care. Also there is a very large volume of literature regarding the delivery of clinical nursing care, mostly focusing on patients with specific medical conditions. Neither of these areas of literature would benefit this study as it does not discuss the organisational aspects of the nursing service.

The Nursing Contribution to the Health Service

> "The very elements of Nursing are all but unknown"
> (Nightingale 1859 pp 6).

Many commentators since Florence Nightingale have tried to describe nursing and the contribution it makes. In 2003 the Royal College of Nursing (RCN) published a document called 'Defining Nursing', with the intention that this could be used by nurses to explain their unique role in the provision of the health service. In this document it describes certain defining characteristics of the nurse and though some of these are not particular to nursing, it is the combination of all these factors that is unique to the profession.

A further role identified as that of the nurse is prevention. Smith (2006) comments that nurses are able to react to difficult situations immediately, having the ability to

recognise and respond to safety issues for their patients. Even at Board level the Nurse Director has a role of being the patient's voice, so their interests are recognised and their wellbeing protected (Burdett Trust 2006).

While these definitions help illuminate the role of individual practitioners, it does not provide a comprehensive description of nursing as a service. In contrast Allen (2004, 2007) defines nursing's contribution through exploring what nurses do in relation to making the organisation work in the interests of the patients. There is little to be found in the literature that discusses the collective role of nurses when their actions together make the nursing service. Literature focuses on the individual rather than the collective actions of a group of nurses. There is evidence, as will be shown later, on the consideration of team work but this is only at one level in the organisation and does not consider the interaction and relationships between the many layers of the nursing service and the effect this has. There is little written about the varying tiers that consist of the nursing service and how their interaction within the organisation works to deliver the service, neither how the different aspects of the nurses' complex role (Procter 2000) needs to be co-ordinated together.

In 2002 the International Council of Nurses (ICN) proposed a definition of nursing that could be used world-wide. It stated that:

> *"Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management and education are also key nursing roles."*

Here the ICN do identify a much wider role for the nurse within the total healthcare system, but continues to fail to recognise the interrelationship of all the elements. Nightingale (1859) considers that both quality care and nurses with wider skills have to be in place for the nursing service to be good.

One significant feature identified which is relevant to this thesis, was the co-ordination of a patient's care (Allen 2004, 2007). Nurses are the glue that keeps the patient services together, ensuring that the right things happen at the right time and place, with nurses having to solve complex problems. Sampson (2008) supports this view commenting that the trained nurse organises the processes of care and is skilled and educated to do so. Latimer (2000) and Allen (2007) further comment that it is the nursing service that moves the patient through the hospital system. The

literature (Latimer 2000, Procter 2000, Allen 2007, Burdett Trust 2006, Nightingale 1859) emphasises the nursing role in the day to day management of a patient's care or a group of patients, so that when this role is impeded the patient is at risk of suffering from failings in their care.   This emphasises that nurses have a vital role of being 'in-charge'. Florence Nightingale (1859 pp24) stated "to be in charge is not only to carry out the proper measures yourself, but to see that everyone else does so too". This role of delegation and supervision (Procter 2000) was also a defining characteristic in the RCN's work (2003). Through being in-charge at whatever level in the organisation, the nurse has the key responsibility for the environment of care. Dennis and Prescott (1985) consider that the management of the physical environment is unique to nursing in the health service. This was explained as meaning that the ward is clean, there is linen for the beds, drugs and supplies are available, the food is nutritious and that the ward is kept at the right temperature. Nursing is much more than this, with a vital role in the totality of the organisation of the patient's care and the delivery of the health service that supports care (Allen 2007). Further Allen (2004) describes eight bundles of activities that comprise the nurses' role. These being; managing multiple agendas, bringing the patient into the organisation, circulating patients, managing the work of others, mediating occupational boundaries, communicating information, making a record and prioritising care and rationing resources. They act beyond the boundaries of the patient's bedside or even the ward. They ensure that the essential activities that support the passage of the patient through the hospital and beyond into the community take place. They co-ordinate other staff (Allen 2004) to deliver activities that act in the best interest and safety of the patient. The nurse is skilled at making things happen and are adept at working in challenging circumstances to create the best outcomes not only for the patients but other staff in the health service (Latimer 2000).

Organisational Failure

All healthcare systems have their disasters (Walshe 2003). For many years there have been high profile failures of care, many of which are discussed in the thesis with some analysed in more detail but what is the real underlying cause of such organisational failures. This section examines theories regarding what causes organisations in general to fail. There are a wide variety of claims as to what leads to organisational failure (Walshe 2003, Mellahi and Wilkinson 2004, Johnson 1999, Finkelstein 2003, Reason 2005) and that without understanding these root causes it

is problematic in preventing reassurance in the future. Walshe (2003) considers that when you examine organisations that have failed the first response is to blame individual human failings but on closer examination the individual's mistakes are found to be rooted on the failure of the organisation, particularly weak leadership. It was further identified that failing organisations were also isolated from their customers and were inward looking with a closed culture that did not consider the environment in which they operated. Walshe (2003) further considered that basic management systems and process were lacking, such as performance reviews of staff, poor internal and external communication, lack of openness and transparency, disempowered groups of staff and customer who were not listened to. These all contributed to the down-fall of the organisation and its ultimate failure. There was no shortage of the identification of causes of organisational failure in the literature but one might argue that if it was so simple to know what makes things go wrong, then why do disasters keep occurring? There has to be more to the causes of failure than these high level factors.

The literature reveals two differing views on what causes organisational failure (Mellahi and Wilkinson 2004, Finkelstein 2003). One has an external focus, considering that managers are so influenced and feel constrained by external influences, such as regulatory requirements or external targets that they are left with little or no strategic choice. Therefore their role as manger is not a factor in the failure of the organisation as it happened outside of their control (Audit Commission 2006). The other view is that as managers are the principle decision makers in an organisation, particularly those in senior roles, then their actions are intrinsically linked to the organisations success or failure.

Reason (2005) describes the combination of both human and organisational failings in the presence of deficits and gaps in the systems, especially the systems that are there as safeguards to prevent error which lead to failure. Human failure as a result of psychological factors such as carelessness, forgetfulness or powerful decision-makers have been identified (Reason 2005, Walshe 2003, Finkelstein 2003). Usually these individual acts are hard to predict but if in addition the organisation has dysfunctional systems, with the safeguards that could prevent these individual acts not in place, then disasters can occur which could have been predicted and prevented. Errors in working practices are therefore symptomatic of both human fallibility and also organisational failings (Johnson 1999). Though individual acts are hard to control, organisational failure can be identified and management action taken to prevent systemic failure. Reason (2005) considers three areas of organisational failure; firstly at an organisational level with poor and inadequate management, there

is lack of organisational processes and an introverted corporate culture with a strong top management control (Finkelstein 2003). Reason (2005) further describes the environment in which staff work, where there is a lack of rules and processes to safeguard staff and the work they do. Health and safety requirements are not in place and so staff do not work to the rule, leading to mistakes. Finally there are the individual errors made by staff that violate rules or make inappropriate decisions based on poor knowledge and experience.

Following on from this theme of human error, many inquiry reports found this as a main cause of failure. Considerable amounts of research into organisational failure focused on the human factors and behaviour (Johnson 1999). This has led to a reduced interest in the other aspects of failure particularly in relation to organisational performance. This could include inadequate staffing levels, leading to staff taking short-cuts; poor staff training and staff lacking direction, so staff do not know what is expected of them. Both Johnson (1999) and Mallahi (2010) consider that there is the need for research to have a greater focus on management and regulatory practices which lead to human error, if we are to have a greater understanding of all the causes and influences that lead to an organisation failing.

A theme emerging from the literature on failure, particularly that based on the examination of organisations that have failed (Reason 2005, Walshe 2003, Mallahi and Wilkinson 2004, Finkelstein 2003) is that the causes of failure are not due to unforeseeable events and that the majority of failures could be predicted and therefore prevented.

Finkelstein (2003) takes this to a stage further when he examined companies that had spectacular failures such as Enron, Royal Bank of Scotland, Motorola and Rubbermaid. In his examination of failed organisations he identified one main cause that was usually overlooked and certainly not evident in the research on organisational failure; this being how the organisation's executives perceive their organisation. He discusses how the organisation is seen by all, how information and control systems are managed and how corporate leaders adapt unsuccessful habits which eventually lead to failure. If failure can be foreseen then why does it happen? Finkelstein (2003) considers that executives in these failed organisations did actually know what was going on but chose not to do anything about it. The reason for this inaction does not have a simple explanation; it potentially is due to lack of personal motivation by the executives, poor leadership, lack of honesty or lack of resources. But Finkelstein (2003) considers that it is more complex than that and that executive mind-set features are at the root of most of the large-scale failures. The executives, usually the Chief Executive Officer (CEO), regularly sends their organisation off in the

wrong direction, giving it the wrong priorities because they have made fundamental errors on the way they think about the opportunities and problems their organisation is facing. This was a key feature in the failure of Mid-Staffordshire NHS Trust (Healthcare Commission 2009). Many of these corporate failures had at their source a breakdown in management reasoning and strategic thinking. Therefore to prevent failure there needs to be a consideration as to how these mind-sets can be overcome. Unfortunately these executives have the wrong picture of the real situation, with no-one in the organisation prepared to challenge the status quo and ask tough questions. The staff, including other senior managers, have been disempowered, fearing the consequences of speaking out (Scally and Donaldson 1998). The next question has to be why these delusional attitudes develop? These attitudes not only dictate how executives behave in the organisation but also how they engage with the outside, such as customers and patients. In failing organisations the CEO focuses on public relations to promote themselves and the company, rather than corporate strategy. These types of organisations have been labelled as 'Zombie Businesses' where they are run by an authoritarian individual. One area of concern is the management of information in an organisation (Mannion et al (2005). Poor communication leads to people and systems not functioning appropriately and the Board being unable to be vigilant regarding the conduct of the organisation (McDaniel 1997, Filochowski 2004i, Vincent and Barker 2005). It is not that control systems are not present in the organisation; it is rather that the control systems are not reviewed and up dated to meet organisational and regulatory need. Like the mind-set of the CEO and executive team they are stuck at a point in time and reinforce the controlling culture (Yourstone and Smith 2008) at the top of the organisation. Clearly because of these failings in the executive the safety-net is not in place to protect the organisation from failure (Finkelstein 2003). The CEO and executives tend to make the same decisions again and again even when they are no longer appropriate.

Further Finkelstein (2003) discusses the theory that it is the CEO's personality that generates corporate vulnerability and ultimately leads to failure. He considers that executives in leadership roles of failing organisations often find it difficult to get people to follow them. They have forceful personalities and believe that they can do whatever they like because of their dominant position. Due to this attitude they spend money on status symbols such as new offices and cars which add no value to the company but promote their superior image. The CEO is clearly in charge and has the answer to all questions and problems regardless of how complicated a situation or challenge is seen by other people. These attitudes of the CEO are seen in failing

organisations, as they are continuing to steer their organisation towards disaster but will not change direction.

The review of the literature on organisational failure has explored the different theories regarding the underlying causes. It is considered that failure can be predicted and prevented if the organisation and the management are alert to the risks. Though it is also recognised that human error will always be a factor difficult to manage, there are still areas where the organisation can have controls to minimise the risk if human error. Further they need to take appropriate action to mitigate the risks and establish organisational controls appropriate to the management and reduction of mistakes and poor decision making. These areas for action in relation to what makes a successful nursing service can be considered by the senior nurses participating in the study. The unique role of the senior executives and the power and influence they have on the organisation and its staff cannot be underestimated. This will need to be explored further in the thesis to understand this in relation to health service and nursing failure. The next section in the literature review considers organisational failure particularly in relation to the delivery of healthcare and the nursing service.

Health Service Organisations – Success and Failure of Systems

In addition to the above views of failure and its causes, the researcher was interested to understand more about failure in the health service and in particular the nursing service. Therefore further literature was examined to ascertain what might also be contributory factors to the success or failure of the nursing service.

It is evident from the inquiry reports that failures in the health service have been documented for decades and yet still continues. The first inquiry into the National Health Service (NHS) took place in 1969; this examined the failure of services provided at Ely Hospital in Cardiff (Parliamentary report 1969). In 2002 Walshe and Higgins undertook a review of inquiries into the NHS and identified consistent themes of poor leadership, an inward looking culture, inadequate management structure and poor systems and processes used in managing the organisation. Despite the considerable time lapse between the first inquiry in 1967, very similar findings were also found in the public inquiry into Paediatric Heart Services in Bristol in 2001 (Parliamentary report) and clearly lessons still have not been learnt over the years. Walshe and Higgins (2002) also identified conditions for failure, such as organisational or geographic isolation, poor communication and disempowerment of staff and service users. Health care is delivered by highly skilled and knowledgeable

professionals and the prevention of failure relies heavily on these staff acting to compensate for operational failures (Tucker and Edmondson 2002). They do this by rapid problem solving and action (Procter 2000).Tucker and Edmondson (2002) suggest that failure frequently occurs, so it is of interest to know why lessons are not learnt and failure is repeated. They suggest that there are 3 main reasons for this; the lack of individual vigilance, a focus on financial efficiency and empowerment that leads to a lack of managerial support (Procter 2000). Aitkin and Patrician (2000) also consider that empowerment of workers is a solution for improving quality of service by supporting the staff to raise concerns so that errors can be addressed. The nurses have to be able to communicate effectively with someone senior who can make the necessary changes (Tucker and Edmondson 2002). These comments could be seen as contradictory since it is unclear whether empowerment is good or bad in improving performance. The interpretation of this is that there must be empowerment for the staff to perform effectively and raise concerns, but there should be safeguards provided by management, which can support and guide junior staff in achieving the best outcome in difficult situations.

Gerlin (1999) in the examination of medical mistakes took a pragmatic approach in commenting that systems are inherently susceptible to errors, particularly those in the healthcare environment. Healthcare organisations exist within a highly complex and chaotic environment and due to this, system errors result due to a confluence of several pathogens entering the system by shortcomings in design. This could be seen as a passive response to failure, with the view that errors are inevitable so little can be done to prevent them. This thesis acts to refute this attitude in identifying that there may be factors that can be in place to prevent failure. Faulkner (2002) challenges how structure, process and outcome are organised in the health service and he proposes that organisations are processual, on-going with no means-end relationship. This can therefore be described as a complex adaptive system, constantly changing as a result of internal and external influences (Burgen et al 2003). This interpretation lends itself to the argument that the nursing service could change as a result of learning from its errors and take action to improve. It would have to be adaptable to both internal and external factors and learn to be adaptive and responsive to change.

It has been identified that traditional organisational structures are most effective in a static environment (McDaniel 1997). McDaniel purports that the more suitable organisational structure for the NHS is as he calls it 'self-referent'. Self-referent

systems encourage autonomy and allow for small fluctuation and changes as people strive to adjust to dynamic local conditions. This literature supports the need for empowered staff if services are to be successful. He feels that this type of management arrangement is better because details of long-term challenges are unknown. Managers must adopt a style of management that relies on processes of self-organisation and participation and complex learning to face such unknowns. This is further supported by Marion and Bacon (2000), who consider that loosely coupled structures are more adaptive to change. Healthcare can be considered to be a field that is complex and perhaps the most complex of any system in any area of the economy (Morrison 2000). It is therefore difficult to establish a functioning structure which delivers to a high standard and is able to innovate, though the above literature does support a more flexible approach to structures in the NHS.

Healthcare delivery systems often have separations between sub-systems which lead to a 'tunnel effect' (Yourstone and Smith 2002) and silo working. Moray (1994) further states that the fundamental concept of systems theory is the relationship between and among components of the system. These interactions are just as important as the design of the individual components of the Healthcare delivery system. There have been proponents of integrated delivery systems being the answer to the health services' problems (Procter 2000, Savage and Roboski 2001) but the debate on their effectiveness is still on-going (Friedman and Goes 2001, Allen 2002).

The literature below builds on these theories of systems management to specifically examine the characteristics seen in high and low performing organisations. The briefing paper produced by the National Co-ordinating Centre for NHS Service Delivery (2006) showed how the complex interplay between organisational performance and a range of contextual factors meant that there was little scope in adopting a 'one size fits all' policy for NHS organisations. Further examination of failing NHS organisations by Filochowski (2004(i)) stated that problems in these organisations are likely to be fundamental with other problems thought to be so big they cannot be solved, when in fact they are really not that great. Since it is claimed that a standard approach to addressing organisations failure may not be possible, it was of interest to see if this thesis is able to deliver on one of it aims in producing a framework for nurses to achieve success.

To fully understand why an organisation fails it is important to identify the root causes before it can be turned around and improved (Filochowski 2004i).

An interesting identification of what makes a high and low performing organisation was articulated by Mannion et al (2005). This can be seen in the table below:

Characteristics	High Performing Trusts	Low Performing Trusts
Chief Executive	Harmony and Order	Personal and Capricious Interventions
Leadership Style	Transactional	Charismatic
Management Integration	Fully Integrated	Clique
Management Orientation	Corporate	Pro-Professional
Senior Management Pre-occupation	Meeting National Performance Agenda	Own Group Maintenance Needs
Senior Team Turn-over	Low	High
Middle Management	Strong Empowered	Under-Developed, Emasculated
Accountability	Clear	Opaque
Rewards	Performance Related	Patronage
Information Systems	Highly Developed	Under-Developed
Performance Management	High Priority	Low Priority
Recruitment Policies	Staff to Fit Culture	Undiscriminating
Local Engagement	Proactive	Reactive
Taboos	Not Hitting Targets	Challenging Senior Management

Mannion et al (2005) state that good organisations hold people to account, empower middle managers, clearly articulate corporate strategy and visionary leadership. In addition to this, these organisations look at transactional detail to ensure the organisation delivers what it has to and is seen to succeed by both staff and external bodies.

The Organisational Perspective

The above table looked at corporate arrangements for success but failed to consider what it is like for the staff working in the organisation. The staff are key to the delivery of the nursing service (Rafferty et al 2007) and as commented by one of the participants in this research "Happy staff means happy patients". In examining the literature for the study a significant area of work undertaken by nurses has been the development of Magnet Hospitals in the United States of America. In the early 1980's the 14 Forces of Magnetism were developed by the American Academy of Nurses. It identified 14 factors that would improve the recruitment and retention of nurses in the USA (McClure et al 1983). This was at a time of nurse shortages and there was competition between hospitals in attracting nurses to work for them.

This piece of work identified the 14 factors as:

- Quality of leadership
- Organisational structure
- Management style – staff involved in decision making and good communications
- HR Policies
- Professional models of care – Nurses accountable and responsible for patient care
- High priority of quality of care
- Quality improvement processes
- Consultation and resources
- Autonomy and team working
- The organisation has good links with the local community
- Nurses as teachers
- Good image of nursing
- Interdisciplinary relationships – team respect
- Professional development and education

Following the introduction of Magnet Hospitals, research has taken place to see if they do have added benefits. Havens and Aiken (1999) undertook a review of Magnet Hospitals and their outcome for patient care. This study provided evidence that healthcare facilities achieving Magnet status do provide positive outcomes for nurses, patients and healthcare organisations. This work was also studied by West et al (2006) and Rafferty et al (2007), who identified a direct relationship between

staffing levels, good workforce planning and patient outcomes. This therefore provides support for this research in that, by identifying the key factors of a nursing service and ensuring these are in place, we should see an improvement in the outcomes for patients and the organisation should be perceived as high performing.

A further study was undertaken to ascertain which of these factors were considered of greatest importance to nursing staff and to be given a higher priority. A study entitled *Staff Nurses Identify Essentials of Magnetism*, was undertaken by Kramer and Schmalenbery (2001), and identified 8 factors that nurses considered to be most important to them in delivering patient care. Unlike the current research study, which is élite in nature and has used as it participants senior and experienced nurses, the 2001 study worked with nurses at the bed side. In addition it was focused on what was important to the nurses and not necessarily of benefit to patient outcomes.

The factors the staff nurses identified were (in rank order):

- Working with other nurses who are clinically competent (80%)
- Good Registered Nurse – Doctor relationships and communication (79%)
- Nurse autonomy and accountability (73.5%)
- Supportive nurse managers and supervision (70%)
- Control over practice and its environment (69%)
- Support for education (66.2%)
- Adequate nurse staffing levels (63%)
- Concern for the patient is paramount in the organisation (62%)

Over recent years work has been done to explore further these key factors. Jooste (2004) found that for an effective nursing service you need leaders that show vision and were positive and open towards followers. Jooste (2004) further identified that there was the need for clear time frames for tasks, as well as team building, promotion of research, a clear professional framework and that leaders develop good listening skills and understand their staff's issues. Building on this Marriner Tomey (2008) also undertook work on identifying the areas for a good hospital. This paper identified the need for transformational leadership, a decentralised structure, multi-disciplinary working, good patient to nurse ratios (further identified by West et al 2006) and the opportunity for education and development. Overall nurse leaders were seen as responsible for developing an environment that fostered the quality of

care delivery (Urden and Monarch 2002). These further studies identified some of the 'Magnet' features and there was overlap between some of the factors. But the question has to be asked 'are all these factors applicable to today's UK NHS Nurses?' The thesis explores this matter further and identifies if there should be other factors considered when striving for a high quality nursing service.

Recognising that the 14 forces of Magnetism have been in use for over 25 years, the American Nurses Credentialing Centre (ANCC) undertook a review. In 2009 the ANCC produce a revised version of the 14 Magnets. The new framework focused on 5 components, which encompassed the 14 Magnets. The purpose of the change was to focus more on measuring outcomes rather than processes.

These 5 components are (ANCC 2009):
- Transformational leadership (Forces 1 and 3)
- Structural empowerment (Forces 2, 4 10, 12 and14)
- Exemplary professional practice (Forces 5, 8, 9, 11, 13)
- New knowledge, innovation and improvements (Force 7)
- Empirical quality results (Force 6)

As mentioned above the 14 forces still remain to underpin the 5 concepts and are the main assessment focus.

It is important to note the context for the use of the Magnet approach. Firstly this system was established to improve the recruitment and retention of nurses and not specifically to develop a high performing nursing service or organisation, though the research does indicate that the two are linked (Havers and Aiken 1999, Rafferty et al 2002). Secondly and more importantly the United States healthcare system is run as separate 'for profit' organisations. Therefore the ability to attain accreditation status was motivated by the aim of improving the organisations' reputation and therefore attract patients and income. The motivation of the management including nurse leaders is to have a profitable organisation, which provides good services. This is in contrast with the publicly funded NHS, where its focus is to provide the best possible care and outcome for patients within the resources provided by government. It is a universal service, free at the point of delivery. The focus of the organisation's work is directed by government and other agencies, therefore allowing them limited scope to do things differently. The environment in which nurses' work is directed by external

bodies, as well as being under constant pressure to do more for less (Faulkner 2002). This therefore focuses the nurses' work more on acute, technical care, as this is what managers want, rather than the personal aspects of care (Latimer 2000) which appear to have a lower value. Does this contrast in the two healthcare systems, with the British NHS based on a social model; lead to the British and for this study Welsh nurses, having a different outlook? Are the key factors Senior Nurses in Wales identify for the framework, different or similar to those identified by the ANCC?

A review of nursing literature for the study would not be complete without reference to the Munich Declaration published by the European division of the World Health Organisation (WHO 2000). In 2000 a meeting took place of European nurses which urged relevant authorities across Europe to strengthen nursing and midwifery by taking specific actions including:

- Ensuring a nursing and midwifery contribution to decision making is at all levels.
- Address the obstacles such as recruitment policies and medical dominance.
- Improve initial and continuing education.
- Create opportunities for nurses and midwives and doctors to learn together to ensure more co-operative and interdisciplinary working.
- Support nursing research.
- Develop comprehensive workforce planning to ensure adequate numbers of nurses.

Again we see some common features between the Munich Declaration and the 14 forces of Magnetism. Though it is clear that the WHO statement only focuses on a few areas relevant to the study, it will be interesting to see if the participants in the research also identify those factors as being important to a high quality nursing service. It is clear that the Focus of the Munich Declaration is to empower nurses to take control of their service and contribute fully to the delivery of patient care. It does not go into any specific detail of how nurses could take forward these actions, which is likely to be challenging to achieve. The Munich declaration is reinforced by the message from the Audit Commission (2006) in that it recognises the danger of having certain groups of staff controlling too much of the power in an organisation, such as doctors (Latimer 2000, Aiken et al 2000, Laschinger et al 1996, Page 2004).

The work of the Burdett Trust for Nurses (2006) should also be considered for the study. Though the focus of much of its work is not on the nursing service as a whole, but rather on the role and development of nurse leaders, it still has a contribution to make to this review of literature. The document 'Who cares, wins' (Burdett Trust 2006) makes it clear that there are critical factors that need to be in place to deliver improved patient care. They state that there should be clear structures of accountability, the organisation should value its nurses, acting on patient opinion and measuring the impact of the nursing service. Finally they feel that there has to be influential champions for patients at Board level, usually the Nurse Director. This is reinforced by the position statement publicised by the International Council of Nurses (2008).

The following sections examine in more detail the above factors and what other literature has identified from failing and successful organisations.

Leadership and Empowerment

There are many descriptions to be found regarding the importance of leadership in a high performing organisation (Jackson 1998, Mannion et al 2005, Scally and Donaldson 1998, McDaniel 1997, Filochowski 2004i, 2004ii, Audit Commission 2006). Furthermore the healthcare commission (2008) in their summary report for that year comment that they found that poor leadership was a problem in nearly all organisations they investigated for service failure. Therefore since this seems to be such a consistent factor identified, it is important that there is a focus in the thesis on the role leadership plays in failure. The previous section on failure identified the crucial role of the person in charge but this section will need to explore the broader aspects of leadership and its influence on the nursing service.

The briefing paper produced by the National Co-ordinating Centre for NHS Service Delivery (2006) makes a point when it suggests that poor leadership and direction from the top of the organisation leads to a mismatch between the objectives of the different professional groups working in the NHS. This is further supported by the Audit Commission (2006) where it considers that you need to have a cadre of Senior Clinicians, who are not only doctors, that lead the service to achieve its objectives and are committed to the organisation's success (Schmieding 1993). To support this Scally and Donaldson (1998), feel that leaders with creativity and keenness to try out

something new, have greater success. It is essential that the staff have a good vision of where they are going and what needs to be done to achieve it (Filochowski 2004i, Jackson 1998).

Nursing literature identifies leadership style as one of the key factors to consider when discussing the features and effects of nursing leadership on the service. Finklestein (2003) describes five characteristics of leadership style, they are; that the leader commands respect, through the leader's talent and personality they build a strong cadre of followers, they provide their staff with clear direction and vision, they create an environment where excellence is rewarded and they empower people to reach their aims. A qualitative comparative research study by Sellgren et al (2006) in to nursing leadership styles found that the style of the nurse leader was fundamental for the subordinates to accept change and to motivate them to achieve the service's goals, visions and to deliver high quality care. This study was interesting in that it compared what the nurses wanted in leadership style in comparison with how the nurse leaders considered their style should be. It highlighted a considerable difference of opinion between the two groups, with nurses wanting their leader to be directive regarding the work to be performed, from this is appears that they require the security provided form their managers setting clear expectations for their work. Whereas the leaders wanted to give fewer directions and provide an environment where the nurses had more discretion over their work. Cook (2001) considers that the style of nursing leadership is learnt from the nurse's observation of their nurse leaders and they then replicate this style when they themselves are in leadership roles. We therefore have to question whether mentorship and a 'sitting by Nellie' approach to nurse development only acts to replicate an old style of leadership which is no longer fit for the delivery of a modern dynamic nursing service. Ekvall (1992) expands this further by considering individual nurse leaders to have a basic operating style that is based on their personality, experience and learned leadership skills. This includes the leader's intelligence, temperament and attitude to the delivery of the services (Smith and Petersson 1988).

Nursing literature discusses two types of leadership style, that being transformational and transactional, with a greater focus on the former being the style of choice for success. Wong and Cummings (2007) consider that transformational nursing leadership is important to improve patient outcomes. They conclude that there is a significant positive relationship between the behaviour of the nurse leader, their style and practice and increased patient satisfaction, as well as a reduction in patient

adverse events. They were unable to find a direct link to reduced mortality rates, but still considered that the overall effect on patient care was positive.

A key feature of transformational leadership was the leader's ability to steer the nursing workforce through change and motivate them to do things differently. They were able to implement effective management practices and develop a culture of safety (Page 2004) and therefore improve outcomes for patients. Therefore in a dynamic ever changing health service, the view is that nursing has to evolve and innovate to maintain its place in the system and deliver good effective care. Transformational leadership is change-orientated and acts to stimulate and empower nurses to be creative thinkers and gives freedom to innovate and drive change (Ekvall 1992). Sellgran et al (2006) concluded that the nursing staff actually had a preference for a leader who demonstrated more transactional traits and was more directive and supported the status quo. A transactional leader is focused on the delivery of a task or targets, feels comfortable in their role if supported by tight systems, structures and processes, with efficiency being rewarded (Bass and Avolio 1985). These findings are contradicted in a study by Dunham-Taylor (2000) where it is found that in a study of 396 nurses they preferred a nurse executive to have a transformational style as this increased staff satisfaction due to increased empowerment and subsequently improved the quality of care. These two studies provide different view on nurses' preferences with regards to leadership styles, but it could be concluded that each style has its place in nursing dependant on the current environment in which the service is operating, with each being appropriate at a particular time. Leach (2005) further notes that you are more likely to find transformational nurse leaders in organisations where there is a culture of inclusion and participation.

The work of Sellgran et al (2006) discussed two different leadership styles; one being employee focused and the other is service delivery focused. But the really effective nurse leader must integrate the two if they are personally to be successful and also to have positive outcomes for the patients. Taking this a stage further Ekvall and Arvonen (1994) describe behaviours that cover three domains of leadership. These being: a person who gives clear instructions and ensures delivery; one that shows understanding for the staff, treating them justly and allowing them to make decisions; and an individual that offers new ideas, initiates new projects and looks to the future. From this it can be concluded that the most effective nurse leader must have both transformational and transactional traits to lead a successful service. It must not be forgotten that the heart of nursing is people and relationships and this equally applies to the patients and the nursing staff (Sellgran et al 2006). Despite the fact that nurses

in general find change difficult and prefer stability, with the need for instruction and a stable work environment (Sellgran et al 2006), this is not how the modern health service operates. It is therefore even more important for the nurse leader to have both leadership skill sets if the nurses are to provide a service that meets the patients' changing needs and responds to advances in medicine. This study further concludes that nurse leaders see themselves as transformational when they are in fact seen by their staff as transactional with a focus on delivering targets. This is an interesting fact as nurses in the research considered that they were driven by targets to be transactional, when they wished to be given the opportunity to be transformational in their work.

Clearly a transformational leader empowers their staff to make decisions and manage the environment of care. A strong nurse leader that empowers staff makes the nurses feel more professional in their work with control over their delivery of care (Manojlovich 2005). Manojlovich (2005) further proposes a theory that the interaction between empowerment, nursing leadership and self-efficacy may by working together support high standards of professional practice behaviour in nurses, who can think for themselves and make decisions in the interest of patients. Interestingly Manojlovich (2005) considers that nurse leaders should use themselves as role models and encourage staff, which will increase the nurse's personal confidence and so improve the quality of service as nurses will feel able to challenge poor practice and other barriers to good care. This is an interesting contrast to the views of Cook (2001) expressed earlier where it was considered that this approach led to stagnation of the nursing service due to leadership styles fixed in the past.

Further literature identified the nurse leadership characteristics needed in having a successful nursing service (Riley 2009, Rouse and Kaplan 2008, Robinson 1991). Upenieks (2003) built on the work of the Magnet scheme and looked at the traits essential for a good nurse leader. These traits included being accessible, a good communicator and listener, supportive and visible, having a positive approach, knowledgeable and be influential particularly at Board level. Jooste (2004) builds on this further, suggesting that it is important that the nurse leader should be visionary, being clear regarding what is expected of the nurses. Nurses need to be influential if the nursing service is to take on the challenges faced in the current health service environment and that of the future (Robinson 1991). Being supportive towards the nursing staff was considered to be important so that they are encouraged to develop their roles (Hardwood et al 2003), be competent and credible (Urden and Monarch

2002), as well as being respected members of the health care team (Faugier and Woolnough 2002). The nurse leader needs not only to be empowered themselves but also needs to empower their staff so they are innovative and able to improve practice (Albert and Siedleck 2008, Schmieding 1993).

Leadership at the top of the organisation is important but highly centralised structures are not associated with high performance (National Co-ordinating Centre 2006, Kanter 1993). A decentralised organisational structure for nurses was felt to improve their empowerment and therefore enhance patient care (Urden and Monarch 2002). Some organisational structures were thought to conflict with the professional practice of nursing and so adversely affect patient outcome (Manjlovich and Ketefian 2002). Further, as suggested by the Burdett Trust (2006), the Nurse Director must be able to influence the Board so that the issues facing the nursing service are heard and addressed, so it is improved (Stickler 2007).

In summary a good nurse leader effectively manages the environment of care as well as providing leadership to the nursing service. They effectively manage the context in which care is delivered, the staff and financial resources which together provide the environment for good quality care (Patrick and White 2005). Pearson et al (2007) identified that there was no simple style of leadership in nursing but rather there needed to be a combination of styles and characteristics that supported sustainability and development of the service and provided a healthy environment for nurses to work in. It was considered that there would be value in exploring with the research participants how they perceived nursing leadership styles and the effect they have on the delivery of care.

Power and Empowerment
How an organisation is structured and where the 'power-bases' lie has a real effect on the empowerment of staff and their ability to innovate (National Co-ordinating Centre 2006, Yourstone and Smith 2002, La Porte and Consolini 1988. Mannion et al 2005). They all observed that high performing organisations have a style of leadership which devolves its power and responsibility to individuals and teams. They further nurture a more participative and decentralised management style. Effective organisations have all levels of staff involved in decision making (Jackson 1998, Kanter 1993), whereas disempowered staff inhibit effective decision making, communication and innovation (National Co-ordinating Centre 2006).

Traditional hierarchical organisational design relies heavily on rank-dependant authority for decision-making (Yourstone and Smith 2008). This is in contrast to 'Nested Authority' structures, which rely on functional skills (La Porte 1988). Due to the complex and chaotic environment in which the NHS operates, it is important to have an empowered structure. The National Co-ordinating Centre (2006) comment that NHS organisations based on networks or other horizontal structures, which are often best at adapting to rapid change and uncertainty, offer the opportunity for local flexibility and responsiveness. The briefing paper (National Co-ordinating Centre 2006) further suggests that decentralisation may increase quality improvement, job satisfaction, efficiency and managerial effectiveness (Kanter 1993).

Organisational change requires there to be development from within and not imposed. It was considered crucial for there to be professional engagement and leadership at a local level (National Co-ordinating Centre 2006), with clinical staff involved in decision-making. This was important as they are able to influence how the service at a local level responds to challenges (Procter 2000, Filochowski 2004 b). There is caution in the above provided by the Audit Commission (2006), when they state that there is a tendency in failing organisations for medical leadership to be over dominant in decision making or completely disengaged from the care management processes, as they can become too powerful and dominate other staff groups in the organisation, leaving them without a voice. It will be interesting to explore with the Senior Nurse participants in the study as to whether they have the same perspective and if their views reflect that of the literature written about nursing empowerment.

If the nurses are to be empowered then the organisation and particularly the nursing service must have an open and accountable culture which does not avoid conflict or problems (Faugier and Woolnough 2002, Gaddis 2007). Hierarchical control, sometimes seen in nursing services, acts to blame others (Gaddis 2007), whereas the modern nursing service requires a culture that supports and encourages creativity and innovation if it is to succeed (Laschinger and Havens 1996). When it is suppressed, the service becomes down trodden and dies (McNichol 2002, Laschinger and Havens 1996), with nurses feeling that they cannot make changes and see themselves as powerless (Sieloff 2004, Fletcher 2006).

The nursing service needs to move towards a 'can do' culture and work in teams to deliver change to patient services and new ideas (Editorial Journal of Nursing

Management 2005, Styles 1982, Hall 1982). The patient experience has to be seen as paramount (Burdett Trust 2006) and this is best delivered when the nurses are empowered in their work. It is important that nurses are able to raise concerns as they can see early warning signs of things going wrong (Cohen and Bailey 1997, Tucker and Edmondson 2002), and should also be empowered to take corrective action (Burdett Trust 2006), whilst learning from mistakes (Dixon-Woods 2010). Innovation is also considered to be important as well as the freedom of nurses to adopt new technologies and practices which improve patient care (Peters 1997). To start this process of innovation nurse leaders should first empower themselves (Upenieks 2003) and then their nurses, who should also be prepared to accept responsibility for their actions. It is not that nurses will not accept responsibility, rather they are keen to be empowered and want opportunities to develop and acquire skills to undertake their roles effectively (Skytt et al 2007). A problem they face is the low value the health care system places on nurses' work and their invisibility (Latimer 2003), which leads to disempowerment. Nurses see the only way of achieving power is by working to a medical rather than a nursing model of care (Latimer 2000). Filochowski (2004i) observes that poor performing organisations which lack empowerment, have no innovation and therefore poor services. A NHS organisation that has good services has empowered staff which are 'bristling with innovation'.

Culture and Ethos

The literature identifies culture as a key factor in the performance and delivery of quality care by an organisation (Clarke et al 2002, Chenoweth and Kilstoff 2002, Boan and Funderburk 2003). But Scally and Donaldson (1998) comment that it is hard to define actually what a good culture is. Despite this they do feel that the feature that distinguishes the best health organisation is its culture. Many use strap lines to describe a culture, such as 'can do' culture (Mannion et al 2005) 'no blame' culture (Scally and Donaldson 1998), 'learning culture' (Yourstone and Smith 2002) and 'open culture' (Filochowski 2004ii , Scally and Donaldson 1998).   Filochowski (2004i) suggests that there is a need to understand the prevailing culture of an NHS organisation to know why things have gone wrong (Gaddis 2007). Scally and Donaldson (1998) sum up a positive organisational culture as being one in which other healthcare professionals work closely together, with a minimum of boundaries and an environment in which learning is encouraged and blame rarely used (Rafferty et al 2001). Though there is a clear need to have a culture which involves clinicians (Audit Commission 2006), Mannion et al (2005) does describe low performing organisations as ones in which a pro-professional culture exists. In this he talks

about how a few senior medical staff exerts undue influences and directs the organisation's priorities to meet their own expectations.

Loyalty to a 'leadership group' where whistle-blowing or questioning of senior managers decisions are seen as an ultimate taboo, are frequently seen in failing organisations (Mannion et al 2005, Filochowski 2004 ii). When top managers are willing to listen to others, change their views and admit that they have made mistakes, it increases the chances of a correct diagnosis of the organisations' problems and corrective action can be taken (Vincent and Barker 2005). The challenge is for healthcare managers to establish a culture where system malfunctions are recognised and treated before they occur (Yourstone and Smith 2002). It is therefore important to have a culture where errors are reported openly and without fear of reprisal (Walshe and Higgins 2002, Yourstone and Smith 2002). Yourstone and Smith (2002) further suggest that if healthcare providers actually concentrated on learning from prior errors, care delivery systems would be progressively refined to prevent further error. In supporting this there also needs to be a culture of continuous improvement (Jackson 1998), with learning from our mistakes (Walshe and Higgins 2002).

Finally the Audit Commission (2006) identifies failing organisations develop a 'victim culture'. Here the organisation feels that they have no responsibility for their failure but that the faults lie elsewhere and is beyond their control to put things right. They feel they are not in charge of their own destiny and see themselves as powerless. This appears to describe the tension between empowerment and accountability.

Team Work

A successful health service organisation has to have a positive culture that promotes and supports team working both across and within functions (Jackson 1998, Scally and Donaldson 1998). Yourstone and Smith (2002) suggest that peer interaction is essential if errors are to be prevented. The Veterans Affairs Surgical Risk Study (Khuri et al 1995) emphasised the essential role of the co-ordination of work and peer interaction (Young et al 1997). This peer interaction effectively integrates the work of key groups of healthcare staff to the benefit of the patient, whereas poorly performing services have team leaders that rarely meet each other or collectively discuss the challenges they face. There are some benefits of occupational silos as they are able to promote innovation and technical change for that professional group (National Co-ordinating Centre 2006). But this silo working produces conflict between staff groups

at the bed side due to professional rivalry and prevents the use of effective care pathways (Dixon-Woods 2010). The adverse effects of silo working, coupled with the professional benefits of uni-professional initiatives, can be effectively managed with matrix structures offering a solution for poorly performing NHS organisations.

Teamwork both multi-disciplinary and uni-professional is important in the delivery of high quality nursing care (Rafferty et al 2001). Rafferty et al (2001) found that there was no reduction in nursing autonomy and care quality when nurses worked in interdisciplinary teams. Nurses also had increased job satisfaction. In fact they built a greater power base when they focused on building relationships with other professionals and through this dialogue developed greater self-awareness (Fletcher 2006). This team behaviour provides group effectiveness and improved quality of work (Cohen and Bailey (1997).

Though Latimer (2000) and Allen (2007) provide evidence to support the nurses' role as orchestrator of the service, not just nursing, there appears to be a tacit acceptance that this role for the nurse is appropriate. It could be further argued that by undertaking this role it diverts the skilled nurse away from the provision and supervision of quality nursing care. They can also be diverted into undertaking non-nursing duties (Latimer 2002). The nursing service commonly fills gaps left by others (Procter 2000) but can this have a detrimental effect on patient care or is this extension of their core nursing role an enhancement to the provision of care and the health service in general?

In failing organisations it has been identified that team work had disappeared and one of the early actions required to get an NHS organisation back on track was to reintroduce team work. As staff work together motivation improves since they are now working towards a common aim (Filochowski 2004i).

Communication

Faugier and Woolnough (2002) comment that information and knowledge are key to empowerment and that nurses will be more eager to help solve problems if they are kept informed and fully understand what is going on in their organisation (Kanter 1993). It is considered by Filochowski (2004 ii) that good communication is the grease that lubricates NHS organisations and the work of their staff. He further notes that communication starts to fail when management loses confidence and control over the organisation. It is a known fact that as information is communicated through

an organisation it is subject to loss, distortion, filtering and delays (Mory 1994) and within the health service there are increased risks of problems with communication due to the complex and ever changing environment in which it operates.

There are many studies regarding the effect that organisational structural arrangements have on communication (Mannion et al 2005, Yourstone and Smith 2002, Mory 1994, Vincent and Barker 2005). Mannion et al (2005) note that low performing healthcare organisations have management that are seen as remote and disconnected from the day to day issues in the wider organisation. In this type of organisation senior managers too often rely solely on written reports and information from staff at the next tier in the structure, rather than using a wide source of information so they can obtain a balanced view. This limitation to communication is understandable if you are an over worked senior manager, as it reduces the overload of information. But these managers run the risk of receiving poor quality information, which is likely to have been inappropriately filtered (Vincent and Barker 2005).

Mory (1994), notes that health care systems are made up of a series of hierarchically organised sub systems, which complicate the ability to learn about what is happening in the organisation. Information flowing to healthcare managers must pass through several organisational levels and 'thinking traps' (Yourstone and Smith 2002). These multiple steps that information has to pass through provides the opportunity for it to be distorted, misplaced or misinterpreted. Often in health service organisations information and decision-making flows tend to be via 'vertical channels'. Clearly because of this hierarchical communication process response times and accuracy of information often suffers (Mory 1994). Mory (1994) considers that in a strongly hierarchical organisation, those higher up do not have time to check work performed by those below. Therefore the senior managers must have robust strategies and arrangements in place to 'listen and learn'.

Staff clearly play an important role in the communication processes and can also act as an obstacle to information transmission. The most common form of human communication is verbal, but this often gets distorted as it passes between people or as it rises through the hierarchy (Vincent and Barker 2005). Vincent and Barker (2005) comment that supervisors can be the worst culprit in blocking information flow. They are often well aware of the problems but can be reluctant to pass this vital information on as they feel it makes them look bad. To compound this they may even 'sugar coat' problems or hide them completely to protect their reputation, they

therefore rely on written reports as a main form of communication as this would limit any discussion. Clearly the organisational culture has an effect on how information flows and one key factor in blocking information is the fear of reprisal by senior management (Mory 1994). In addition, if staff are so busy at their work they will not have the time to communicate. This will subsequently lead to errors and poor reporting of problems and incidents. Engaging with the nursing workforce is important if the nurse leaders are to understand the issues at the front line. It is therefore important that nurses' voices are valued especially those at the bed side (Faugier and Woolnough 2002). Without this confidence that they are being listened to, the nurses feel powerless and perceive themselves as inferior to other professionals. Faugier and Woolnough (2002) suggest that if we do value nurses' voices, nurse leaders need to engage in active listening to their staff. By 'walking the job' nurses views and concerns are valued, acted on and foster an open environment for on-going dialogue.

To overcome these problems and blockages of communication in the health service, specific action needs to be taken. Evidence of top level commitment to effective communication is essential (Jackson 1998). This commitment needs to be visible to the staff and is best demonstrated through regular 'walk-abouts', this enhances communication by having face-to-face contact, the ability to interact with senior management and to ensure the staff feel involved (Filochowski 2004 ii). Staff and management need an open and honest relationship with regular communication, which is of a type that is both acceptable and easily understood by the staff at all levels. This should not just be one-off, but it should be on-going to ensure organisational objectives are attained (Jackson 1998). Filochowski (2004 ii) also encourages senior managers to turn up even when not invited so they can find out what the real issues are. Senior Managers in the health service should talk frankly to every level of staff and service users, so they can learn how the organisation is performing in delivering care. Such frank discussions can often reveal where real problems are in an organisation (Vincent and Barker 2005). This is summed up by Filochowski (2004 i) when he suggests that communication should be honest, transparent and consistent from one day to the next.

Staffing

The healthcare team has to have the correct number of staff with appropriate training and skills (Filochowski 2004 i). The start of this process is having systems in place

that plan for the correct workforce to meet the service needs. Filochowski (2004 i) suggests that a high performing NHS organisation should have a ward-by-ward analysis of its staffing requirements with periodic adjustments to staffing establishments to meet demands and needs of the patients. It is important to be sensitive and responsive to service need. Procter (2000) suggests that despite the large number of nurses in the NHS, organisations are still unable to effectively calculate the number of nurses needed to provide the care services.

The number of nurses available on a ward or unit to deliver quality care is important (Journal of Nursing Management Editorial 2005, Faugier and Woolnough 2002, Marriner Tomey 2008, Rafferty et al 2007). Staff who are overworked due to inadequate staffing levels provide poor patient care (Yourstone and Smith 2002). This is not only due to not having enough staff on wards or units, but is often caused by poor nurse scheduling systems. Middle managers are often to blame for not introducing such systems, but also for not monitoring the staffing situation and the resultant quality of care provided (Yourstone and Smith 2002, Filochowski (2004 i).

The nursing staff, their numbers and their education are undoubtedly factors in the delivery of a high quality nursing service (Journal of Nursing Management editorial 2005, Urdon and Monarch 2002, Faugier and Woolnough 2002, Rafferty et al 2007, Klein 2006). When things went wrong at the Royal United Hospital in Bath (Healthcare Commission 2004), it was reported that staff considered there was a serious disconnection between senior management and the rest of the organisation. This led to a lack of focus on the needs of the nursing workforce, which impacted badly on recruitment and retention and therefore ultimately on patient care (Faugier and Woolnough 2002, McClure et al 1983). It is documented that wards with a good reputation have relatively high staffing levels (Hawley et al 1995).

High performing healthcare organisations give priority to the recruitment and retention of staff, as was described in the Magnet hospital work, with an emphasis on training and education (Mannion et al 2005, Scally and Donaldson 1998, McClure et al 1983). The valuing of staff and letting them know they are valued is frequently over-looked, since supported and valued staff are more effective in their practice (Scally and Donaldon 1998). In low performing organisations they have Human Resource policies, but these are ignored or even under developed with staff having a low priority in the organisation's business. Human Resource policies also have a place in delivering a high quality nursing service (Robinson 1991). Nurses should be recruited using robust processes and they should have a good induction programme

with periodic reviews of performance and the development of an education plan (Journal of Nursing Management Editorial 2005, Urden and Monarch 2002). The ability for staff to progress, with training in place to support succession planning is also essential for an organisation to succeed (Jackson 1998). In low performing organisations staff are underdeveloped, particularly the middle managers, with there being a shortage of resources for training and development (Mannion et al 2005). Also for an organisation to be effective, staff should have clearly defined spheres of responsibility with clear lines of reporting. In poor performing health organisations there are confused and fragmented systems of accountability (Filochowski 2004ii).

Not only is there the need for the right number of nurses, but the nurses must have the skills for the job (Black 2005). Therefore there is the need to invest in developing the skills and expertise of the nursing workforce, so they are educated and developed to provide high quality care (Burdett Trust 2006). It is essential that the nursing resource is optimised (Marriner Tomey 2008), as well as having the opportunity to have role models demonstrating acceptable professional behaviours (Aiken and Patrician 2000).

Service Quality and Outcomes

It was interesting to note that in this review of the literature the issue of service quality and patient outcomes receive less attention than the other areas identified. There are discussions by Yourstone and Smith (2002) and Young et al (1997) regarding the value of having clinical guidelines, policies and the development of care pathways. They comment that these should not be seen as a constraint on practice, but if implemented appropriately will enhance the standards of care and the performance of the organisation. In fact high performing surgical services used a large number of care pathways to guide practice and set standards of care expected (Young et al 1997). They were not viewed as hard and fast rules, but rather as recommendations for care delivery. It was considered that there is a need to guide nursing practice with evidence based policies and procedures to ensure it is effective and delivers good outcomes for the patient (Jooste 2004, Robinson 1991). These should have been developed and implemented with the full involvement of the nursing staff (Omen et al 2008). This discussion therefore implies that the use of documented guidance for clinical staff can be of benefit in assuring consistent quality of care and can be used to empower rather than to control.

Errors in health care systems are unacceptable (Yourstone and Smith 2002) and to prevent these there needs to be good system design and management to avoid errors. This has to be supported with systems of open reporting of errors, without blame so that lessons can be learnt and errors not repeated (Dixon-Woods 2010). Without this approach being embedded in the organisation then the chance of the clinical services failing will increase.

The purpose of a high performing nursing service has to be the delivery of good quality patient care with patients feeling they have had a good experience of the nursing service with positive health outcomes. It has been suggested that nurses at all levels were prepared to make judgements upon the quality of care and the organisation of the wards (Hawley et al 1995). But what is the crucial contribution nurses make to the delivery of patient care? As Allen (2007) and Latimer (2000) suggest the nurse has a key, if not crucial role, in the provision of high quality and safe care to the patients. The nurse is the organiser of bundles of direct patient care, as well as organising services to support care and orchestrate the contribution of others in the healthcare team, so ensuring the correct care is delivered at the right time and place. When the nurse fails in this fundamental role as the organiser of the patient's pathway of care, it could be considered to be a key reason for the failure of the nursing service. It is bringing all the components of the nursing service together that makes it either effective or a disaster. The Senior Nurses have a role in articulating to front line staff the expected standards of practice and what happens if these are not achieved. There should be a continual focus on service improvement with the elimination of malpractice (Faugier and Woolnough 2002).

To enable the nursing staff at all levels to assess the quality of care and delivery of the service, specific quality measures should be set. These measures should articulate what is expected at each stage of the patient care pathway (Burdett Trust 2006), as without these how will the nurses know if they are delivering good quality care? To support this there have to be good information systems and robust data collection.

Information and Monitoring

For an organisation to have assurance that they are performing to the expected standards and delivering health services as expected, there have to be systems in

place for data collection, analysis and information reporting. This needs to be supported by the formulation of a strategy for sound information management, which is timely (Jackson 1998). In high performing organisations sophisticated information systems which support performance management had been developed (Mannion et al 2005). Poor NHS organisations have inadequate systems to ensure targets are obtained. They tend to have chaotic processes and very little monitoring of what is being achieved (Filochowski (2004 i).

One specific area identified was that of having clear expectations of performance (Mannion et al 2005). These expectations are detailed through performance objectives and the corporate business plan agreed by the Board (Jackson 1998). But how does the Board know it is delivering its business plan and objectives? It was identified that good leaders have access to robust monitoring information (Mannion 2005) and sound data to make decisions (Scally and Donaldson 1998). This use of management information should provide an early warning of things going wrong in the organisation. McDaniel (1997) suggests that Healthcare bodies have a primary responsibility to detect, assess and correct system errors. By doing this they have systematic order and so reduce errors and this then instils predictability in an otherwise chaotic setting. This reinforces the views of the Audit Commission (2006) that the organisation, through its Board, needs sound governance, both financial and corporate as well as learning from clinical failure and taking action to improve patient care if it is to be successful.

The Board and senior management need to set the performance targets and ensure the staff are held accountable for achieving them (Mannion et al 2005). It is therefore critical that the correct information is collected and scrutinised (Filochowski (2004 i). The use of poor information can lead to a poor understanding of the organisational problems and incorrect action taken, whereas better information assists in perceiving what the real problems are, so they can be addressed in a timely way (Vincent and Barker 2005).

How information is presented to the Board is important if the information collected does its job. Often failing Boards have been provided with scant information (Healthcare Commission 2009) and therefore fail to address issues and make improvements. As the Audit Commission (2006) comments, failing organisations have weak information available to manage the organisation effectively. Information must be presented and discussed at the Board, so its members fully understand what

is happening to the patients and appropriately perform its role in monitoring and directing the 'Business of Caring' (Burdett Trust 2006).

Conclusion

Much has been written both by experienced NHS managers, academics and nurses on why healthcare organisations and the nursing service succeeds or fails. They have also explained what specific actions can be taken to ensure an organisation and its nursing service provides high quality care. Since there seems to be considerable information on what factors need to be in place for a high quality nursing service, the reader may ask why undertake the study?

Despite all the evidence available to nurses and particularly nurse leaders, today we still see nursing services fail and patients suffer and die. In the United Kingdom there is no definitive framework containing the factors that, if in place, can assist Senior Nurses to attain a quality nursing service delivering effective and safe care. The information available is fragmented and usually focuses in detail on one specific area e.g. communication (Faugier and Woolnough 2002), leadership (Jooste 2004) or staffing levels (Rafferty et al 2007). It fails to explore the interaction of these factors and what are the underlying conditions that led to these failures. In addition the influence of these factors on the organisation of care (Allen 2007) is missing.

The work that is nearest to the research study is that described by the accreditation process for Magnet Hospitals. It should be noted that this system was introduced nearly 30 years ago to improve recruitment and retention of nurses. It was not established to ensure a high performing nursing service though undoubtedly there is a link between these two factors. In the revised Magnet system the 14 key factors are aligned with the 5 components, in all the assessment process involves the examination of 65 standards. In a busy and chaotic NHS environment it would be too much to ask Senior Nurses to develop work against such a large number of standards. Therefore they are more likely to be receptive to fewer high level factors, which this study is intended to produce. There is also a greater chance of success if the factors have been identified by British Senior Nurses. They are more likely to own them and therefore use them. The environment in which the NHS operates is quite different to that in the USA and the British, not for profit arrangement, could

mean that UK nurses have different priorities than those in the US for identifying the key factors for a modern quality nursing service.

A common theme emerging from this literature is the need for empowerment of staff (Procter 2000, Filochowski 2004i). This was reinforced by the nursing literature which emphasised the need for empowerment at all levels of the nursing hierarchy (Manojlovich 2007, Schmieding 1993). This included nurses at the Board having their voices heard (Procter 2000, Burdett Trust 2006), as well as being involved in decision-making and able to communicate key issues regarding the nursing service and patient care to the Board. Furthermore, the nurses at ward level should be empowered to have control over the environment of care, how care is delivered and who delivers it to the patient (Page 2004). The nursing literature did not explore this issue of power further, but rather it was linked more to the status of the profession (Styles 1982, Hall 1982). There was no explicit reference on how empowering nurses may have implications on the delivery of the service and its subsequent failure or success. The non-nursing literature did briefly identify this as an issue but it was not explored in sufficient detail. The culture and ethos of the organisation has been linked to the quality and safety of care (Clarke et al 2002) and has a direct effect on whether or not staff are empowered. This culture accounts for a significant proportion of the variability in service quality and improvement (Boan and Funderburk 2003). It is of interest for the research to explore with the participants their views on empowerment. Whether they feel they are in control or are suffering oppression / repression in today's health service. Also how they feel this impacts on the nursing service and the care delivered to the patients.

A further conclusion that can be drawn from the review of literature was that the various studies focused on one or a few key factors. The literature failed to acknowledge the impact of the combination of factors and their interrelationship, which can also have an influence on the success or failure of the nursing service.

Chapter 3
Methodology

Introduction

This chapter details the research processes undertaken to investigate what positive actions could be taken to prevent failure in the nursing service. Also with the aim of identifying the key factors that need to be in place if it is to be high performing and deliver quality, safe care. The research sought to examine the conditions for success or failure in the context of the real life situation in the NHS today. Its aim was to explore nurses' perspectives, perceptions and experience on how a nursing service can be successful and identify key aspects of a 'quality nursing service'. In order to address these aims and 'get inside' (Latimer 2003) the issues from the perspectives of nurses at the front line of service organisations and management, a theoretical framework mixed methodology was used for the research. By using an inductive qualitative research method this allowed the researcher via semi-structured interviews to obtain the in-depth views and experiences of the Senior Nurses delivering the nursing service. This was further supported by a thematic analysis of the results and prioritisation of these themes using a questionnaire which was analysed using a quantitative technique, together these were used to form the Senior Nurses Framework. The use of case study analysis at the beginning of the research provided a sound basis of data about the research topic before progressing with the semi-structured interviews. It further supported the approach in sorting the data in to themes and sub-themes as discussed in the analysis of results.

Critical Nursing Science

The basis of many qualitative research studies (Reason 1998, Whyte 1991) involves listening to and recording the voices of the participants (Bryman 2004), it was important for the study to be of value that the voices and experiences of the Senior Nurses were heard. In many of the inquiry reports and in the literature (Nord and Jermier 1992) it was reported that the voices and experiences of the people involved in having a key role in managing the services were not listened to due to the dominance of a few. The researcher for the study was determined that through the semi-structured interviews and questionnaires, the voices of the Senior Nurses were heard and their experiences and views recorded.

Commentators on research methods used in nursing such as Leiningers (1985), focus their discussions on qualitative and quantitative being distinct approaches each

having their place in the research methodology but not being used together in the one research study. The researcher for the study considered that this approach would limit the findings and not provide the depth of discovery necessary for this to be a meaningful research activity. It was considered that not only was there the need to listen to the Senior Nurses' voices through the semi-structured interviews, but also in order to achieve the objective of identifying if some of the factors identified had more importance, there was the necessity to apply a form of quantitative research to assess prioritisation. Harding (1989) considered that there are three methods used for undertaking research; listening to participants, observation and examining records. Each of these could lead to the use of either qualitative or quantitative research methods, but this is a simplistic approach and it was considered that the research required a more integrated approach to using these methods where numbers and narrative co-exist to produce a richer analysis and more profound results.

As a result of the above requirements, it was considered that a Critical Nursing Science (CNS) theoretical framework using a mixed-methods approach (Berman et al 1998) would most appropriately deliver a robust methodology for the research. The researcher not only wanted to collect data as the sole output from the thesis, but the aim was to identify factors of a successful nursing service that can assist the Senior Nurses who participated in the study, to deliver high quality services to patients. Researchers, who use a critical paradigm such as that of CNS for their research methods, are not just interested in the results of their research but also how the data collected can be used to bring about social change (Berman et al 1998). Therefore by the analysis of the results acquired through a combination of the use of qualitative and quantitative methods and the statistical and illustrative results they produce together, a persuasive argument for the development of the Senior Nurses Framework is made.

Research Design: Methods

There were three stages to the research with the approach taken having each stage of the study influencing each other, for example the case study information helped to validate and quality assure the results of the semi-structures interviews and questionnaire. The first stage involved the analysis of secondary qualitative information, in the form of inquiry reports, which provided rich information regarding factors that led to a poor nursing service. This stage informed the design of some of the questions for the semi-structured interviews and the questionnaire. Stages 2 and

3 formed the primary data collection, including semi-structured interviews and questionnaires. The information obtained from semi-structured interviews informed the development of the questionnaire which in turn acted as a form of validation of the information obtained from the semi-structured interviews (Hammersley and Atkinson 1995). In using semi-structured interviews as a method, there was the opportunity for the researcher to get more engaged with participants and so obtain a greater amount of information but this was at the risk of becoming too involved and influencing the responses. Therefore an explicit approach to familiarity was identified and the use of reflexive practice employed. The benefit of this semi-structured interview approach was that it is simple to use and provided rich information on issues and views of nurses at the frontline of organisation and management, which was key to the progress of the study. Further, using the CNS approach, the questions allowed the nurses to explore and critique their own views, experiences and perceptions of the nursing service and the organisation it is located in. The matter of giving the Senior Nurses a voice was important for the study, with the revelation that they considered that the lack of personal power being a key reason why their views were often over looked. This was such a significant issue for the research that the researcher explored the aspects and effects of power on the nurses and the delivery of the service further in Chapter 7 – Professional debate.

Participation

Fundamental to the research was the participation of Senior Nurses in Wales, whereby through their experiences they have developed opinions, views and personal perspectives and using a critical nursing science approach, (Denzin and Lincoln 2005; Bryman 2004) there can be a greater understanding of what could be done in practice to prevent failures happening in the nursing service. The end-point of this work is for these nurses to take forward the findings and recommendations of the study to bring about change in their own working environment.

Undoubtedly the study involves a collaborative approach between the researcher and the participants. The participants needed to be open with their comments and self-critical of their own working practices and explain how the nursing service currently operates (Denzin and Lincoln 2005; Koch and Kralik 2006), for the study to be of value to them in the future. Through the process of interviews and then the questionnaires, participants were able to objectify their own lived experiences so their

voices and experiences are heard in a safe environment of anonymity. There was a common goal for all involved of improving services to patients.

This process of participation (Smith et al 1997) started small, with interviewing nine Senior Nurses, so that in the early stages the research processes can be managed due to the unknown nature of the participants' reactions to the study and the nature of their comments. It then expanded to a wider audience with the use of the questionnaire. This ensured full involvement of all those affected by and involved in this area of work, and who can influence any action that could be taken as a result of the findings of this research (Denzin and Lincoln 2005; Koch and Kralik 2006)

Secondary Data Analysis

Review of Documentary Evidence
Secondary data sources, such as Health Care Commission, Healthcare Inspectorate Wales reviews and Audit Commission reports on health service quality failings, were considered for their relevance to the research and the provision of background information and case studies.
The use of case studies was designed to provide a basis for the other stages of the research process. It provided data and an understanding of other's findings in this area of study and information that would be used throughout the research stages to ensure reliability in the findings and validity of the final conclusions. The results of the analysis would provide a basis for comparison between all three research stages. A thematic approach was taken to the analysis of the findings from the case study reports to provide a clear understanding of the main factors involved in these services failing.

Case Studies
Following the examination of the above documents, specific case studies were identified where there had been an organisational level systems failure in the National Health Service (NHS). These failures directly involved the Nursing and Midwifery services and in several cases resulted in the dismissal of the Nurse Director and other Senior Nurses in the organisation.

The focus in undertaking a review of these case studies was to identify what were the 'root causes' that led to the failure in the delivery of the nursing service. The analysis

of the case studies was time consuming but provided objective evidence on what made a bad nursing service. This differed from the remainder of the research which, through the interview and questionnaires relied on more subjective information.

A total of fourteen case study reports spanning a time period from 2000 through to a more recent report into deaths at Mid-Staffordshire NHS Trust in 2009 (Health Care Commission) were analysed. Each report was read and the content of each was analysed (Graneheim and Lundman 2004) and through this process areas or themes of failure were identified and the frequency of each type of failure was recorded. This same process was repeated for all fourteen reports. The content areas from the case studies were clustered into three overarching themes. From this, each heading was further analysed for specific factors. The heading of **Leadership** had 7 key factors**; Staff management and HR processes** had 6 key factors and **Communication and Information** had 7 key factors identified. Each case study was read and the incidence of each of these factors was recorded and frequency charts produced (see pages 66 - 71) showing how often these factors occurred in the cases studied of failing nursing services.

Options of how best to analyse the case studies were discussed with the researcher's supervisors and it was considered that the method of analysis of the case studies should be based on achieving the purpose of this stage of the study. The purpose of the case study stage was to provide an awareness and introduction for the researcher to the subject matter to be considered. A further purpose of this stage was to provide information and data which could be used by the next two stages in the research process as a means of providing dependability of the results. The method of quantitative thematic analysis was considered to be the most appropriate approach to meet this objective, as it would provide objective information regarding not only the factors that could lead to errors but also which of these factors most frequently occurred. This would therefore provide an indication as to which factors potentially could be the most important within the findings of the study.

The case studies looked at the negative aspects of the nursing service through failure or 'disasters'. The development of the semi-structured interview questions for the next stage of the research focused on both the positive and negative aspects of a good nursing service. The questions for the semi-structured interviews were therefore designed to encourage the participants to explore what they thought were the factors that would not only contribute to failure but also make a good nursing

service. It was considered to be important not to focus on the negative but rather encourage the Senior Nurses to identify what could be found in a successful service. By examining the case studies it not only provided further insight into the area being researched but would also be used during the analysis of the results as a cross reference to the findings from the semi-structured interviews and questionnaires.

Primary Data Collection

Ethical Considerations

The results of the research produced a framework that could be used by Senior Nurses to evaluate, benchmark and plan changes to their nursing service, so preventing failure. The results will also be available for use by NHS managers and could under the Freedom of Information Act be accessed by the public and therefore must be seen to be robust and credible.

The study has been designed to limit the ethical implications, as it only used as its participants senior nursing staff. It was not the intention to involve patients and members of the public in the research. As such it did not breach patient confidentiality. The confidentiality of the staff must though be recognised and written assurances were given and consent forms have been signed (Appendix 2). All participants were provided with an information sheet (Appendix 2) and assurance given that the comments made by them, either verbally or in writing, would in no way be attributed to them, or recognised from the text of the document.

All Senior Nurses approached to participate in the research, agreed to take part and at the conclusion of the interviews were keen to know how their interview results; compared with the findings in the case studies. This was provided as a way of providing them with a 'reward'- reciprocity. As suggested by Oppenheim (1992) most interviewees found their involvement very interesting but generally there is little in the process of benefit to them. By providing feedback it was hoped that the participants gained something from the experience.

To ensure the research complies with the requirements of the University and the National Health Service (NHS), the study proposal with supporting information was approved by the NHS Ethics Committee (MREC). (Appendix 1)

Semi-Structured Interviews

We live in an 'interview society' (Atkinson and Silverman 1997, Holstein and Gubrium 2003), one where members believe that interviews generate useful information about lived experience and their meaning. Therefore in the current context the researcher wanted to hear the voices and gain an understanding of the Senior Nurses' ideas, views, experiences and perspectives, as well as what they thought were the solutions to improving a failing nursing service. Through a critical nursing science approach (Berman et al 1998), the semi-structured interviews assisted the participants in telling their stories of the nursing service as a primary source of data. Many participants found the process empowering, as it was the first opportunity for them to express their feelings and views and be listened too. It allowed for the maximum involvement of the stakeholders, gaining awareness of their situation and an understanding of the barriers they face in bringing about change (Berman et al 1998).

The Semi-Structured Interview Schedule

It was decided that the most appropriate method for collecting data for the research would be the use of semi-structured interviews. With a semi-structured interview the researcher prepared a list (schedule) of questions to be covered at the interview (Appendix 4). The semi-structured method gave the interviewer the ability to allow the interviewee flexibility on how they wished to reply (Lofland and Lofland 1995). Therefore through the process the questions were modified and adapted to the responses provided. Modification was limited to small variations of the wording of the questions but all participants were asked the questions in the same order, so a similar approach was taken to all interviewees to ensure consistency. Questions were developed using an approach which would obtain information about the participant's beliefs, motivations and desires, as well as using other approaches to obtain their views and opinions. This ensured that the main questions facing the nursing service were answered (Sandelowski 2003

In preparing the questions the approach taken was based on that suggested by Lofland and Lofland (1995), here they proposed that the researcher ask themselves 'Just what about this thing is puzzling me?' The questions were also designed to ensure that they were not so specific so that alternative avenues of enquiry that might arise were not closed off (Bryman 2004). They were also written to ensure that all necessary areas were covered and that they could be understood by the interviewee. The researcher wanted a real world perspective and the Senior Nurses

used in the study were a source of understanding and knowledge. Two academic supervisors acted as a sounding board to test out the questions. Modifications were subsequently made to ensure there was a flow to the questioning and that the participants could understand the logic behind the progression from one question to another. The usual problems of leading questions, difficult language and questions too long for the interviewee to remember were all considered in designing the final interview schedule (Marshall and Rossman 1999).

It was important that the interview questions were designed in such a way that they acted to achieve the objectives described in chapter 1. The objective ' to identify what positive actions could be taken to prevent such failures in the future' was addressed through question 4; 'From a Senior Nurses point of view what do you think needs to be in place for the delivery of a quality nursing service?' The objective 'To identify key factors for a successful nursing service and ascertain if these factors have equal weighting' were explored through questions 3 and 5. The objective 'To explore nursing service failures from a service level perspective' was discussed in questions 7, 8 and 9 in part 2 of the interview schedule.

The introduction to the interview process used a CNS approach in that the explanation provided to the interviewees regarding their reason for participating in the interviews was not purely for the satisfaction of the researcher and the preparation of the thesis, but rather was to generate new knowledge that was for the benefit of the nursing profession and in particular Senior Nurses leading the service (see objectives in Chapter 1). From a critical perspective it was recognised that the interviews would be value laden and that the responses would be shaped by the individual's perspectives and experience of being a nurse and working in the health service. It was proposed that these value-based responses would further have an influence on the analysis of results but more importantly be revealed through the discussion process in Chapter 7.

The interview questions (Appendix 4) commenced with one that was broad and open to allow the interviewee to relax and open up in their discourse (Denzin and Lincoln 2005). As the questions progressed they became more focused and asked the participants to actually make a decision regarding what were their top, most important factors in a high performing nursing service.

Prior to undertaking the interviews a pilot was undertaken with two participants. Following the pilot a few small changes were made to the interview schedule, but otherwise the process was considered to be fit for purpose. It was acknowledged by

the researcher that reflexivity would be required throughout the interview process to ensure the questions obtained the true, unbiased views of the participants and that the researcher did not influence the interview process.

Sampling

The sample consisted of 1 Local Health Broad (LHB) and 1 NHS Trust Nurse Director, 2 Deputy Directors of Nursing, 2 Senior Nurses working for the Government, 1 Nurse Director from the voluntary sector, as well as 2 Nurse Consultants. The total sample was comprised of 9 senior experienced nurses (n=9). As Oppenheim (1992) suggests, there is no correct number of interviews, but rather quality is more important than quantity. The choice with the research was based on the need to have a good cross-section of experienced Senior Nurses involved in the study.

The research took the 'Élite' interviewing approach (Marshall and Rossman 1999), a method of interviewing that focuses on a specific type of interviewee. Élite individuals are those that it is considered are influential, prominent and well informed in their particular field of work or their organisation (Marshall and Rossman 1999). Due to this approach the sample was limited and the participants clearly identified by the title of the role they undertook in the health service. The sample was only to include these élite individuals who had the title of Nurse Director, Deputy Nurse Director, Nurse Consultant or Nursing Officer. It was considered that the knowledge and experience of these individuals was required if the research was to have validity within the nursing profession. These élite individuals were able to provide valuable information because of their position in their profession. They bought a wide perspective and contributed insight and meaning to the research. They were also in a position to understand the value of the research activity and therefore more willing to participate as there may be benefits for them in the findings.

There are disadvantages of these élite people being involved in interviews. They can be difficult to access to arrange appointments for the interview due to their workload and other commitments. Fortunately this was not the case, as the researcher was also in a senior position and they were willing to set time aside for this work. For some people the interviewer had already been an interviewee in their own research, so there was a reciprocal arrangement.

A further disadvantage of using this sample of individuals was that as they are used to being in-charge, they may have a tendency to take-over and lead the interview.

They also might respond to questions based on the beliefs and values of the culture of the organisation they work in, rather than what they really believe (Giddins 1984). Despite this, these mixed views from the participants gave a meaningful perspective. The choice of individuals involved in this study was done by self-selection. Nurses working in the above categories were e-mailed to see if they were interested in participating in the research. Within two days sufficient responses had been received from individuals to fill the sample size required for this part of the study. Recruitment of these individuals was relatively easy having explained to them the reason for the research. All appeared to be keen to get involved in a project which looked at how to stop things going wrong with the nursing service. Also what in their professional lives they could do to ensure they were in charge of a high performing Nursing Service.

Undertaking the interviews in the summer and when it was relatively quiet was of help. The cross-section of recruits for the interviews was deliberate to ensure the views of Senior Nurses working in the different fields of nursing could be considered; therefore we had nurses working at Director, Deputy Director and Nurse Consultant level. Their backgrounds ranged from mental health, midwifery, acute and community nursing. Their current organisations included NHS Trusts, Primary Care organisations, Advisory and Voluntary Sector bodies.

In all cases the interviews flowed well, on a few occasions the questions needed explanation for clarity, but this did not affect the process or responses. The questions (Appendix 4) progressed from very broad focussing on first impressions to finally getting the interviewee to describe a 'failure' situation they had been involved in.

Semi-Structured Interview Method

As described by Kahn and Cannell (1957) these semi-structured interviews were conversations with a purpose. The semi-structured interview questions developed from the findings from the 'case studies', provided a rich source of information from experienced nurses. It gave their perspective on the areas they considered were the key factors that contribute to a quality nursing service. It was important to understand their perspective if the final conclusions of the study were to be accepted by nursing peers as realistic and of use in their work.

The Researcher was keen to undertake these in-depth semi-structured interviews which are grounded in the tradition of qualitative research and the way we understand these experiences in developing a view (Bryman 2004). Through this

approach it was possible to describe the meaning of a concept or phenomenon that several individuals shared and described through their responses to the questions (Marshall and Rossman 1999). Since these semi-structured interviews were a conversation, it was important that the researcher was not only clear in their questioning, but particularly good at listening (Denzin and Lincoln 2005). The interviewer was assisted in their listening by the use of a Dictaphone to record the responses to the questions.

All interviewees were asked where they wished to be interviewed. They were offered the opportunity to be interviewed at their place of work to save them time in travelling. The majority of participants opted to be interviewed at their place of work. One was interviewed at the researcher's place of work in a quiet meeting room. Two others chose to be interviewed at a neutral premises away from their work, as they were concerned at being interrupted during the interview. It was emphasised to those that chose their place of work that it was important that the interviews were not interrupted, so they all arranged for calls to be diverted and that a sign was placed on the door to prevent disturbance. It was considered to be important if the interview was to be a valuable exchange of views and information that the environment should be private, quiet and comfortable (Oppenheim 1992). This was promoted by offering the interviewee a cup of tea and the researcher took biscuits, which acted as an ice-breaker at the start of the interview process.

The participants were asked if they were agreeable to being recorded and all agreed, it was also explained that notes would be taken (Spradley 1989). They were all provided with an information sheet prior to the interview and signed a consent form (Appendix 2) before the interview commenced.

The interview started with a broad question

"Can you tell me about your experience of visiting a hospital; how would you judge what the hospital is like?"

This worked well in getting the participants to express their views, as they clearly developed confidence when answering this question and some spoke rather too much and had to be re-focused on the question. It set the scene for the rest of the interview and clearly relaxed the participants.

To ensure the interviewer did not get involved in the responses an approach was taken which involved reading the question and then leaving a silence for the response. The second participant had difficulty in understanding a question, so it was repeated. The individual then repeated the question back and re-phrased it for clarity. This was obviously easier to understand so this question was slightly re-worded for future interviews and worked well in getting appropriate answers. As the interview questions progressed they became more focused, so that responses would give specific answers to the research questions. They were undoubtedly more directive, but to prevent bias the interviewees were given different options to consider e.g. "Do you think a nursing strategy is of use? Or do you feel it has little benefit?"

When the participants were directly asked to identify their top key factors it was surprising how quickly and spontaneously they responded. None of them had to think about their response, which gave the researcher confidence that these really were the most important factors to them. The participants did find it harder to answer the questions on their experience of 'failure'. Several individuals were unable to answer the final question as they claimed that they had not personally been involved in a service failure and they were generally relieved that this was the case. Some did give very frank and honest accounts of when things had gone wrong and showed that they had learnt from these mistakes.

The interviews took on average 2 hours and both the researcher and participants did on a few occasions lose track of the response. This was addressed by reading back to the interviewee their previous responses to refresh their memory. Some questions had short responses, but these were expanded by asking supplementary questions or a non-directive probe such as "could you explain further" as suggested by Bryman (2004).
The interview concluded by asking if they wished to add anything further. The majority of participants wanted to know if their responses were similar to others and to the case studies. It was considered by the researcher that to provide feedback was a form of reciprocity and reward to the participant and that this would not have a detrimental effect on the research findings, as this would not influence the results from other interviews or the questionnaire results. When the interview concluded there was often informal discussion afterwards that did add further richness to the information obtained by the interview. Therefore as recommended by Bryman (2004) the tape machine was left on to capture extra narrative for the results of the research.

Documentation

Undertaking interviews are a good way of collecting large amounts of information (Marshall and Rossman 1999). The problem with this is the management of the information during the interview, so that it is understandable when it comes to transcribing and analysing the results.

It was decided that to ensure all the information was collected, that the researcher correctly interpreted what was being said, and that what was said could be thoroughly examined, that both notes of the interview and the tape recordings would be used. (Bryman 2004).

All participants were agreeable for their interviews to be recorded. It was found to be very helpful to both the researcher and interviewee to periodically go back over the responses and repeat the answers back. This allowed for clarification of their responses and also refreshed their memory of what they had said and provoked them to provide further information.

The note taking could be distracting when the interviewer was asking the questions, listening to the answers at the same time as writing the responses. This required considerable concentration and the advice given by Lofland (1971) to write down everything you can was helpful when it came to transcribing the tape, as some people did not speak too clearly at times and the notes helped to clarify their comments.

The researcher decided to undertake the transcribing herself, so that she could at the same time fully understand what was being said and start to formulate views of what the research findings could be. The themes started to come through quite clearly during the transcribing. The notes were considered alongside the tape recording and it was found that both reinforced one another and provided greater information. This was a time consuming exercise but was worthwhile when it came to the final analysis.

The volume of information to be analysed was quite considerable. The advice given by Lofland and Lofland (1995) to analyse as you go along and not to leave it until the end was followed, this meant that the workload was spread throughout the process. It also made it interesting to see the results at an early stage and encouraged the researcher to carry on with the study.

Analysis of the Semi-Structured Interviews

These semi-structured interviews formed a key part of the research for the study, it was therefore important to use a method which identified the main themes from the interviews, without losing the 'richness' of the information provided by the participants. It was noted that some processes over simplified the identification of themes, which introduced the risk of excluding some dimensions and interpretations (Ayers and Poirier 2003). Consideration was also given to different information technology (IT) methods such as 'ATLAS'.

During the exploration of different analysis methods a description of an interview analysis was found on 'Economic and Social Data Service 'ESDS website; ESDS qualidata online.

(www.esds.ac.uk/qualidata/data/evaluations/themes.asp). Here it describes a 'cut and paste' approach, which provided the most appropriate method for the interview data. It was also a very simple and easy method to use.

From reading the transcriptions of the interviews certain themes emerged. By over-reading the transcripts more detail showed and sub-themes became evident. It was important for the researcher to find and show the themes, but not to over interpret them as this may introduce meanings that were not intended (Ayers and Poirier 2003). For each theme a new 'Microsoft Word' document was opened. Then each transcript in turn was also opened on the computer as a word document. The transcript was then read and relevant sections highlighted and copied into the relevant themed document.

This process was undertaken for each of the 9 interviews and at the end of the process six 'theme' documents had been produced. From this the themes were examined further too fully understand their meaning and views on the subject being studied. A detailed analysis of the themes, by re-reading the notes and looking for patterns in the responses (Smith and Osborn 2003) was undertaken, which provided a focus on the lived experiences of the participants by attempting to make sense of the meaning of events and experiences the participants described. This interpretive approach allowed the researcher to empathise and identify with the respondents' comments. This being useful for the researcher as both her and the participants come from the same professional nursing background. This approach was very appropriate for a semi-structured interview as it used flexibility, providing the opportunity to reflect on the responses. Finally descriptions of the key factors that

make a high quality nursing service were identified from the interview themes. This process of looking for patterns in the interviews of the participants, which becomes more apparent as you read the interview notes, is described by Guba (1978). He explains how this process reveals the salient grounded categories of meaning held by participants.

The Questionnaire

The next stage in the research process involved the use of a questionnaire, which helped ensure the researcher's independence and allowed the participants to provide their views freely, which could have been perceived as a possible problem with the interviews (Oppenheim 1992). The questionnaire (Appendix 5) was designed to be clear to understand and straightforward to complete, requiring a minimum of responses so it could be completed in a short period of time. It was intended that this approach should encourage a greater response rate.

The questionnaire was designed to achieve the research objective 'To identify key factors for a successful nursing service and ascertain whether these factors are of equal weighting or whether some are more important than others.' To achieve this objective a total of three pilot questionnaires were produced to test the validity and reliability of the questionnaire and method of data analysis. These were each distributed to the 9 interviewees in stage 1 who were asked to test them for usability. Prior to commencing the design of the questionnaire the 9 individuals were asked to provide a view on the questionnaire methodology. It had been the intention of the researcher to use the Delphi technique for this part of the research process as it was a proven method for undertaking prioritisation to reach a consensus (Keeney et al 2000). The senior nurses had recently been involved in a national study which had also used the Delphi technique and strongly advised that it took too much of their time to complete the process, particularly as it involved repeated questionnaire completion. Their opinion was that should this approach be used there was likely to result in a poor response rate. Since it was considered to be important to have a large response rate to ensure reliability in the findings, it was decided to seek an alternate method.

The first two pilots used different Likert scale approaches requiring the participants to identify for each of the sub-themes contained within the six overarching themes, a place on a scale. The first scale asked them to indicate the degree of importance. The results of this did not achieve the prioritisation required as generally the

participants chose important for the majority, without differentiating between the sub-themes and so prioritisation was not achieved.

The second pilot used a numerical Likert scale with scores from 1 (not important) to 10 (most important). This did create a wider differentiation between sub-themes, but due to the large number of sub-themes, some sections containing up to 7 items to score, the analysis of the data became too complicated and the results inconclusive. Advice was sought from a member of university staff regarding the most appropriate questionnaire design to use to achieve the required research objective. Following this a questionnaire was designed using a ranking method. In choosing this approach it was recognised by the researcher that this could have drawbacks but that it would provide the greatest opportunity for prioritisation of the sub-themes, with each item having equal value. This then allowed the identification of the prioritized sub-themes that should be included in the final Senior Nurses Framework.

Ranking questions in general can be harder to complete for the participant as they require greater thought and therefore take a longer time for completion, resulting in a lower response rate. It was considered by the researcher that since the subject area was of important to the élite participants; it was more likely that they would be willing to spend time completing the questionnaire. The method of ranking rather than using the Likert scale also helped to eliminate the risk of participants assigning the same score to all the sub-themes in a section and therefore not identifying priorities. Furthermore as the maximum number of ranks to be used was 7 (it is recommended that no more than 10 should be used to make the questionnaire manageable (Oppenheim 1992)), the data was relatively straightforward to analyse using an excel spread sheet. This also provided a method for keeping a log of responses. It was noted that statistical analysis was limited with the use of ranking and that mean values should not be used.

Overall the 9 participants in the pilots stated that they found the final questionnaire had clear instructions to complete and that the language used was easy to understand. They were also asked as a method of assessing the rigour and validity of the questionnaire, if they considered the themes represented their views from the interviews. None of the respondents made changes to the sub-themes.

Finally it has been identified (Oppenheim 1992) that people tend to rank the first few items in the list higher than others. This bias was checked for in the results and found not to be the case with the study. This indicated that the ranking by the Senior Nurses was a valid representation of their opinions regarding prioritisation.

The final questionnaire was subsequently distributed to the participants who were required to rank the statements included on the questionnaire form. Their responses were to be based on their professional opinion, with an aim of obtaining the views of a wider group of stakeholders. There was also a section for free text comments if the respondents wanted to clarify their responses. This provided some rich sources of information that reinforced the comments made by the interviewees.

The questionnaire was distributed to 65 (n= 65) named Senior Nurses across Wales, using the same categories of participants as had been used for the interviews. This purposeful sample (Oppenheim 1992) comprised all Senior Nurses in Wales in the following categories: NHS Trust Nurse Directors; Local Health Board Nurse Directors; Deputy Directors of Nursing; Nurse Consultants; Government Nursing Officers (Welsh). This was a very inclusive sample which it was felt provided sufficient responses for analysis. Each participant was asked to complete a short pro-forma identifying their position in the health service, so enabling an analysis of the response rates between the Senior Nursing groups identified. This would also allow the researcher to ascertain if there was a differential response rate for the different groups involved. An introductory letter was attached to the e-mail explaining the reason for the study. It was hoped that the personal approach would help to improve the response rate. The e-mail system was used rather than sending the questionnaire by post. This was done because it was quicker and more economical to send to a large group of participants. The participants were all familiar with using the e-mail system and it only involved them clicking on the reply button to send in their completed questionnaires. By doing this it was hoped that the response rate would be higher than using conventional methods. This proved to be correct, with the overall response rate being 63% (41 returned questionnaires).

The questionnaire was sent as an attachment, which was checked during the pilot to make sure it could be opened easily by the recipients using a variety of e-mail systems. In using the e-mail system it was recognised that the participants could be identified by their response address. Though the information provided was purely numerical, participants were given the option to print off their response and send it by post to the researcher, which would maintain their anonymity.

Quantitative Data Analysis

The questionnaire was developed from the themes and sub-themes that emerged inductively from the semi-structured interviews, so that participants could rank them regarding their importance to delivering the Nursing Service. These questionnaires were analysed using a spread-sheet to store the ranked data. Comments were further clustered into the identified themes. Through this process the key factors were prioritised. Another researcher was invited to cross-check the data and found the same themes. The prioritisation exercise was a robust method of validating the findings from the interviews along with the comments from the questionnaires and the results of the case study analysis (Oppenheim 1992).

Familiarity

Throughout the research there were two areas of familiarity that needed to be addressed in undertaking the research. These being, firstly personal familiarity with the interview participants and secondly the researchers cultural familiarity with the subject matter of nursing. Becker (1971) suggests that considerable effort and imagination is required if we are to see things differently from what we expect to see whilst undertaking our research.

Reliability and Validity of Qualitative Research

As mentioned before (p. 48) the use of case studies was one approach to an assurance process in achieving reliable and valid results in the study. The use of words such as reliable and valid in respect of qualitative research can by some be seen as misleading and inappropriate. Linclon and Guba (1985) use the word dependability rather than validity and other words such as trustworthiness and rigorous are often used instead of validity and reliability. Trustworthiness and rigourousness are only substitute words for reliability and validity and qualitative researchers have every right to use these words in their work as a demonstration of confidence in the robustness of their findings. Davies and Dodds (2002) suggest that the issue of validity can be adequately addressed in qualitative research by the use of reflexivity to limit bias and manage familiarity in the study.

Personal Familiarity

Fieldwork undertaken as part of qualitative research, particularly having a participatory research approach, has an intrinsically personal involvement. It is in fact

for some research legitimate for the researcher to write themselves into the research study (Scott 1997). The researcher will either consciously or unconsciously become personally involved with the people and culture in which the study takes place.

It can potentially be problematic if we do research in our own area, though it has to be recognised that it can be equally difficult if we stray into areas unfamiliar to us. An interesting example of the pros and cons of personal familiarity is shown in the study by Serrant-Green (2002). She describes a study in the 1990's of teenage mothers of black children. Here two researchers were involved, one black and one white. It was found that the white researcher was not accepted as well by the teenagers, as was the black colleague. The results the two researchers obtained from their interviews were quite different even though the questions used were the same. It was noticeable how the black researcher was invited to participate in activities and gained significantly more information by doing this. The white researcher had to negotiate entry into the community, whereas the black researcher had automatic access as she was seen as 'one of us'. A disadvantage of this was that the black researcher took much longer to do the work and went beyond the remit of the study.

Undoubtedly the researcher had personal familiarity with the Senior Nurses interviewed in this study, just as the black interviewer had in the above example. Agor (1980) called this problem 'indexicality', which refers to the shared knowledge and background of the researcher and the participants.
The researcher was a nurse, a member of their profession, an insider who knew and understood what it was like to be one of them. This personal familiarity produced great advantages in taking forward the research, allowing easy access to the participants. The interviewees already knew the researcher and so the process of engagement was straightforward. Arranging appointments was easy and their willingness to give up their time for the interviews ensured that the fieldwork was quicker to start and was completed in a shorter time period than anticipated. Like the example above the interviews themselves did take longer than anticipated as the participants felt able to fully participate in providing their views on the topic being investigated. This familiarity did have risks, in that it had potential for influencing the way the participants responded to the questions. They might have provided less detail as they assumed the researcher knew what they were talking about or even worse there was the potential for providing answers that they thought the researcher may wish to hear.

On a positive note this professional closeness helped the researcher to understand the nature of the non-verbal messages passed during the interaction. This would also apply to the language and phrases used, all being specific to the profession, so that only insiders would fully understand their meaning. As the researcher was seen to be 'one of us' the interviewees appeared to be very open and at times a little indiscreet in their responses. To alleviate concern the researcher reassured the participant of the agreement to confidentiality. The researcher early in the study found that she probed more with the questioning in areas of personal interest.

With these potential problems of personal familiarity and relationships with the participants, it was important that actions were taken to ensure bias was minimised. The interviewees needed to feel in control, that it was their professional opinions that were important and not that of the researcher. To aid this, the interviews took place in the participants own chosen environment. By the use of reflexivity following the interviews, the researcher ensured that they kept more closely to the script of the interview schedule. A focus on the research activity was essential to ensure that a true representation of their views was recorded. This was further protected by the use of the tape recorder so that their unbiased voices were heard through transcription. The researcher undertook the transcription so that she could have a greater understanding of what and how areas were being discussed by the participants, providing further insight into their views and experiences, which were not evident during the actual interview process. In these interviews the ability of the researcher to listen and not to talk was essential. Through listening and accurate recording of the interviews, the true, unbiased views of the participants could be heard.

This did not mean that the research was not without some emotional involvement. Being a nurse gave the researcher an understanding of the pressures and demands of the work these Senior Nurses undertake. This emotional interaction added richness to the responses and greater depth of understanding of the problems these nurses faced in their everyday work. A record of these feelings and thoughts were kept in a personal notebook by the researcher to consider later.

Cultural Familiarity with the Nursing Service

Not only was personal familiarity a potential problem, but also the researcher's personal knowledge of the culture of the nursing service. In these circumstances the

researcher could either consciously or unconsciously become personally involved with the people and environment in which the study took place.

This involvement does not just occur during the practical fieldwork but starts from designing the study, right through to the final writing-up of the results.
In deciding on this particular research topic the researcher had already stepped into the area of familiarity. In choosing this topic the researcher identified an area of major interest for herself and an area where she considered it was important to expand the knowledge of the nursing profession and take action where possible to improve the quality of the nursing service to patients. Alvesson and Skoldberg (2000) believe that emotion is inevitable and a vital part of the researcher's motivation and choice of orientation for the topic chosen.

The Insider / Outsider Researcher in Qualitative Research

The issue of using insider or outsider researchers for qualitative research processes has been explained and examined at length (Allan 2004, Dwyer and Buckle 2009). Most of the discussion around this topic are based on the two being distinctive people and with each type of researcher having both positive and negative aspects, with the external observer of qualitative research processes taking different positions dependant on their personal views and the circumstances in which the research is being undertaken. To fully appreciate the position of the insider and outsider, it is necessary to understand the full influence they may have on the research process and the limitations this could cause on the findings and analysis. It could also be considered that the researcher may occupy both positions during the research process. For example in the research the researcher may be considered an insider at the interview stage but an outsider when it comes to the questionnaire.
As a qualitative researcher the insider role neither makes for good or bad research technique, it just makes the researcher different to the outsider. As an insider the researcher has to be cautious about their own emotional involvement which is considered to be a potential problem, it is considered that the outsider would not have this difficulty (Dwyer and Buckle 2009). But do not rule out the emotional baggage the outsider may also bring to the research based on their personal experiences. How do we know that an outsider has not experienced a family member suffering from a medial mistake or read about such cases as highlighted in the introduction in the media? Both insiders and outsiders are likely to have a personal view and some knowledge of healthcare services.

During the research the researcher's situation was never discussed or raised by the participants. The empathy of the researcher with the participants and the subject being studied was considered an advantage as the interviewees were more willing to discuss the issues as the researcher was 'one of us'. Again the higher than expected response rate to the questionnaire was perceived to be due to the acceptability of an insider to receiving their views, which they would not have been willing to share with an outsider.

There are many arguments for outsider researchers as there are against their use as there is with insiders (Serrant-Green 2002). For each of the ways that being an insider enhances the depth and breadth of understanding not available to an outsider, questions about objectivity, authenticity and the need for reflexivity are also raised because the researcher knows too much or is too close to the subjects being studied. (Kanuha 2000). The role of the insider researcher seen by many outsiders is often considered as subjective, with the researcher having a conflicting role between being loyal to the participants as well as playing the role of the observant researcher. The more intimate the researcher is with the area of study the higher is the risk of familiarity affecting the research outcome (Allan 2004, Brannick and Coghlan 2007). Though the shared status assists with the insider gaining access to the participants and increases their engagement, it can cause issues during the research process (Watson 1999). These issues can occur as participants make assumptions about the researcher's knowledge and therefore do not necessarily provide the full details in their responses (Allan 20004). In addition the researcher's past experience could also cause a bias in how they perceive and document the participant's answers. In the research this issue was overcome by the use of the questionnaire, where the researcher had no direct influence over the respondents. In fact the volume and detail of comments received demonstrated that being the insider paid dividends in gaining rich information an outsider would have been unlikely to have obtained.

The analysis of results can also be at risk of being influenced by the insider researcher, where the emphasis on factors of interest to the researcher could be dominant with participants views ignored (Watson 1999).

Papers have been written regarding the phenomena of the role of the insider /outside in qualitative research (Allan 2004, Serrant-Green 2002, Brunnick and Coghlan 2007, Watson 1999). None of the literature draws any clear conclusion, only outlining the risks and benefits associated with each type of researcher being used. The outsider can bring their own negative factors, difficulty in engaging with participants, lack of understanding of the subject matter and their own personal bias and knowledge (correct or incorrect) of the subject matter. The negative aspects of the insider's

familiarity providing bias, lack of detailed information provided by the participants and the researcher's personal interpretation of the results, can all affect the final research outcome. As explained before both insiders and outsiders also bring positive benefits to a study.

But are insider and outsiders discreetly different? Fay (1996) promotes the belief that insider or outsider may be one and the same dependant on the circumstances and experiences of the individual. We are all human and bring to the research our personal experiences, social standing, demographic position and our individual personalities, all of which can influence the researcher and the final outcome of the study. Qualitative research of its nature is an intimate, personal process for the researcher, with both insider and outsider being different at the beginning than they are at the end. How long does the outsider remain really an outsider? Just being part of the research will over time transform them into someone who could be called an insider. The research process will affect both insider and outsider. Both have to be alert to the effects they too have on the research and ensure that both use methods to reduce the influence and bias each can have on the research outcome. The analysis below shows some of the activities undertaken by the insider researcher in the study to reduce the risk of them influencing the outcome of the research.

Reducing Bias and the Use of Reflexivity

The research approach chosen was important, as it ensured appropriate individuals with élite knowledge of the nursing service were involved fully in the research and this therefore reduced the likelihood of the researcher's knowledge of the service having any undue influence on the results (Castelloe and Legerton 1998).

In interviews the informant is often seen as a passive possessor of facts and knowledge, while the researcher's role is to be objective and stand back from the process to ensure that the data is not influenced or contaminated (Kavel 1996). In these interviews there was the need for an interaction between the researcher and the interviewee (informant), to create complex 'pictures' of the subject being explored. In these circumstances the researcher and informant constructed 'the knowledge' together. To ensure the researcher maintained an awareness of their involvement, keeping the subject novel throughout the process and appropriately managing the consequences, reflective notes were kept for reference and considered before undertaking the next interview (Delamont and Atkins 1995). This ensured that any problems identified could be appropriately addressed and any cultural bias reduced. It was important to have a balance in the process of reflexivity, so that it did

not become an over indulgent process (Allan 2004) on the part of the researcher, deflecting the focus from the subject matter. After each interview the researcher took time to thoughtfully evaluate what had been discussed and the meaning of the interview responses, to ensure true reflection of the participants' views and opinions (Reed and Procter 1993).

The process involved in the research had a structured discipline to it to ensure bias was reduced and the senior nurse's voices and experiences were heard and not that of the researcher. As Becker (1971 pp3) stated;

'It takes a tremendous effort of will and imagination to stop seeing only the things that are conventionally 'there' to be seen…… it is like pulling teeth to get them to see or write anything beyond what everyone knows'.

The above statement had potential for being true with the research, if action was not taken by the researcher to mitigate this risk. As Allan (2004) suggests we need to understand our own enterprise in the research in much the same way as those we study. The researcher was personally familiar with the setting for the research and the individuals involved, with this there is the clear risk that the significance of certain routine behaviours could be overlooked and assumptions made about meaning of events or comments without clarification being sought (Allan 2004). The researcher therefore ensured that the interviews were not hurried but rather provided time in the process to discuss further the views and opinions expressed by the participants. This ensured that the transcription contained a true explanation of the interviewees' comments. It is worth noting that the interviews took over 2 hours to ensure sufficient time for the participants to reflect and expand on their responses so providing rigour to the process and reduce any bias by the interviewer.

There were potential risks of introducing bias at all stages of the research process, from research design, which was intentionally detailed to ensure transparency and maintain rigour (Allan 2004), through to the writing up. To manage the familiarity and keep the research area 'strange' the researcher had to take action to manage their behaviour. Firstly the researcher had to justify what sort of impression they wanted to give to the participants. The researcher constructed a different 'self' (Hammersley and Atkinson 1995) to ensure valid information from the semi-structured interviews was obtained. For some of the participants the researcher was their professional leader and there was the need to reassure them that the role the researcher played was entirely different for the interviews. After reviewing the tape of the first interview and applying reflexivity through documenting the experience in a note book, the researcher considered that she was becoming too authoritarian with the questioning. Therefore for subsequent interviews the researcher took on a more relaxed approach

and dressed informally which by the length of the participants' replies, clearly put them at ease and provided much more information, insight and honesty in expressing their personal views for the tape.

The interviews with the Nurse Consultants were more difficult, as they did not show the same interest in the topic. They considered the questions to be more managerially focused rather than the area they felt comfortable with which was clinical practice. Again having used reflexivity for the first Nurse Consultant inteerviews and made records in the researcher's note book of experiences, the researcher realised that though there was nothing fundamentally wrong with the questions, there was the need first to talk to these interviewees about clinical situations of failure that they faced, rather than managerial ones. This not only helped the participants, it also reduced the researcher's ability to influence the answers as this was an area they were unfamiliar with.

Part of the reflexive process involved listening to the audio tapes within a day of the interview. This meant that the interview was fresh in the researcher's mind, so that they could recall not only the words but behaviour of the participants. Secondly this process allowed the researcher to document her thoughts and feelings in their note book, so that any problems of familiarity could be addressed in the next interview. One area that required personal control by the interviewer was regarding the question, 'Tell me about a failure you have been involved in?' The researcher was personally aware of some instances of failure that they anticipated the interviewee would recall. It was interesting to note that in the majority of cases the participants were unable or unwilling to recall such errors. It would have been all too easy for the researcher to prompt the participants but this was not appropriate. In fact their responses were very valuable to the study as, through reflexivity and records in her note book, the researcher came to realise that the participants did not want to admit or discuss failure (Spear 2005). A significant finding on its own, which would not have been identified, had the researcher become involved. On subsequent enquiry of this type of phenomenon, it has been identified by the researcher that it is a common trait for people not to want to discuss failure, but only success stories. Finally by asking the nine participants to read the factors identified for the questionnaire, to make sure they represent their views, the researcher obtained a further method of obtaining their unbiased voices and reducing the risk of the effect of familiarity on the results.

One of the strengths of the methodology used in this research is the real involvement of the fieldworker in the setting. A weakness is not that the researcher may become totally immersed in the study area, but rather that they fail to realise this and in this,

do not consider their own position within the study. Through these processes of managing familiarity, the information obtained by being alert to the researcher's role and the frequent use of reflexivity provided great richness in the results obtained. Wolcott (2004) considers that bias in qualitative research is not only something we must live with but something we can't do without. Throughout the research the aim should be for structured subjectivity rather than trying to demonstrate a pretence of objectivity, if we are to really obtain the best results from this qualitative research study.

Conclusion

The research design used in the study had an approach with each stage being influenced and reinforced by the three stages of the research process (Crabtree and Miller 1992). The results of each stage of the study needed to be analysed before proceeding, as the findings were used to provide a method of ensuring validity in the subsequent stages of the research.

From the research design it can be seen that the participants of the study had a significant role to play in both the design and ownership of the final outcome. Unlike many traditional methods of research, which has the researcher designing the research and its questions, the method used in the study ensured a major involvement of individuals in the research work (Castelloe and Legerton 1998). The use of this approach had the aim of creating ownership of the findings by senior nursing professionals, with the intention of them using the result to their advantage in the future.

Chapter 4

Presentation of the findings of the research

Introduction

This chapter is set out in three sections each outlining the results obtained from the three stages of the research. Though each step in the research was undertaken discretely, each formed part of the process in ensuring the overall outcome demonstrated rigour. It was essential that the final conclusions were based on sound evidence and reliable results; therefore cross-referencing back to each stage provided a system of obtaining dependability (Lincoln and Guba 1985) of the results obtained. The three sections are therefore linked together, which culminates in the analysis of results in chapter 5. The first section of this chapter outlines the findings from case studies of service failure, the second documents the outcome of the semi-structured interviews and the final section has the results of the prioritisation of factors from the questionnaires.

Learning from Others' Mistakes

This section reviews strategic reports which have documented issues of failure. All too often we read today of significant failures in the delivery of care to the patients using the National Health Service. What all these incidents have in common is that no one thing led to these tragedies, but rather a collection of events or things going wrong. This in turn led to the failure of the system providing care.

The first part of these results examined the secondary data in relation to publicised documents, which identified failure in the NHS, and in particular the delivery of the nursing service to patients. The reason for undertaking this review of reports or case studies was to ascertain what the key themes emerging from these documents were, focussing on the key factors that had failed in the nursing service system which resulted in serious consequences for the patients. Secondary data analysis was undertaken to provide evidence for comparison with the outcomes of the semi-structured interviews and the results of the questionnaire. This provided a method of assessing dependability (Lincoln and Guba 1985) of the final overall conclusions and validation of the Senior Nurses Framework.

This section relied on reports produced by independent inspection bodies in the UK, which were published since 2000. The period of 10 years was identified as being most up to date and relevant to today's health service. The main organisations

involved in the inspection process are the Health Care Commission (England), formally known as the Commission for Health Improvement (CHI) (England and Wales). This inspectorate again changed in 2009 to become the Care Quality Commission. The equivalent organisation in Wales is the Healthcare Inspectorate Wales (HIW). The Audit Commission (England) and the Wales Audit Office (WAO) have also produced reports on organisational and service failure which were found to be relevant to the thesis. These organisations are non-governmental and were established to undertake independent critical reviews of public sector organisations. The reviews are undertaken using a number of individuals who are identified as experts in the field of health care or represent the interests of the patient. They have the role of publicly raising concerns and identifying action that organisations should take to improve the delivery of services to the patients.

The criteria for selecting reports to analyse was that the inspectors identified clear failure in the nursing service in the organisation, and that in most cases the Nurse Director left the organisation as a result of the findings of the inspectors. These reports summarize the failings in the nursing service and from these, clear themes common to the majority of the investigations emerged.

The following 14 reports were reviewed:

1. Investigation into patient deaths as a result of an outbreak of Clostridium Difficile at the Maidstone and Tunbridge Wells NHS Trust – Healthcare Commission (2007)

2. Report into the removal of the wrong kidney from a patient and his subsequent death at Prince Phillip Hospital, Llanelli – Commission for Healthcare Improvement CHI (2000)

3. Investigation into 10 maternal deaths at Northwick Park Hospital – Healthcare Commission (2006)

4. Learning Lessons from Financial Failure in the NHS – Audit Commission (2006)

5. Portsmouth Healthcare NHS Trust, Gosport Hospital; investigation into the unexplained death of 5 patients - CHI (2002)

6. Special Assurance Review of Cardiac Surgery at Swansea NHS Trust - HIW (2007)

7. Special Assurance Review of Maternity Services at Gwent Healthcare NHS Trust as a result of high numbers of Maternal Deaths – HIW (2009)

8. Investigation of the Maternity Services at Royal Wolverhampton Hospital – Healthcare Commission (2004)

9. Investigation into the North Lakeland Healthcare NHS Trust following an inquiry into the abuse of elderly patients by staff – CHI (2000)

10. Clinical Governance Reviews of Acute and Community Services and investigation into Mental Health Services due to high levels of serious incidents at Pembrokeshire and Derwen NHS Trust – CHI (2004)

11. Investigation into failing in systems to protect the safety of patients at Mid-Cheshire Hospitals NHS Trust – Healthcare Commission (2006)

12. Investigation into the care and treatment of people with learning disabilities provided by Cornwall Partnership NHS Trust – Healthcare Commission and commission for Social Care Inspectorate (2006)

13. Investigation into outbreak of Clostridium Difficile at Stoke Mandeville Hospital – Healthcare Commission (2006)

14. Investigation into Emergency Admissions – Mid-Staffordshire NHS Trust – Healthcare Commission (2009)

The themes that emerged from these reports were clustered under 3 main headings; Leadership, the workforce and communication and information:

Leadership

All too often in these reports it was identified that the Nurse Director had failed to report to the Board areas of service deficiency or clinical areas that were a cause for concern (Maidstone and Tunbridge Wells 2007). It was sometimes unclear what the

Board expected from the Nurse Director and what the Nurse Director thought their role was at the Board (Stoke Mandeville 2006). More commonly it was stated in the report that there was a culture at Board level of not wishing to hear bad news (Wolverhampton Maternity Services 2004) and only focussing on the tangible information, which they considered to be more important to the organisation's success, this included financial reports and reports on achievement of measured targets (Mid-Staffordshire 2009).

It was evident from the Cornwall partnership report (2005) that the Board did not accept that there were any deficiencies in care. In Cornwall the Nurse Director had failed to ensure that Clinical Governance arrangements were in place and therefore the Board were unable to effectively monitor services or know that the quality of care was poor. Despite the production of this investigation report the culture of the Board influenced their continued denial that there was anything wrong with the patients' care and in fact considered that services were no worse than many others in the country. This showed the lack of insight by the Board, who had been led to these conclusions by the Nurse Director. This culture of ignorance or cover-up by the Board was repeatedly seen in these reports.

Overall these reports reflect poorly on the nursing leadership. This is not necessarily just at Director level, but also, as shown in the Northwick Park Maternity report (2006) where there was poor leadership at Head of Midwifery level. The empowerment of nursing staff to lead and have control of the environment of care comes through as a further theme (Wolverhampton maternity services 2004). This absence of leadership at the varying levels across the nursing service led to the nursing staff being unclear as to the direction of travel for the service, what their contribution was to be and the standards expected (Pembrokeshire and Derwen 2004). From examining all these reports, there was no evidence of the nursing service having any Strategic Direction. There was no indication of expectations of nurses on the standards of care they should be delivering and how their service should be modernizing to meet a changing environment in the NHS. Twelve of the services investigated appeared to be in a time warp, unchanged for years and with no plans to move forward. There seemed to be no understanding of how nurses would meet patients' expectations today and in the future.

Highlighted was the lack of management systems for clinical risk (Cardiac Services, Swansea 2007) with the learning of lessons by the nursing service from untoward

incidents or patient complaints also being absent (Mid-Cheshire 2006). There seemed to be a culture of acceptance across the organisations and the nursing service that things will go wrong. The report on cardiac surgery at Swansea NHS Trust contained a comment from a member of staff that 'we have to accept in a busy, complex Health System such as the NHS, that things will go wrong and there is little we can do about it.' (Healthcare Inspectorate Wales 2007)
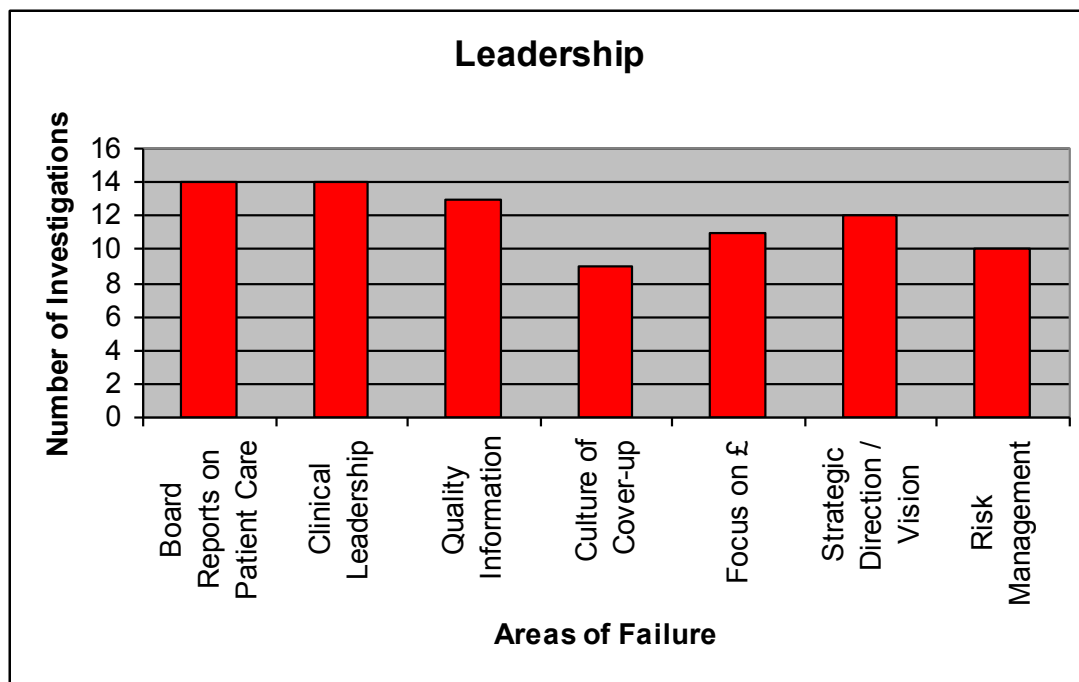
This graph shows the factors of failure in leadership identified in these reports. From this, 3 factors were identified in nearly all the reports. These were; poor reporting on patient care issues to the Board; lack of clinical leadership at the top and throughout the organisation; and poor availability of information regarding service quality. The other factors of culture cover-up, focus on finance, poor strategic direction/vision and lack of risk management systems all seem to have occurred equally.

The Workforce

Since nursing staff make up 52% (Statistics for Wales 2009) of the NHS workforce in Wales, it was not surprising to find that a considerable number of issues raised in these reports relate to the workforce and specifically nurses and midwives. One of the main reasons for service failure was the shortage of staff (Wolverhampton Maternity Services 2004), which was further compounded by the high use of agency nurses and poor processes in planning for the future workforce. In eleven cases staff

development processes were missing or haphazard (Healthcare Inspectorate Wales, Swansea, Cardiac Services, 2007), with no evidence of performance review processes and training and development plans. This appears to have led to staff having inadequate skills to do the job.

Organisations have been encouraged for many years to support the process of clinical supervision (North Lakeland Trust 2000). The process is mandatory for midwives, but is also advised for all nurses. It provides a system to support nurses in their roles, giving them the opportunity to discuss their clinical practice with another professional who does not have a line management responsibility. In nine of these investigations it was found that this form of support was absent. This meant that nursing staff were unable to discuss concerns about working practices except with their managers, which was often not appropriate.

It was found by the investigations that nurses did not have up to date role descriptions, were unclear about the job they were expected to perform and also what they were accountable for (Mid-Cheshire Trust 2006). This environment of poor accountability led to a culture of staff abdicating responsibilities for what was happening to the Service and the patient being cared for. They considered it was not their place to raise concerns and even if they did, nothing would happen (Wolverhampton Maternity Services 2004).

Finally in this section, one of the other failings identified was the lack of team working (Mid-Staffordshire NHS Trust 2009). This was both within the nursing team and the multi-disciplinary team including nurses. It was interesting to note that this factor was particularly prevalent in investigations into maternity services (Gwent Healthcare NHS Trust 2009; Northwick Park Hospital 2006; Royal Wolverhampton Hospital 2004). There was a clear detrimental effect in the maternity service provided to pregnant women when the midwives and consultant obstetricians were unable to work as a team. Rather they seem to work as enemies in a battle for supremacy in the service (Gwent Healthcare Trust 2009).

Staff Management and HR Processes
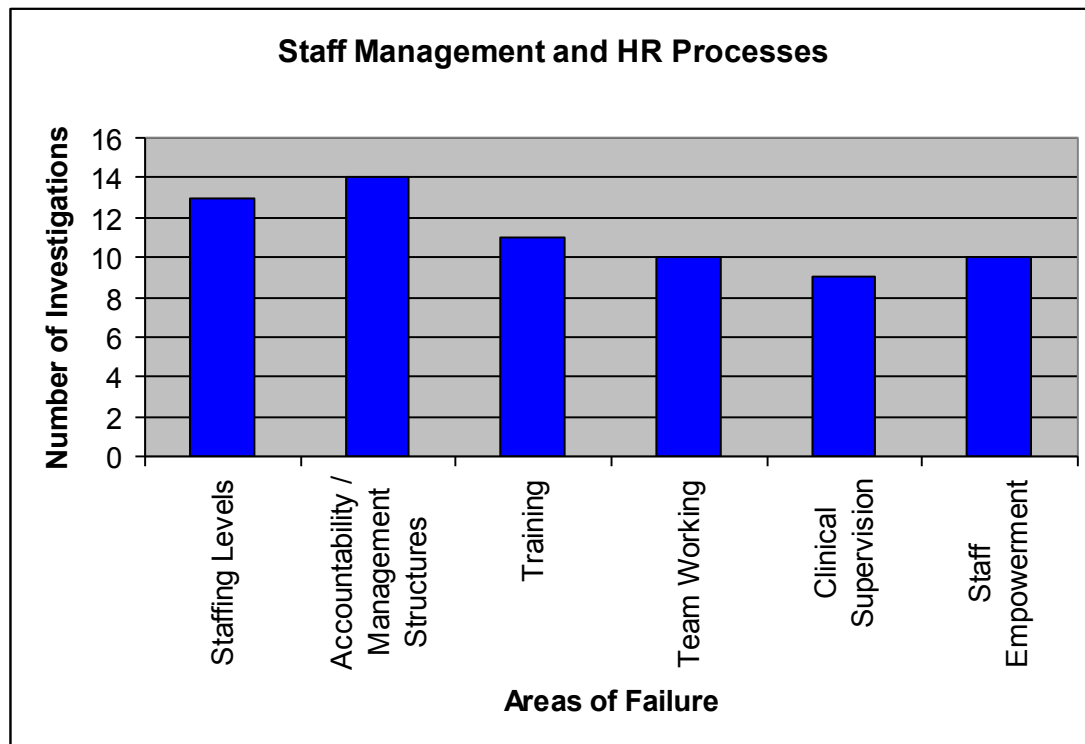
On considering the graph on workforce, the greatest number of factors identified was the lack of clear roles, failure to accept accountability and poor staffing levels. The other factors of poor training, poor teamwork, lack of clinical supervision and lack of staff empowerment were identified in approximately 70% of the investigations reviewed.

Communication and Information

Poor communication throughout the nursing service was frequently a problem. There seemed to be a general absence of visibility of Senior Nurses out in the service (Mid-Staffordshire NHS Trust 2009). The concept of senior management walkabouts by Senior Nurses was absent. It was commented that the Nurse Director was rarely seen and there was little opportunity to raise concerns with the nurse leader or understand the strategic direction, values and objectives for the organisation the nurses worked in (Gwent Healthcare NHS Trust 2009). Two-way communication with the nursing staff was not supported, with the top of the office and nurses working at the bedside working in isolation from each other. An example in the Maidstone and Tunbridge Wells investigation (2007) was that nurse managers in the middle of the organisation were confused by the instructions they were given from on high and

what was actually required of nurses on the wards. They did not match up and reflect the real situations nurses were facing at the bedside.

Frequently failure in communication throughout the service led to it becoming dysfunctional, with staff being unaware of what was going on or expected of them. Staff felt undervalued, as there was no system to provide praise or encouragement. A recurrent theme was that the little communication received by staff solely focussed on meeting financial balance or achieving specific targets e.g. waiting times (Stoke Mandeville Hospital 2006).

A fundamental flaw found in eleven of the investigations was inadequate serious incident reporting. This was such a common theme, which resulted in lessons not being learnt from incidents and therefore lack of corrective action. In the Northwick Park report (2006) it comments that there was a culture in the service which did not facilitate learning from incidents. Why this type of culture in these organisations had developed was variable, from Boards and senior managers not wanting to hear bad news (Mid-Staffordshire NHS Trust 2009), to poor or lacking incident reporting systems (Wolverhampton Maternity Services 2004), or even reporting systems that were so complicated that no one used them (Maidstone and Tunbridge Wells 2007). Overall the Boards did not see the reporting and learning from patient incidents to be important and did not give them the priority they should have.

This inadequacy was not confined to patient incidents, but general reporting, documentation and record keeping was also found to be a systems flaw in these organisations (Pembrokeshire and Derwen Trust 2004). To compound this there was

a lack of policies and procedures for nursing staff to work to as guidance for the expected standard of practice (Portsmouth, Gosport Hospital 2002). Where policies and procedures did exist there was a culture of ignoring them and lack of implementation (Mid-Cheshire NHS Trust 2006).

Communication / Information
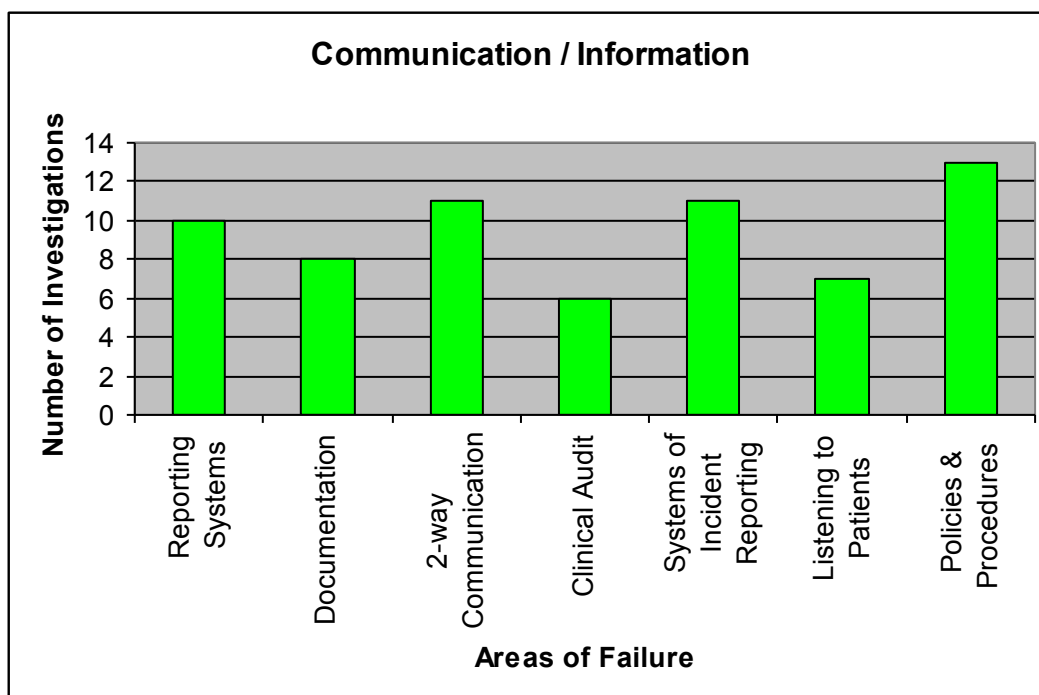
Factors relating to communication and information are shown in the graph above. The lack of policies or poor policies and procedures was found in 13 of the investigation reports, with factors such as poor 2-way communication and poor systems for Serious Incident reports also occurring in a large proportion (79%) of the reports.

A focus on finance and targets along with a Board level culture that failed to focus on the core business of quality patient care was frequently seen in the investigations. This was exacerbated by a Nurse Director on the Board who went along with this culture and demonstrated no challenge to the Boards' views. It would have been expected that the Nurse Director would have had a key role in protecting and voicing the interests of patients, which was lacking in all these investigations. The reason why Nurse Directors failed to have a voice at the Board was not articulated, this would benefit from further exploration in the next stages of the research. Finally it was interesting to note that in the majority of these investigations the Nurse Director left their post, often along with the CEO. It seems that the only way to bring in a new patient centred culture was to have a new Nurse Director and CEO.

The next section of this chapter explores the views and experiences of Senior Nurses in Wales. It discusses how they see the situation in real life and what they think leads to failure and disasters in the nursing service. Also what they think can be done to create a high performing service.

The Semi-Structured Interviews

This section focuses on the semi-structured interviews undertaken with nine of the most senior and experienced nurses working in healthcare in Wales.

Presentation of the Findings of the Semi-Structured Interviews

The interviews commenced with the interviewee being asked to say what their thoughts and impressions were when they entered healthcare premises. The responses in all cases talked about appearance of the environment particularly how it smelt and the noise.

> *I think you make your impression in 90 seconds, there is a nice calm noise in the environment, then it makes you think that things are as they should be. Certainly the smell and the noise are important as well as welcoming staff, who have pride in their environment. This attitude of the staff is influenced by the culture of the organisation and the environment in which they are asked to work.*

The implication here was that there should be a sense of calm signifying well organized and purposeful staff. The smell was of particular note as many of the interviewees stated that a bad smell usually indicated patients were getting substandard care and the building was not kept clean.

> *It is the smell that is important. You just know when you walk into the ward if it smells then there is something wrong. I would start looking at the patients' care straight away.*

The interviews further progressed by getting the interviewees to discuss what they thought professionally were the key factors that are missing when things go wrong. Later in the interview this question was repeated in reverse, so that there was a positive focus on factors that make things go right. This was done to ensure all relevant views and information was obtained.

Following on from these responses the participants were asked to identify which they thought were the 3 most important factors. Their responses did vary dependant on the background of the participant. The Nurse Directors' responses were biased towards the strategic issues and were looked at from a wider organisational perspective:

The nurses and the nursing service must have a clear direction; know what is expected of them and also the standards and behaviour. They should share the vision for the service. By having these in place you are more likely to have a successful service.

Whereas the Nurse Consultants focussed on issues at an operational level:

You must have clear standards of care for the staff, which is evidence based and effective. There needs to be a nursing philosophy which puts the patient first as well as clear policies and procedures to work by, but not constrain your practice.

The Deputy Directors gave a perspective that covered both areas:

There has to be leadership at every level, not just the top, not just leading a team but being a good role model for other staff. The leader has to indicate a clearer direction of travel for the service but with compassion for the patient, with them at the centre.

These views could have been anticipated due to the position individuals hold within the organisation.

The Semi-Structured Interview Themes

Following the analysis of these nine interviews, key themes were identified, supported by several sub-themes for each of them. These key themes are discussed below.

Strategic and Leadership

The strategic and leadership section explores the sub-themes associated with nursing leadership. The first clear message from the interviews was that the Nurse Director has to set the expectations and standards for the nursing service, which have been developed through a process of whole staff engagement.

> *It is important that people know what is expected of them. There is a shared expectation and vision permeating throughout the organisation, which all the staff own.*

The Senior Nurses considered that these expectations have to be articulated and understood at all levels of the service from clinical team to the Board. The approach of the Nurse Director setting the expectations could be considered as dictatorial, which is contradictory to the aim of having all staff ownership. To overcome this attitude several interviewees commented that a system should be used that involved the nursing staff in developing the standards and expectations for service delivery, so ensuring ownership and a greater opportunity for effective implementation. One participant suggested this could be done with the development of an annual operational plan which would guide the nurses' work and measure attainment.

> *I do think that people need to know what the plan for the service is, why and where we are going with it. It is a tool to present some things to the Board so they understand the nursing service, what it is aiming to achieve and whether it is getting there or not. It is essential that staff understand what is expected and what they are there for; that is to provide high quality care to patients. These high standards should be understood and endorsed by the top and the Board must keep an eye to ensure things are delivered as expected.*

Mannion et al (2005) suggested that one specific area identified as good leadership was that of clear expectations of performance. These should be detailed in the business plan agreed by the Board.

Many of the participants considered that there was better understanding by the staff if the Nurse Director had a high profile, set an example by their actions and acted as a role model for nurses. One individual said that she felt that:

Poor quality nursing leadership leads to poor practice, the leader needs to be there to spot things going wrong and change things to put them right. Things go wrong if the Nurse Director does not have a handle on what is happening in the service, out there in practice. You have to have buy-in from the staff and you can only get this if the leader is good.

The comment above is reinforced by Jooste (2004) who found that for an effective nursing service you need leaders that show vision, are positive, open towards followers and gave clear direction. This was expanded further by several interviewees who considered that there was the need to plan for the succession for the Nurse Director and also develop Nurse Leaders throughout the organisation. Three participants specifically talked about mentorship and the value of *'sitting by Nellie'* to learn the art of leadership.

I have worked with some fabulous clinical leaders, their attitude and role model rubs off onto the rest of the team. So we have to have a system for 'passing the baton' of experience. We must have succession planning and an assurance that nurses are competent for the job. This does not mean sitting in the classroom, but rather 'sitting by Nellie', watching and learning how to do it right.

But some Senior Nurse participants commented that they had come across colleagues that were not happy with the development of junior nursing staff, as they saw the process as a threat to their position and status.

I have worked with a Nurse Director who did not like his deputy deputising for him, as he considered that they might have an eye on his 'chair' and take it away from him. He was too frightened to develop his staff in case they were better than him.

None of the participants in the study expressed this view themselves, but several reinforced the comment below from their own experiences.

Some Senior Nurses are selfish creatures and do not develop others, they see them as some sought of threat, keeping the limelight for themselves. We need to let junior staff have the opportunity to watch the more experienced and learn from them if the service is to develop.

Concern was expressed that if there was a lack of continuity of nursing leadership, then there was a higher likelihood of service failure. It was considered that though in the short-term things might be alright, lack of consistent nursing leadership could have an impact in the long-term delivery of the nursing service, as it lacked direction.

> *I have personally experienced the lack of continuity in Nurse Director, but we did not see an immediate effect, but it certainly had an impact on the long term delivery of the nursing service we had no clear direction, the service just stagnated.*

The Audit Commission (2006) commented that you need to have a cadre of senior clinicians who lead the service to achieve its objectives and are committed to the organisation's success. Poor nursing leadership without clear expectations and standards could potentially result in the nursing service focusing on the wrong priorities, which was clearly seen in the Maidstone and Tunbridge Wells outbreak of Clostridium Difficile in 2007 (Healthcare Commission Report 2007). Here the lack of senior clinical leadership and reporting of infection control information to the board led to over ninety patient deaths. Overall nurse leaders were seen as responsible for developing an environment for good care and fostering high quality of care delivery (Urden and Monarch 2002).

The interviews made a natural progression from leadership and direction to the pros and cons of having this explicitly stated in a Nursing Strategy and the value this could give to the nursing service. Not all interviewees were in favour of a nursing strategy. This was based on their own personal experiences.

> *The documents just sat on the shelf; they served no purpose 'a something or nothing document' and had little meaning for myself or the nursing staff.*

Despite this negative attitude, the majority did feel that having a nursing strategy could make a difference in improving services to patients. Though It was considered that how it was developed and written was important if it was to have meaning and influence on the delivery of the service.

> *A strategy should provide clear, professional direction for the staff, it should provide the vision that is very necessary for us all to go in the same direction.*

But it must have clear tangible actions and a plan with it, which is regularly evaluated and amended to keep it live and to make sure we deliver it.

Generally the view was that the nursing strategy can help to give direction. If it was to have a positive effect it had to reflect the views of the nursing staff and be in a language that had meaning to them.

A nursing strategy should not be long and wordy, it has to be succinct and focuses on areas that are important to staff, it means they can understand it and use it in their work – it is real. It will provide a vision for the service, so nurses can sign up to it and live it every day.

One of the benefits identified of developing a nursing strategy was that it gives nurses the opportunity to reflect, making time for reflexivity, looking at where they are now and where they want to be in the future. It then helps them focus on the gaps and inadequacies in the service and develop plans to address them. It was also considered that a strategy put nurses in control of their future, giving them a sense of purpose and ownership. Jooste (2004) supports this, commenting that it is important that nurse leaders should be visionary, be clear what is expected and know that the service can meet the challenges of the future.

One interviewee said that:

With proper planning processes and contingencies the nursing service should run like a well-oiled machine. The nursing strategy can be a powerful tool, which provides a structured approach to the running of the service and the development of the staff. I also think that a strategy can be particularly good for nursing when it seems at a low ebb and needs a bit of a push.

The process of developing the strategy was also considered to be important. In writing it the authors needed to:

Look outside the organisation, as well as inside to understand the direction of travel. This is essential if the service is to be kept up to date with developments, if it does not do this it can be caught out. An example of this is to look at the demographics to understand the population's needs and how the service will address these such as more births means more midwives are

needed. The strategy needs to look at the long-term, not quick fixes, but must be deliverable in realistic timescales so staff see some results from the strategy.

A further comment was made that:

The strategy needed clear milestones that can be measured to assure it is achieved, with the Board owning the strategy and being involved in monitoring its implementation via board reports and presentations by the Nurse Director and other Senior Nurses.

The interviews then progressed to consider the role policies and procedures play in the success of a nursing service. There was a broad acceptance that there needed to be robust policies and procedures in place, which were evidence based, to ensure the 'expectations' of the service were delivered.

Many commented on the need for these documents to be 'alive' and kept up to date with modern practice through periodic review.

They should be clear and easy to use, but not so prescriptive that they stifle innovation. I am concerned that procedures can reinforce the view that nurses are trained to follow rules, what we need are expectations not rules.

In Yourstone and Smith (2002) they suggest there is value in having guidelines and policies and that these should not be seen as constraints on practice, but rather enhance standards. The policies have to give nurses space to try new things and take some risks. Policies can set expectations rather than constraining rules. Jooste (2004) agrees that the service needs evidence based policies and procedures for good patient outcomes.

Another participant commented that:

Too many policies lead to transactional staff rather than transformational staff. We need nurses who challenge the status quo, try new things and adapt to change around them – not driven by a culture of rules, doing as you are told. By taking this approach we lose our professional control and authority.

A further interviewee said:

> *It's about putting policies into practice, you can have all the policies, procedures and guidelines available, but this does not make any difference if they are not implemented. This happens so often, you have to have a champion to make them real.*

To sum up, the interviewees generally considered that policies were necessary, but that there should be 'procedural frameworks' or guidelines rather than step-by-step procedures if the nursing service is to remain dynamic in meeting the needs of the patients. These views are supported by Young et al (1997) when they comment that policies and procedures should not be seen as a constraint on practice, but if implemented appropriately will enhance standards of care.

The final sub-theme focussed on the role of the Nurse Director at the Board and the role of the Board in supporting the work of the nursing service.
There was an overwhelming view that the Nurse Director must have a loud voice at the Board. That when the Nurse Director was unable to articulate the issues facing the nursing service at Board meetings, there was a much greater chance that things could go wrong. The Burdett Trust's (2006) work demonstrates the need to have nursing and clinical issues coming to the Board, so the Non-Executive Directors are engaged with the business of the organisation. They need to know the good and bad and what is going to be done to put it right.
The work of the Burdett Trust (2006) showed that often the Board forget what they are there for and it is the Nurse Director that can remind them of their core purpose, which is delivering high quality patient services.

There were many factors identified by the interviewees that can facilitate and enhance, as well as block the reporting to the Board by the Nurse Director.

> *The Nurse Director must be in contact with what is going on throughout the organisation. You need to see reality so you can present the real picture to the Board. You can then translate for the Board the reality of the patient's experience into a language the Board can understand, such as information on complaints and serious incidents, which sometimes they don't want to hear.*

Unfortunately some Nurse Directors fail to do this.

> *Before we had our new nurse director we never saw our old one, she just never came out of her office. I think she was frightened of the staff and what they might say to her. She just had to go! – She had no credibility with the nurses and had no idea of what was going on.*

This is reinforced by McDaniel (1997) who suggests that healthcare bodies have a primary responsibility to detect, assess and correct system error. Further the Audit Commission (2006) comment that through the Board, an organisation should learn from clinical failure and take action to improve patient care.

It was further considered to be important for the Nurse Director to have good team working with the other executives and particularly the Chief Executive and Chair.

> *The Nurse Director needs to interact with the other Executive Directors to ensure as a team they focus on the patient. They have to have their say in the team, you know, treated as an equal. So often this doesn't happen. We have to be equal in the team at the top.*

The Burdett Trust (2006) comments that if the Nurse Director is heard and taken seriously, leading to action where necessary, then patient care improves.
Through these processes it was considered that the Nurse Director would be able to influence corporate priorities and policy decisions:

> *Where the Nurse Director is positioned at the Board is important. Do they have the ear of the CEO and Chair, do they have regular reports to the Board and are they taken seriously and so they influence the Board's decisions. The Board should particularly support the development of the nursing service to the benefit of the patient. Sometimes the 'Destruction factors' of money and targets cause the wrong priorities to be followed, such as happened at the Mid-Staffs Trust.*

One participant explained what she thought the problems were that the Nurse Director faced at the Board:

Senior Nurses are compromised by two agendas, one of service quality and the other is targets and money. In this competition quality can lose out. The current finance agenda does not facilitate the care agenda. If there is a lack of strong clinical leadership you don't get a proper balance between finance and quality. It's all about having the right balance. If the nurse colludes with this approach they are seen by the profession to have gone over to the 'dark side'.

This comment above was the scenario found in the Mid-Staffordshire NHS Trust inquiry. The report comments that finance and targets pursued to gain Foundation Trust status, lead to a lack of focus at Board level on service quality, which led to the deaths of several hundred patients.

If the Board do not know what is going on it can bring the organisation down. Mannion et al (2005) and Vincent and Barker (2005) note that low performing organisations had management that were seen as disconnected and remote from the day to day issues of the wider organisation. So the interviewees' views were that if the Board supported and listened to the opinions and issues of the nursing service, they would learn to understand the role the service plays (Procter 2000) and how integral it is to the organisation's business, and a key factor to its success.

You have to be able to present a clear picture of a situation or problem (to the Board) and if necessary make a case for more staff and the Board must understand the consequences of not listening to their Nurse Director.

Culture and Ethos

The participants frequently referred to first impressions:

Does the building look dishevelled, in poor order? Many would think that this is an indication of the standard of care you would receive. I think you make your impressions in 90 seconds. But I can take you to an old hospital near here, it does not look too good from the outside but I know from my experience of visiting the hospital,that it provides some of the best care I have seen. You can't tell a book by its cover.

These first feelings were considered to be a good indicator of the ethos of the organisation and the nursing service*:*

The welcome staff give you, their attitude and how they behave, it's the attitude of the staff which is influenced by the culture of the organisation, the environment in which they work and how they are treated themselves.

It was interesting to note that many interviewees commented on how quickly you form impressions about the ethos of the service. The individuals 'Gut feeling' of what the culture and ethos was like was a comment several people made based on their many years of professional experience.

When I go through the front door I have quite a good temperature gauge of what a place is like. You form an impression of that hospital and sometimes you don't touch or feel it, but you just know what it is like. When you go down the corridors and see staff looking tidy and professional this can give you a good idea as to what leadership is like and what is excepted of staff. This can all be got from your first 5 minutes.

Smell was referred to on many occasions as an indication of poor care; particularly where continence care was not a priority:

It is bad that I still go into hospital wards and there is that terrible urine smell; well that's just a sign of poor care and that staff are not bothered. You just should not have that smell today, it's unacceptable.

The participants provided many examples of both negative indicators of a poor ethos, as well as positive comments about a good ethos in the nursing service:

A calm atmosphere, staff look professional, act calmly and with purpose, like a well-oiled machine, the place has a sense of order. There is clear evidence of someone being in-charge and in control.

It was considered that if you have the above positive ethos in place then it gives the patients' confidence in the nursing care they will receive. It was not only the Senior Nurses that could sense the service ethos but they also believed that the patients could in some-part understand what was good and bad about the nursing service ethos.

The need for someone seen to be in-charge was reinforced by the comments of Filochowski (2004i), when he suggested that there is a need for sound leadership throughout the organisation and that a high level of clinical involvement and leadership is essential to direct the service.

A further strong sub-theme emerged from the interviews, which focussed on nursing staff being empowered:

> *Not just the Nurse Director but all nursing staff need to be and feel empowered. There has to be the environment and culture to support empowerment and learning. If the Nurse Director is not empowered then the other nurses can't be empowered. When you look at things going wrong in hospitals it is often clear to see that nurses who should have influence are cut out from making decisions in their organisations. They become puppets doing what they are told, powerless to influence and challenge. Oh dear you can just see how things go wrong.*

> *When the minister for Health visited one of my wards, the ward sister told her that they had lots of ideas but no one listened to them or valued their contribution.*

Following on from this the participants then reflected on how they saw their place in the organisation and the healthcare team. Clearly they did not feel equal with others nor their contribution valued:

> *Organisations have a responsibility to ensure staff are empowered and given the tools to do the job, being able to work as equal members of the healthcare team. There has to be good working with other members of the multi-disciplinary team, as well as the good working relationships within the nursing team. Nurses should not be treated as junior members of the team if you are going to get effective working and care for patients.*

The role team-work plays in the delivery of patient care was raised by participants on many occasions. This is supported by comments made by Yourstone and Smith (2002) that peer interaction is essential if errors are to be prevented. Jackson (1998) also comments that there has to be a positive culture that promotes and supports team working. It was considered to be important by one participant that nurses had:

> *A clear place in the team and that they play the right part in the patient's pathway. Partnership working has to be real and equal, not tokenism with nurses seen as bedside floosies.*

It was identified that it was important for the Senior Nurses to be in control but this had to be balanced alongside allowing staff to have freedom to be autonomous (Rafferty et al 2007)*.*

> *It's that balance between running a tight ship and allowing people to be autonomous, but within clear parameters that make it safe for the patient.*

The organisation has a responsibility to ensure staff are empowered, are working within clear parameters for patient safety and can make decisions. This power to make timely decisions (Procter 2000) by nursing staff at all levels, particularly the ward sister/charge nurse was considered to be important by the majority of interviewees and came through as a strong theme.

> *The Nursing Service needs to be innovative and so we need to give it permission to make changes, by doing this we can best address the needs of the patients and meet the targets as well. I have seen some excellent service developments when nurse are given the freedom. One senior nurse I worked with established a local haematology service as she was concerned at the time her patients spent travelling every day for treatment. She won the nurse of the year for this innovation. More should be allowed to do this.*

McDaniel (1997) supports this suggesting that the health service needs self- referent systems, which encourage autonomy and allow for fluctuations and changes in the service, as people strive to adjust to dynamic local conditions. In addition to this there was a view from the participants that linked back to earlier statements, that from both the Senior Nurses and patient's point of view, there was also the need to be clear who was in control.

At this point it might be interesting to hear the views of a nurse not interviewed for this research but who has a valuable contribution to make to this topic:

"From the most colossal calamities down to the most trifling accidents, results are often traced (or not traced) to such want of someone in-charge or of him knowing how to be in-charge. To be in-charge is certainly not only to carry out the proper measures yourself, but to see that everyone else does so too, ensure that each does that duty to which he is able."
(Florence Nightingale – Notes on Nursing 1859 pp 24.)

Leading on from empowerment their comments progressed to support in the nursing service for innovation. There was an over-whelming view that innovation was essential in a high performing nursing service and that nurses needed to be given permission and encouragement to push the boundaries and try out new ideas.

> *The nurses must be free to think independently and if so they will innovate and be creative in addressing problems and find solutions. Senior Nurses must welcome innovation and if they don't then the service will stagnate. I feel it is usually worth trying something new, as you may find you make great gains in service provision.*

It was considered to be important to value ideas and innovation and the nursing staffs' contribution to the service.

> *Yes, we have to take risks and manage them, but without them we have no innovation or change. We stagnate if we don't take a risk or two.*

In supporting this there is the need to have a learning culture which promotes continuous improvement (Jackson 1998). The editorial in Nursing Management (2005) comments that the Nursing Service needs to move towards a 'can do' culture, which supports and encourages creativity and innovation if it is to succeed (McNicol 2002).

Communication
All interviewees discussed the importance of effective communication in supporting the delivery of a high quality nursing service:

> *If you have nursing staff that communicate well with the patients they usually communicate well as a team and this is set as an example from the top of the office as well. We must have good relationships with each other, which aids*

communication and improves our job and the care of our patients. I have been working with an obstetric team where we had maternal deaths; the main thing that was wrong with the team was that they never spoke to each other about the mother's care – they all did their own thing.

It was said on several occasions that deficient communication by nurses leads to poor interaction with the patient and is detrimental to their care.

The visibility of the Senior Nurses especially the Nurse Director out in the field was considered to be important by all participants:

You have to engage the staff, not just by using e-mails or the phone, but face to face, get out and see them. Communication is essential so Senior Nurses need to be out and about to pick up what is going on. You need visibility so staff can talk to you and don't forget to congratulate them as well!

There was not only the need for an open door approach, but for the senior staff to leave their offices and get out into the clinical environment and meet the staff and patients.

They have to go and look for themselves and being out there amongst it. I often visit my clinical areas to see what is going on I need to be realistic and understand what it is really like out there.

This approach makes the Senior Nurses, particularly the Nurse Director accessible, able to praise staff for good work and constructively criticise if necessary. They also have the relevant information to present a true representation of the service to the Board.

One Senior Nurse stated that*:*

They call me the 'Jack-in-the-box' as the staff never know when I might pop up and have a look at what is going on. In a big organisation this can be difficult for Senior Nurses, so you have to make extra effort to get out and talk to staff and listen of course.

It was essential that the Nurse Director and their senior team were approachable and highly visible, without this they are not in touch with the nursing service and do not understand what it is really like out there and what nurses have to put up with. Mannion et al (2005) notes that poorly performing organisations had management that was seen as remote and disconnected from the day-to-day issues of the wider organisation.

As well as an open, visible approach by the Senior Nurses, many participants considered that there did need to be systems in place to support 2-way communication:

> *There has to be a structure in place to support communication up and down and back and forth. This is essential, rather than relying on ad-hoc mechanisms, as this helps you intervene early if things start to go wrong, you know what I mean: no surprises! Sometimes there is a degree of blindness.*

Frequently the use of nursing forums was mentioned as a good method for disseminating information to staff at the clinical level and if managed effectively also provides a good source of feedback.

> *To help with communication in these large organisations we have tried to be innovative in how we engage with the nurses on the wards. Some Nurse Directors have forums in the clinical environment so nurses can engage with you and get to know you and you understand their issues. I find it interesting that often Senior Nurses don't understand that they have it within their power to get things sorted. If only they knew what needed to be done to put things right for the staff.*

It was further suggested that the Nurse Director could use 'information champions' to disseminate information. None of the participants found the use of newsletters for staff as a good method of communication:

> *I have tried to use newsletters but find they are impersonal and staff feel they are being talked at, they want the personal touch.*

A strong message was that the human contact was important. It was further suggested that some Nurse Directors found an effective communication method was to:

> *I often have sessions in the clinical environment so that nurses can come and talk to me. I operate an open door approach but at the bedside.*

It was identified by Faugier and Woolnough (2002) that engaging with the nursing workforce is important if nurse leaders are to understand the issues at the front line. It is therefore important for the voices, experiences and opinions of nurses to be valued, particularly those at the bed side.

In the large organisations with many thousands of nurses it was considered to be much harder to communicate and have this face-to-face presence. It was therefore important for the Nurse Director to have a management structure that facilitated the flow of communication up and down the organisation.

> *There needs to be a strong network of Senior Nurses to keep the Nurse Director informed, so there are no surprises and also they can disseminate information to the troops.*

These multiple steps in an organisation's structure which information has to flow through were identified by Yourstone and Smith (2002) and that this provides the opportunity for information to be distorted, misinterpreted and misplaced. Several participants commented that the role of Senior Nurses was very important in supporting or blocking the information going up and down the organisation, particularly what goes to the Nurse Director.

> *Well I know that some of the Senior Nurses keep things to themselves, seeing it as a threat to their power if they give other people information. Also they don't want to look bad when things go wrong, so it's better just not to tell anyone. This can be very dangerous.*

It was considered that communication gets stuck at a level in the organisation, particularly at middle management. It was stated that some middle managers do this to hold power for themselves and disempower their subordinates. What this then did was that junior staff no longer felt accountable for their actions.

> *It's the group of staff above ward sister that are the ones that can make the difference. They often sit between the Nurse Director and the front line*

> *nurses and I have seen them either facilitate or block communication up and down the nursing structure.*

It was therefore important for the Nurse Director to ask the right questions to find out what was going on.

> *They need to have confidence in the communication skills of their Senior Nurses and act as an example for them to follow. They also need to challenge and look for themselves to get the truth.*

Vincent and Barker (2005) also found that staff play an important role in the communication processes and can act as an obstacle to information transmission. Information often gets distorted as it passes between people or as it rises through the hierarchy. Supervisors can be the worst culprit in blocking information flow.

A strong message is for Senior Nurses to listen to the shop floor, and act on what they hear.

> *Unless we sort out the means of communication we don't value the views and opinions of the people working at the ground level. If we do value nurses' voices, nurse leaders need to engage in active listening to their staff.*

If the Nurse Director 'walks the job' it acts to demonstrate that the nurses' views and concerns are valued at the top of the office. (Faugier and Woolnough 2002).

Staffing and Management Arrangements

The Nurse Staffing establishments (numbers of staff budgeted for) and the skill-mix of the nursing team were frequently raised as a factor that affected the delivery of the nursing service.

Inadequate staffing levels can have a serious effect on morale and the delivery of a quality nursing service and care (Rafferty et al 2007). We must challenge and ask the question, do we have the right staff to deliver the service, both now and in the future?

> *It is important to get the right establishment and skill mix with the right attitude, enthusiasm and capabilities to build your team.*

It was considered to be of great importance to have the right number of staff for a ward or department.

> *Not only do you need staff with the right skills, but you also have to have the right number of staff to do the work. A poor skill-mix leads to poor care which to me is a false economy, as poor care costs more due to the mistakes that happen and complications for patients, as we saw at Maidstone and Tunbridge Wells Trust .*

One participant commented on how nursing staff levels can be seriously affected by financial pressures:

> *Clinical care can be compromised if you don't have the right staff and equipment to do the job to the right standard. We know lack of money is a real challenge, so I have seen nurses asked to take on extra work, nurses can't do everything, but I have often seen nurses used to fill the gaps left by others. There is great pressure for Senior Nurses to manage this and you have to make difficult decisions to make ends meet.*

Filochowski (2004i) supports the above comment when he suggests, that undoubtedly the healthcare team has to have the correct number and mix of skilled staff. This is further supported by the research undertaken by Rafferty et al (2007) which unequivocally demonstrates the link between staffing numbers and patient outcome, as well as comments written by Marriner Tomey (2008) and the editorial in the Journal of Nursing Management (2005). All these authors share the view that the number of nurses available on a ward is important for quality care to be delivered.

In addition to poor care, an inadequate nursing establishment and skill-mix can have a serious effect on the morale of the staff leading to staff burn-out, with poor job satisfaction (Klein 2006). The delivery of poor patient care is often shown as poor staff attitude, as they are finding it hard to cope with the workload.

> *Well I often say to myself, is it a 'happy ship' or not and if not do we know why not? For I am a firm believer that happy staff means happy patients and staff can only be happy with their work if they have the right number of staff and the right tools to do their job.*

Some interviewees described how it was important to have:

> *Nursing teams that had a mixture of abilities and skills, which could best meet the various needs of the patients. All too often I see that the establishments are based on delivering traditional, old fashioned nursing services and we need to modernise and change as a result of innovations and changes in nursing practice and roles nurses are expected to play today. Establishments are very traditional and do not reflect service change and innovation. We just have to change the way we look at nurse staffing today so we can cope with our future.*

For the nursing service to have the right levels of staff they must be planned for and trained (Rafferty et al 2007). It was considered by the participants that workforce planning was essential, but unfortunately most organisations do not get it right (Procter 2000). When Filochowski (2004i) went into a low performing organisation to turn it around he commented that one of the first things that needed to be done was a ward-by-ward analysis of the staffing requirements, in order for there to be establishments to meet the demands and needs of the patients. One participant stated that:

> *Today there is unfortunately a lack of systematic planning processes linked to the organisations' strategic direction and the ability to horizon scan to predict the future nurse staffing requirements. Workforce planning is essential, but most organisations don't really get it right and so though there could be great value in doing it right, we don't make the most of it.*

The participants further identified that with the changing roles of nurses and blurring responsibilities with other professions (Procter 2000) that too accurately plan the workforce was difficult.

> *Today we do workforce planning on gut instinct and sometimes it works and sometimes it doesn't. We really do need a standardised model for staff planning that all organisations use.*

What workforce planning did provide was the opportunity to look at the gaps in the nursing workforce and the skills available to meet future service needs.

> *It then helps to focus management actions and recruitment to address these gaps, as well as supporting succession planning and staff development. If workforce planning was done properly and on a sound basis then it should be of use.*

The Munich Declaration (WHO 2000) identified as one of the actions necessary to improve the nursing service was to develop comprehensive workforce planning to ensure adequate numbers of nurses.

Participants discussed the need for a clear nursing structure, with a distinct hierarchy, to ensure that staff have good lines of reporting and know who they are accountable and report to. A sound management structure has to be in place so that everyone understands and know where they sit in the structure. The NHS is often hampered by its size, so the nursing management structure needs to be such that this problem is mitigated. The participants considered that the nursing structure should be simple with few layers. If the structure is clear with everyone knowing their roles and what their responsibilities are, then service failure will be identified more quickly and appropriate action taken to improve the service.

> *There has to be a good chain of command and with the wrong structure you are prevented from knowing what is happening in the service. From my experience I find that nurses expect and need a clear hierarchy for them to function effectively. For some reason we like order, it's a bit like being in the army with clear lines of command. I don't think you find this so strongly in other healthcare professions.*

The participants thought that if the structure was wrong it prevents communication and there is no clear order for delegation. Other relevant comments included*:*

> *You may have a structure that looks right, but you still need the right people in the structure*.

The National Co-ordinating Centre (2006) suggested that organisations based on networks or horizontal, rather than vertically layered structures, are often best

adapted to rapid change and uncertainty and provides local flexibility and responsiveness.

One participant commented that:

> *Lots of tiers in the management structure can mean that there is lack of visibility and awareness of what is going on by senior staff. It just seems to dilute reporting systems and chain of command. With lots of layers you can always say it's not my responsibility it's the person below or above. Fewer tiers make it much clearer as to who is accountable and nurses act appropriately. Letting nurses at the front line take control makes things much better for the patient, and by having fewer layers they can easily speak to those at the top.*

A decentralised organisational structure for nurses helps to improve their empowerment and therefore enhance patient care (Urden and Monarch 2002).

Many participants commented on the difficulties caused by frequent reorganisation or restructuring of management arrangements.

> *During this process of reorganisation I noticed that staff lost direction and became unclear about their own accountabilities and who they reported to. The frequent turnover of our Nurse Director and other Senior Nurses combined with acting arrangements had a real effect of stagnation on the nursing service, we have gone nowhere and we don't feel able to move things forward on our own. The staff got confused as to what is expected, I suppose it was the lack of stability.*

Not only was continuity of nursing management thought to be important but also continuity of the nursing workforce.

> *To know what is going on with your workforce you must examine such things as staff turn-over rates, vacancy and recruitment data, along with sickness levels as this would be a good indicator of the state of the workforce and the effectiveness of workforce planning and the management of workload. It is also an indication of whether you should anticipate problems with the quality of care nurses are providing to the patients. Staff retention has to be*

watched, as a good indicator of what nurses think of working in the service in your organisation.

The 14 forces of magnetism (McClure et al 1983) introduced as an accreditation process in American Hospitals, was initiated as a response to improve the recruitment and retention of nurses and address many of the issues identified above.

Role and Fit for Purpose

Understanding their role and responsibilities came through as a clear message from the interviews.

Do all the staff have good role descriptions and annual objectives? The Senior Nurses need to know they are accountable and shoulder responsibility for the service. We need to be sure that people are clear about their roles and responsibilities and that nurses are prepared for new roles. Without a good understanding of their role and what is expected from them, nurses do not feel empowered nor will they accept accountability for their actions. This is asking for trouble and then things go wrong.

As Mannion et al (2005) suggests, for an organisation to be effective staff should have clearly defined spheres of responsibility with clear lines of reporting.

To reinforce this:

Nurses should have good role descriptions which they agree and understand. I have found that with the frequent changes and developments of nursing roles it was essential that role descriptions were regularly reviewed and updated to reflect modern practice if staff are to be clear about their roles. There should be a periodic review process in place and evaluation of the role, supported by clear job descriptions. It is disappointing to see how many nursing roles have been developed that have done nothing to improve the nursing profession, such as physician's assistants.

Particular reference was made by several interviewees regarding the vital role played by the ward sister / charge nurse and how important it was for this grade of staff to know what was expected of them, what they were accountable for and that they were

empowered to do their job. The work undertaken in the 'Free to lead, Free to care' project (Welsh Assembly Government 2008) was considered to be important in strengthening the role of the sister / charge nurse. The Sister / Charge Nurse's role, along with the Nurse Director's role were thought to be the most important for the delivery of a successful nursing service.

> *From my experience it is the Ward Sister or Charge Nurse who provides the clinical supervision essential for good care, whilst the Nurse Director sets the expectations and vision for the service, but they can only fulfil these roles if they are allowed to do them how they feel is appropriate. There are too many people out there trying to tell nurses how they should do their job. They should leave us alone to decide for ourselves. Give us our power back. Only then will we take on the accountability for the service we provide.*

To undertake their roles and particularly the posts identified above, the individuals had to have the skills and demonstrate the competencies for the role. Further, to ensure this happens, it was stressed that the appointment and selection process had to be robust if we are to have the right person for the job*.*

> *Too often we have square pegs in round holes and they just can't do the job. Staff need to know their competences and work within them and people need to understand their limitations if they are to deliver safe nursing care.*

Scally and Donaldson (1998) and Mannion et al (2005) comment that a high performing organisation gives a high priority to the recruitment and retention of staff, with an emphasis on training and education to undertake their roles. Magnet accreditation also recognises the importance of good human resources policies and professional development and education if the nursing service is to be a success (McClure et al 1983). These factors were also identified in the Munich Declaration (WHO 2000). This identified that actions were necessary to address obstacles to recruitment and improve continuing education.

To support the development of those skills and competences it was considered that all staff needed annual objectives supported by a personal development plan.

> *They must have objectives, which have clear links to the organisational strategy and business plan, if they are to make a real contribution to the*

organisation and the nursing service. By doing this others can see how the nursing contribution is of benefit to the success of the whole organisation.

This focus on personal development that equips nurses to contribute to the changing health service and the acquisition of new knowledge and skills, were thought to be essential for the delivery of a high quality nursing service.

There are some fundamental things you have to have in place, such as training and development and Personal Development Plans, as staff need to have the knowledge and skills to do the job. Too often these are over looked and staff feel no one is interested in them and their skills and standards of care slide until mistakes start to happen – it's too late then. For a little time invested in your staff can give great rewards.

The 14 forces of magnetism (McClure et al 1983), The Munich Declaration (World Health Organisation 2000) and the study of important factors for staff nurses (Kramer and Schmalenbery 2001) all identified the need for nurses to have access to professional development and education. It was important for nurses to be kept up to date and be given the opportunity for personal progression.

There was also the need for periodic review of objectives and an evaluation of the personal development plan to ensure that they were implemented and that education and training actually took place.

Proper training plans for staff are necessary and there needs to be systems such as audit in place to make sure we are delivering evidence based care, as without development and education opportunities neither the nurse nor the service will develop and improve.

Support for a learning environment was needed if nurses were to be given the opportunities to develop in their roles and develop new roles to improve patient care.

You have to have a learning culture, a hunger for knowledge and skill development, if our services are to keep up to date.

The above processes needed to be supported through a system of clinical supervision and mentorship. Nurses need guidance and direction from those who are

more experienced. As well as the Senior Nurse supporting more junior staff, they themselves should have confidence to be challenge by other professionals. They have to make sure the expectations of the nurses are clear to them and that the care is delivered in the right way, at the right time and place. They should also be open to others suggestions on how care can be improved.

Staff nurses surveyed as part of the Kramer and Schmalenbery (2001) study also considered that they needed supportive nurse managers and clinical supervision to undertake their role effectively. Having support and supervisory systems in place were thought to be an important mechanism for reviewing practice and recognising examples of good practice from which people can learn and develop.

> *The staff need to know their competencies and work within them. To do this they must have support and supervisory systems in place, as well as professional conduct issues being appropriately managed. If you accept poor practice it becomes the norm. We have to have checks and balances in place and clinical supervision can provide a non-threatening way to maintain standards of care. The role for clinical supervision and mentorship provides reassurance and guidance for individual nurses, which helps them improve their practice particularly when they have had problems to face or things have gone wrong.*

Finally several participants talked of the need for assurance with respect to professional statutory requirements. The regular checking that people are registered with the Nursing and Midwifery Council and that they meet the requirements of periodic registration through professional development was identified as something that organisations sometimes failed to do. Following on from this there needed to be robust systems and processes in place for the management of poorly performing nurses. This included supporting them with training if identified or taking them through the disciplinary process. It was considered to be important to the maintenance of a high quality nursing service for such nurses to be removed from professional practice.

> *Well I would expect to see procedures that ensure all the nurses have kept their registration up to date and poor professional practice is dealt with. I know of a nurse director who was sacked for not being registered himself, what sort of example does is this? Staff need to know what is expected of*

them and what happens if they step over the line. You have to have a line you don't cross, if not patients can die.

Service Quality Assessment and Monitoring

Managing and delivering a high quality nursing service was identified as being very important for the reputation of the profession, the organisation and the wellbeing of the patients. It was thought that these should be top of the agenda for all nurse leaders.

There must be a culture which focuses on quality with the patients as a priority, it's all about what nursing is and we really must not forget this.

Staff nurses in a study of their key factors identified 'concern for the patient is paramount in the organisation' (Kramer and Schmalenbery 2001, Burdett Trust 2006) and the 6th force of magnetism (McClure et al 1983) was high priority of quality care.

You have to maintain a quality nursing service and the nurse leaders should not be reticent to seek external support and advice. I know an organisation where the nurse director would not get external support as she perceived this as a failure in her ability to lead and do her job. Rather I think there is great value in external help and learning from others who have probably been in a similar situation. It can be really helpful in picking up on things (seen by others) and taking early action.

Participants spoke of the importance of having systems in place to monitor and audit the quality of the nursing service. It was considered essential to have the systems in place so you know what is going on and if it is not going as expected, you can put it right. This can only be done if the service has clear standards, so that the nurses know what is expected of them. As Jooste (2004) suggests, ensuring an effective service is delivered, the service needs to have evidence based policies and procedures. These should have been implemented with the full involvement of the nursing staff (Omen et al 2008). This is further supported by Yourstone and Smith (2002) who suggest that there is value in having clinical guidelines and policies to enhance the standards of patient care.

You have to have appropriate standards in place that actually take place in practice and you have to make sure they do.

Frequent reference was made to the 'Fundamentals of care' (Welsh Assembly Government 2003), a document published by the Welsh Assembly which clearly states the standards of care a patient can expect and covers all areas of core nursing care and is applicable to any health care setting. The participants all thought that this should form the basis for monitoring the quality of nursing service.

There should be a sound audit of the service, so you know what the quality of the nursing service being delivered is like and that you can pick up problems and put them right as quickly as possible. I have used the 'Fundamentals of care' audit tool to show me how good or bad a nursing service is and I think it is great for this and that every nurse manager should use it to assure them that things are ok.

It was suggested that monitoring could be undertaken in several different ways. Making regular visits to the clinical area by Senior Nurses and the Director of Nursing was one of these.

This high visibility could also act as reinforcement for the standards, as there would be a sense that you are being watched.

I remember a ghastly ward sister who spent her whole day watching what you were doing all the time. But no one stepped out of line, never, but though I hated the way she did it, you know she did it because she cared and wanted the highest standards for her patients. She made it quite clear what she expected and made sure it happened.

Other systems that needed to be in place included data collection and analysis of quality indicators:

We have developed indicators in my Trust such as infection control rates; mortality rates; rates of pressure sores; patient length of stay in hospital; complaints and incidents and near misses to patients, which help to assess the service at ward level, and if we are delivering good care.

The Burdett Trust (2006) supports this approach and considers that to assess the quality of nursing care and service delivery, specific quality measures must be set and monitored using robust information systems.

Clinical audit was considered to be underdeveloped, but was an important tool in evaluating the quality of the nursing service.

> *Nurses could audit their practice using methods such as the e-fundamentals of care audit tool.*

The reputation of the nursing service was thought to be important not just for the public and patients, but also for the staff.

> *Would you want to work for an organisation with a reputation for poor nursing care? You have to listen to outside messages. What is the reputation of your organisation and the nursing service? We need a 'reputation monitor' to keep us on our toes.*

Complaints, compliments and incidents were described as a way the nursing service's reputation was reported.

> *Are patients and their relatives happy? What do they think about us and our service? We need to look at ourselves and try to make things better.*

The interviewees thought that patient safety was an important aspect of quality. Therefore*:*

> *Having systems to learn from incidents and near misses is vital if the nursing service is to manage clinical risk and improve patient safety. Nurses need time to reflect when things go wrong, with a fair blame culture so we learn from incidents. There is the need to be open and honest when we make mistakes.*

It is important that nurses are able to raise concerns as they can see early warning signs of things going wrong (Dixon-Woods 2010). They should learn from mistakes and be able to take corrective action (Burdett Trust 2006). Looking closely at

complaints and what they say about the nursing service was also a good method of monitoring quality. It was stated that:

> *The Community Health Councils were of great assistance with this area of monitoring, giving an independent view of the quality of the nursing care.*

Finally some interviewees thought that the views of the patient about the care could be monitored by the use of patient satisfaction surveys.

> *We regularly undertake patient surveys, we get them independently issued and analysed and the outcomes and trends reported back to me on a regular basis and also to my organisation's Board. They should provide a system of feedback to the people in-charge of the organisation on how good the nursing service is and what people using it think of it.*

Conclusion

From the analysis of the 9 semi-structured interviews with Senior Nurses in Wales, the themes and sub-themes outlined in the sections above emerged. Through their words the Senior Nurses identified what they considered to be the key factors necessary in the 'Nursing System' for there to be a high quality nursing service.

The themes and sub-themes identified from the interviews above, along with the findings from the review of the case studies were then used to develop the questionnaire. This was used to further ascertain the views of a wider group of Senior Nurses across Wales, and through the results of the questionnaire, prioritise the above factors. This is now described in the next section. It will also provide a validation of the views of the nine Senior Nurses interviewed and ensure these factors are applicable to a wider group of Senior Nurses across Wales.

The Questionnaire

The final part of the research for the study considered the key factors identified by the élite interviews. These factors were then clustered into the following themes:

- Strategic
- Role and Fit for Purpose
- Culture
- Staffing and Management Arrangements

- Communication
- Service Quality and Monitoring.

The key factors under each theme were developed into a questionnaire (Appendix 5) and participants were asked to rank each factor in the theme, as well as providing comments if they wished.

The questionnaire was distributed by e-mail to 65 (n=65) Nurse Directors, Deputy Nurse Directors and Nurse Consultants across Wales. The purpose of this stage in the study was twofold. Firstly to test that the key factors identified by the interviewees were also acceptable to a wider group of experienced nurses. Secondly it was considered that some of the factors may be of greater importance to Senior Nurses than others, the ranking exercise would reveal whether this was the case or not. Since the outcome of this work was the development of a framework for Senior Nurses to enable them to have an effective nursing service, it was important to have the factors in the list that were really important to the nursing service.

The Response Rate

Respondents were asked to identify their category of Senior Nurse (Director, Deputy or Consultant), but no other identifying information was requested, unless they wished to be sent the final framework. It was considered that anonymity was important if the responses were to be honest and open. Because of this approach it was not possible to encourage people who did not respond to submit their questionnaire.

A total of 65 questionnaires were distributed (n=65) to Senior Nurses and despite anonymity, the overall response rate was 63% with 41 (n=41) questionnaires returned.

There was a difference in response rates between the three groups of Senior Nurses. The highest response rate was amongst Deputy Nurse Directors at 66.7% (n=16). Deputy Directors appeared particularly interested in this study, as they thought the results may assist them in identifying areas they needed to focus on for their own career development. Also, many of the deputies were themselves undertaking studies and had empathy for the research.

The lowest response rate was from the nurse consultants at 50% (n=6). This was discussed with nurse consultants involved in the interviews, who considered that nurse consultants were most interested in clinical practice and that this study was more management orientated. Therefore the study was not of so much interest to them as the other groups of nursing staff involved.

The Nurse Directors had a response rate of 65.5% (n=19), which considering their very busy work agenda was a response rate higher than expected. This response rate might show the value Nurse Directors put on having a framework to help them in their work, with one of the Nurse Directors commenting:

> *I am new to my post as Nurse Director and it would be very helpful to have a check list to help me get things right.*

The information gained from the questionnaires (Appendix 5) was very informative for the study. It was not just the ranking information, which provided insight into the views of Senior Nurses, but more importantly the comments they made. There were a very large number of comments, which proved to be of great value in developing the final list of key factors.

How did the Senior Nurses Rank the Key Factors?

The Respondents (n=41) were free to rank the factors as they wished. Following discussion with several Senior Nurses who had been sent the pilot questionnaire, it was agreed that factors could be equally ranked. Many considered it to be too difficult to identify one factor as more important than another, so ranked them at the same level. Because of this a larger proportion of factors were ranked 1 and 2. This was beneficial as it demonstrated that it was important to have the majority of the factors identified in the interviews included in the framework.

Strategic Theme

The respondents were given the following statements to rank:

1   A local Nursing Strategy, 'Designed to realise our Potential' is in place (Welsh Assembly Government 2008).
2   There are clear and accessible policies and procedures to guide nurses in providing and managing care.

3   There are regular reports by the Nurse Director covering service quality and professional issues presented to the Board.

4   Nurses have an active role in the making of key strategic decisions.

The rankings are displayed below:

Question Numbers								
	1		**2**		**3**		**4**	
Rank	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**
1	13	32%	16	39%	11	27%	25	*61%*
2	8	19.5%	11	**27%**	11	**27%**	11	**27%**
3	8	19.5%	8	19.5%	10	**24%**	5	12%
4	12	**29%**	6	15%	9	22%	0	0%

The table above shows a clear front-runner for the most important of these key factors, that being 'nurses having an active role in decision making'. 61% of respondents (n= 25) ranked it number 1 and this was supported by their comments.

There was a view that the development of a nursing strategy (1) was linked to nurses being involved in making key strategic decisions including what their strategy contained.

> *However, in my experience, unless nurses are involved in the formulation of the strategy, ownership and understanding is variable. Nurses need to feel that their professional views are valued and point 4 is a very positive way forward in ensuring the strategic direction of patient care is influenced by all nursing disciplines.*

It was further recognised that to be involved in the decision-making processes:

> *Nurses need to foster professional credibility in and outside of the profession to be able to influence and have an active role in making key strategic decisions.*

Not only was credibility important but recognition by others in the health service that nurses had a valuable contribution in the decision making process (Procter 2000).

> *Nurses need to be perceived as being key in decision making processes for the development of strategic direction in the NHS.*

This factor was summed up in the following statement that:

> *Nurses with active roles at all levels of the organisation using their knowledge and skill to influence key strategic and operational decisions are essential.*

Including factor number 4, two other factors tied for second place, these were factors 2 – 'clear and accessible policies and procedures' and 3 – 'regular reports by the Nurse Director to the Board'. These rankings indicate the problem some respondents had in prioritising the key factors.

> *All are essential to ensure effective delivery of evidence based care as the overall nursing contribution to patient care is maximised.*

The Nurse Director's role at the Board had several comments and though it was not ranked 1ˢᵗ they did not wish to see this reduce the value of this factor.

> *Whilst I have scored 2 in two areas, I think it extremely important that the leadership is clearly demonstrated at Board level.*

The nursing voice at the Board was considered to be important.

> *Ensuring that the nursing voice is heard on the Board is important, as often others feel they can speak for the profession and also it is important that nursing is a significant agenda item for Boards.*

Respondents considered that all 4 factors were linked together, but some thought that unless there was a voice at the Board the other factors were difficult to effectively implement.

> *It is key that there is a vision in place and that the nurses' voice and position is heard that in turn ensures that bedside is in the Board room. Nursing has a key unique contribution to make in ensuring the patient is central to the service and business.*

One individual summed the situation up:

It is difficult to rank as all are important, but rationale is that the Nurse Director reports on care / nursing issues to the Board is the key with each of the other three points following automatically.

The factor that ranked last was statement 1 – 'A local nursing strategy'. No one ranked this as number 1, with 29% (n=12) ranking it 4th. This ranking was reinforced by the statements made, such as:

Whilst I agree all aspects are important, I believe that the development of a local strategy will be informed by the other statements.

One respondent explained the reason for ranking it 4th by stating that:

All 4 are important and although I have ranked the nursing strategy as 4th, it is important for there to be a clear local strategy in place which enables local interpretation of the national strategy, setting clear objectives for all nurses.

A further comment made considered that perhaps a local strategy was not needed as there was already a national one.

Whilst the strategy is important at local level, I have ranked this 4th as the national strategy is in place.

One participant was concerned at the strategy not being based on real life and that the important thing was not just having a strategy, but rather that nurses were involved in deciding what was in it and had control over their future.

In my view the majority of the nursing profession see a strategy as something divorced from their day-to-day practice and not something they need to get involved in. I would suggest that having a clear understanding of how the strategy is developed and how the profession can influence the strategy followed by how the strategy can be implemented in local practice, are key ingredients for high quality care.

In this section of the questionnaire some people considered that all key factors were important and so gave them all a high ranking.

> *All are essential to ensure effective delivery of evidence-based care as the overall nursing contribution to patient care is maximised.*

In support of this another participant stated:

> *I feel all the above are key issues in providing high quality nursing service. Nurses at all levels must be involved and own the vision.*

Role and Fit for Purpose

Statements from the questionnaire that were ranked:

5 Nursing staff have clear relevant job descriptions to enable them to perform their role.

6 Nursing staff have annual objectives and performance reviews.

7 Nursing staff have training and development plans agreed regularly.

8 Professional registration checks for nurses are in place.

The rankings are displayed below:

Question Number							
5		**6**		**7**		**8**	
Rank n =	%	n =	%	n =	%	n =	%
1 11	27%	19	46%	13	32%	25	*61%*
2 15	**37%**	7	17%	13	**32%**	2	5%
3 7	17%	15	**37%**	5	12%	4	10%
4 8	19.5%	0	0%	10	**24%**	10	**24%**

With this section of the questionnaire there was a clear key factor that ranked 1. This being the 'registration checks for nurses'. This was an unexpected issue to be identified, but the comments revealed why this had been put first. 'Nurses have to be registered'.

> *It is our duty to protect the public, it is most important that professional registration is monitored. However, to comply with re-registration requirements it is essential that staff work to agreed job descriptions, receive annual reviews and training and development needs are identified. This is why I have ranked all the above as most important.*

It was still interesting to see this issue was number one, as it had not been identified as a factor in any literature. One respondent put it 1st as:

> *This is a statutory requirement.*

This could be the reason why so many put it first. Since it has to be done by law, it therefore must be put first above the other factors that were seen as optional.

With respect to the other factors it was evident that many respondents found it difficult to prioritise them as they considered them to all be important.

> *These are all of utmost importance to ensure the nursing workforce are functioning and delivering high quality care.*

What the respondents did do was link the factors together, with question 5 (job descriptions) and 7 (training and development plans) being ranked 2nd.

> *Whilst I have ranked these in order of importance they are interlinked and could be seen as of equal importance.*

Though clear, relevant job descriptions (5) were seen as important.

> *There is evidence that one of the indicators for effective governance is role clarity, therefore I think this is the most important of these options.*

There were a few negative comments regarding the use and reliability of job descriptions.

> *Job descriptions do not hold all of the detail and very rarely keep up to date with changes / responsibilities experienced by staff within their working*

> *environment. Too much focus on Job descriptions could lead to an environment which does not allow for freedom to act.*

It was also considered that job descriptions should be robustly written and linked to the knowledge and skills framework (KSF) used by the NHS for developing staff.

> *Job descriptions are often variable in their information, sometimes providing a 'skeleton' of the role and must be supported by a full KSF profile. By constructing a job description in this way there is a clear link to statement 7, that training and development plans are agreed. It is this profile (KSF) that enables nurses to consider more fully their training needs and annual objectives, which in turn should enable them to better fulfil their role.*

Another respondent articulated how the job description is clearly linked to training plans and that without a role description it was difficult to construct a realistic performance development plan (PDP).

> *To undertake a PDP, set objectives and agree a training plan, you need a good job description, personal specification and post outline.*

The importance of training and development to delivering a high quality nursing service was discussed by the participants:

> *Competency is critical and supporting nurses to gain and maintain the necessary levels of competency is essential if safe, quality care is to be delivered consistently.*

Further if staff are to be competent in their work then training has to have a priority*:*

> *Training and personal development of nursing staff allows for a skilled workforce.*

This again links back to the role nurses are expected to perform, so it is obvious why participants find it difficult to separate these two factors when undertaking the ranking.

> *The core to an individual is ensuring that they have the knowledge and skills to perform the role for which they are employed.*

Moving on to statement 6, (annual objectives and performance reviews) which was ranked 3rd, but interestingly was the only statement to have no one ranking it 4th. The other 3 statements (5, 7 and 8) all had approximately equal numbers of respondents placing them 4th.

Respondents considered that by having an annual performance review it provided the opportunity to review their job descriptions.

> *Many nurses don't look at their job descriptions following appointment but by having performance reviews in place, the job descriptions should be updated and reviewed as part of the process.*

It was also thought that through this review process there could be reflexivity on the nurse's practice and their contribution to the nursing service.

> *Nursing is a dynamic profession; nurses must therefore have the opportunity to reflect on their practice and contribution to health care improvement. This should be through a formal appraisal process, supplemented by clinical supervision on clinical team reflections.*

The value of annual performance reviews was summed up by one of the respondents when they stated:

> *Without regular review and clear defined annual objectives, it's very easy for nurses' roles to 'drift' as current climate is very reactive rather than proactive. They need regular opportunities to reflect on achievements as well as identifying needs for further development.*

As stated earlier participants found it difficult to rank these statements as they thought they were all important. The following two quotes sum this up:

> *This section was difficult to rank as each are interdependent rather than mutually exclusive.*

All the above (statements) must go hand in hand if the workforce is to be fit for practice.

Culture

The following statements were ranked in relation to the culture of the organisation and the nursing service:

9   Nursing staff demonstrate a professional deportment at all times.

10   There is a positive approach to multi-professional team working.

11   Ward managers/sisters/charge nurses having control over their budget (staff and equipment).

12   Nurses are empowered and able to make decisions regarding the clinical area they work in.

13   Nurses are free to raise concerns without fear of sanction.

14   The organisation supports nursing staff to be innovative in their practice, allowing risk taking to promote change.

15   There is a learning culture which supports the delivery of a good nursing service.

The ranking are displayed below:

	Question Number												
	9		**10**		**11**		**12**		**13**		**14**		**15**	
Rank	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**
1	15	37%	9	22%	8	19.5%	22	***54%***	13	22%	7	17%	12	29%
2	2	5%	10	24%	8	19.5%	12	**29%**	6	15%	12	**29%**	6	15%
3	2	5%	9	22%	2	5%	1	2%	3	7%	8	19.5%	11	**27%**
4	9	**22%**	2	5%	2	5%	2	5%	7	17%	3	7%	5	12%
5	2	5%	6	**15%**	6	**15%**	3	7%	7	**17%**	2	5%	1	2%
6	4	**10%**	5	**12%**	5	**12%**	1	2%	3	7%	5	**12%**	4	**10%**
7	7	17%	0	-	10	**24%**	0	-	2	5%	4	10%	2	5%

Statement number 12 (nurses are empowered) was a clear 1st ranking, scoring over 50% (n = 22) with 29% (n = 12) also scoring it rank 2nd. There were strong views expressed that without empowerment of nurses, they were unable to deliver on the other statement areas identified.

> *By ensuring factor 12 is in place, it will ultimately encourage all the other*
> *factors above and develop a culture that promotes innovation and change.*

There was a poignant comment made in that nurses perceive that they are not empowered and this is reinforced by the attitude of other professionals and nurses themselves.

> *There is a perception that the organisation is medically driven with little*
> *support or consideration given to other professions (including nursing).*
> *This gives a feeling of disempowerment and lack of confidence.*

Several respondents refer to the Welsh Assembly Government (WAG) initiative for sisters / changes nurses, called 'Free to Lead, Free to Care' (Welsh Assembly Government - WAG 2008). This was a project designed to empower front line nurse leaders, who had expressed concern to the Minister for Health and Social Services, that they no longer had any authority or control over the nursing service they managed.

> *The philosophy of 'Free to Lead, Free to Care' is crucial if nurses are to*
> *influence the culture of the organisation and team in which they work.*

The same view as expressed by another participant when they stated:

> *Given the recent commitment by WAG to clinical leadership to improve*
> *patient care, it is crucial that nurses are empowered to improve patient care*
> *otherwise policy direction is mere rhetoric.*

It was interesting to see that statement 9 (nursing professional deportment), though highest at the 4th ranking, also scored high in the 1st ranking with over a third of the participants ranking it 1st.

> *A professional approach to work, behaviour and attitude is key.*

The work of the Free to Lead, Free to Care project (WAG 2008) did identify the need for a new uniform, which clearly identified the nursing profession from others and a policy on the appearance of staff not wearing a uniform.

> *Number 9 'professional deportment', if this is inclusive of wearing uniform properly and acting in a professional manner at all times then this is ranked 1.*

Further to this it was identified by a recipient that if nurses are professional in their appearance and attitude, then they earn the respect of others for the nursing profession and service.

> *It is important that the nurse works in a professional manner and often this is forgotten. The ability to be professional in outlook engenders respect and trust from others.*

Along with statement 12 (empowerment), statement 14 (nursing innovation) was ranked 2nd. Several of the participants commented that innovation is closely related to the nurses' willingness to take risks and in some cases their reluctance to push the boundaries due to the chance of negative consequences.

> *You want people to deliver a good quality service, but you also want risk taking and promotion of new practices. However, in the society in which we are working with high volumes of litigation this promotes negative ways of practicing.*

This concern at the effect of risk taking was commented on:

> *Number 14, risk taking must always be 'assessed', patient safety must be paramount.*

An interesting comment was made in relation to the patient's role in risk taking and innovation.

> *Patients have a right to determine their own outcomes and too often that right for them to take acceptable risks may be hindered by nurses and other professionals who may be risk averse.*

This clearly blames nurses for lacking innovation which could improve patient care because they are frightened of the consequences of taking a risk. This links back to the previous comments, with patient safety being important, as well as empowering nurses to make changes.

One participant summed up the views on this statement by stating:

Managed risk taking within a supportive infrastructure can bring about positive change.

Ranked 3rd was statement 15 (a learning culture):

A learning organisation will value and learn from effective nursing practice and promote multi professional working.

A culture that supports learning and professional development was thought to be important for a quality nursing service. This learning needed to be supportive through clinical supervision and participation in research.

A culture that promotes the use of evidence based care and encourages individuals to understand why they are doing something is needed. I think more needs to be done to promote clinical academic careers and the undertaking and application of research in practice. Staff should have clinical supervision and monitoring support as they develop in their roles / careers.

It was also identified that a learning culture:

Encourages and promotes innovation and change.

With respect to statement 10 (multi-professional team working), it was ranked 1st, 2nd or 3rd by a large number of respondents, who clearly considered it to have an important role for the nursing service to thrive and for nurses to have their professional roles recognised.

Nursing has been subjected to the hand maiden image, which is still very evident in the current climate. Nursing must demonstrate the ability to be equal partners in a team and bring different but valuable skills to the others in that team.

The statement that had the highest number of people placing it last in the ranking was number 11 (budgetary control). This was not identified as particularly important for a good nursing service and received no specific comments.

Many general comments were made regarding this section on culture, particularly in the relationship the statements had to each other.

> *This section was hard to rank as they are all important. I ranked in the way I did because I saw my ranking as incremental. One leads to the other but they are all important.*

> *The prioritisation of these are very much relative, they are all important to a quality nursing service.*

Further comment was made with respect to the link between the culture of the organisation and that of the nursing service*.*

> *It is the culture of the organisation that can empower nurses and allow the nursing service to thrive. The culture of the profession is one topic whilst the culture of the organisation is another, but the two are intrinsically linked, especially as nurses usually make up the highest proportion of the workforce. However, large numbers do not necessarily mean high influence and there is a need to support the nurses' ability to believe she has some power and authority to both shape the culture and have a voice within the organisation.*

Staffing Levels and Management Arrangements

The following statements were ranked:

16   The nursing service has appropriate staffing levels, relevant to the specific clinical area.

17   Dependency assessment tools are used.

18   There are robust workforce plans.

19   Nursing staff have clear lines of reporting in the management structure.

20   Frequent management changes are stimulating and a positive benefit for the nursing service.

	Question Number									
	16		**17**		**18**		**19**		**20**	
Rank	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**
1	34	*83%*	6	15%	12	29%	11	27%	1	2%
2	4	10%	11	**27%**	14	**34%**	14	**34%**	4	10%
3	2	5%	9	**22%**	9	**22%**	8	**19.5%**	6	15%
4	1	2%	13	**32%**	5	12%	8	19.5%	3	7%
5	0	-	2	5%	1	2%	0	-	27	**66%**

The table above shows the rankings for statements 16, 17, 18, 19 and 20.

There was an overwhelming view that the top ranking statement, and therefore the most important factor, was that the nursing service should have the appropriate staffing levels, relevant to the clinical area.

> *It is paramount that we have the correct workforce in place that includes appropriate agreed up-lifts.*

> *Adequate staffing levels are needed to provide a safe level of care and this should be paramount in any service.*

Participants further commented that it was not just having the correct numbers of staff, but there had to be the right skill mix.

> *Number 16 is top, with appropriate staffing levels and appropriate skill mix with defined levels of responsibility and accountability.*

Another respondent stated that having the right numbers of staff was not only necessary for safe care, but also nurses need the time to innovate and change practice.

> *Staffing levels and skill mix must be sufficient to provide good quality and safe care but should also be sufficient to support innovation and practice development.*

All nurses have a responsibility to ensure patient safety; this can be through a combination of registered and non-registered healthcare assistants. However, the latter must be supervised.

Even more serious were comments one participant made, which indicated that low nurse staffing levels could lead to an increase in patient deaths.

The RCN report which evidenced that hospital deaths can be linked to low staffing levels was criticised by many general managers as being poor research (often the case when you don't like the findings). In my professional view this is the single most important factor in delivering a high quality nursing service.

It was identified that staffing levels were not static but required periodic review to ensure they continue to meet the demands of a changing health service. Frequently appropriate staff numbers was raised in the study and also that this matter has still not been tackled. This issue is also well documented in literature (Rafferty et al 2007, McClure et al 1983) and research undertaken over decades, but still this important factor has yet to be appropriately addressed. This was identified as a major contributory factor in the patient deaths at Mid-Staffordshire NHS Trust (Healthcare commission 2009)

It is important that staffing levels are constantly reviewed to take into account the dependency levels and clinical outcomes.

Statement 20 (frequent management changes are stimulating) was ranked last (5th) by a large proportion of respondents (n=27) who strongly disagreed with the statement. There was a clear view that frequent changes in management arrangements were detrimental to a high quality nursing service.

I am concerned that too frequent changes (20) may cause instability and therefore less clarity.

Constant changes at management level can cause disruption and de-motivate staff.

The reason for the negative effect of frequent management changes was thought to be due to the way it caused staff to worry about their own job and how it affected members of their nursing team including their leader.

> *Frequent management changes can bring anxiety and destabilise a team. Although there are benefits to changing management, the risks should also be considered.*

Some participants saw there were some positive advantages to changes in management structures.

> *Although management changes are often necessary they can be stimulating, change can be a positive thing which supports and stimulates improvement, but frequent change does not benefit patient care or staff development. I do feel that this stimulation has greater benefits which outweigh the negative consequences.*

Undoubtedly the nurses surveyed considered that frequent management changes were not good for a high quality nursing service to succeed.

> *Whilst I agree that change can be stimulating, it can also de-stabilise staff.*

> *There is not always a clear understanding of why the change has taken place. This can lead to low morale, which in turn has a negative effect on the nursing service. Nurses are left tired and frustrated.*

Question 17 (dependency tools), 18 (workforce plans) and 19 (clear lines of reporting) had similar rankings, with question 17 having the largest number at rank 4th.

Participants identified the value of dependency tools:

> *Therefore robust dependency assessment that indicates the dependency of the patient and the staff skill mix to meet the patient needs is essential.*

They also indicated the connection between staffing levels, skill mix and dependency assessment.

> *Staffing levels, skill mix and work load assessment can only be done effectively if the dependency and needs of patients are assessed using an evidence / research based tool.*

Several respondents commented on workforce planning, but generally in a negative way.

> *Historically workforce planning has been poor and has lacked integration. If robust workforce plans are in place, appropriate staffing levels will be available.*

It was recognised that despite the current position of generally poor workforce planning in the health service, it was important to get it right if we are to have the correct staffing levels in the future.

> *Historically nursing establishments and workforce plans have been inadequate and cannot just change overnight. Evidence based adequate planning will identify the adequate levels that should be in place.*

A point was made that workforce planning had focused on secondary care services and that with the development of new nursing roles, workforce planning for the nursing service needed to be adapted to take account of these changes to the service.

> *There are no tools that can be used to help with workforce plans. Much of what is developed is aimed at a secondary care service and those who work within a different environment often struggle with tools and plans laid out for these organisations. This often gives the impression that nursing is chaotic and does not fit well into less traditional professional roles.*

One statement made sums up the views in saying:

> *Dependency tools and workforce planning are valuable but should not replace professional judgement.*

Finally statement 19, clear lines of reporting in the management structure, was ranked fairly high with no-one ranking it last. Only one participant commented on this factor:

> *Clarity of structure affords transparency*.

Respondents did not feel this was worthy of comment despite ranking it as a fairly important factor.

Communication

The following statements were ranked:

21   The Nursing Director and Senior Nurses have high visibility across the organisation.

22   The nursing service has robust systems of 2-way communication within the management and professional structures.

23   The Senior Nurses / Director listen and respond to the nursing staff.

24   There are Nursing Forums at all levels of the nursing service.

25   The vision / strategy for the nursing service are communicated to the nursing staff.

The table below shows the ranking of the statements:

Question Number										
	21		**22**		**23**		**24**		**25**	
Rank	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**
1	18	*44%*	16	*39%*	18	*44%*	10	24%	18	*44%*
2	9	22%	8	19.5%	5	12%	9	22%	12	**29%**
3	5	12%	6	14.6%	8	**19.5%**	7	17%	3	7%
4	5	12%	6	14.6%	9	**22%**	3	7%	5	12%
5	4	10%	5	12%	1	2%	12	**29%**	3	7%

This section on communication was interesting in that out of the 5 statements 4 were ranked 1st. The comments showed that the Senior Nurses involved in this questionnaire considered that all except one of the aspects of communication identified were important for a quality nursing service.

> *There is a need for nurses to feel valued and that contributions they make are heard and responded to, either to accept their contribution or not to adopt it, but nurses need the feedback to encourage the learning culture for them individually, for the nursing profession and for the organisation in which they work.*

As one respondent summed it up:

> *It was difficult to rank as 22, 23 and 25 are all crucial.*
> *Leadership and engagement are critical at all levels.*

The visibility of the nurse leaders, particularly the Nurse Director was seen as key in facilitating wider communication throughout the nursing service.

> *Having a visible Nurse Director would enable effective communication between management and the professional structure.*

Visibility was clearly considered to be important.

> *"High visibility in and outside of the profession is an essential component of effective leadership."*

Visibility of leaders was not just important for communication but:

> *Visibility through many forms establishes trust and honesty and a culture of freedom to share concerns, issues, developments, opportunities and threats.*

One respondent commented on the difficulties reorganisation can have on the Nurse Director having the time to be out in the service and visible and that at this time a focus on communication had to be a priority.

Whilst I believe that item 21 is the most important it is likely in the new organisations that the Director of Nursing is unlikely to be very visible and will need to consider ways of better engagement.

A comment was made that:

Number 21 is absolutely crucial in delivering high standards of care and if the example of good communication was set by the Nurse Director, then the other statements that support good communication in the nursing service would also happen. If Nurse Director / Senior Nurses are visible at all levels (2 way communications, not just top down) the other things should follow. Accessibility and approachability is key to good working relationships.

Systems of two-way communication were also considered to be important*:*

In my opinion the 2-way communication system is slightly more important than the visibility. All of the above are important though I think 22 can have the most impact on the organisations culture and nursing empowerment.

The focus on two-way, rather than top down communication was emphasised and how important it was for the nursing service to be successful*.*

Good communication is key to any organisation or professional group's development. How it is done is important. Often nursing messages are seen as bureaucratic, top down, imposed and negative, limiting or stopping the service moving forward. If communication is done in a constructive way they can engage not only the nursing staff, but others.

This system of two-way communication was seen to empower the nurses so they can provide feedback to the nurse leaders. Getting the right method of communication was essential for it to be effective*.*

Good communication would also need to include the methodology of how it is undertaken, with feedback to ensure the correct messages have been received. It is a vehicle not just an act in itself.

Two-way communication has to involve Senior Nurses listening to their staff, without this they are unable to act to address the issues being raised by the front line nursing staff.

> *Directors of Nursing need to listen and not only 'physically' be seen within the organisation, if their (or nurses) views are to be heard and acted upon.*

One suggestion made during the interviews was that nursing forums were a good way of communicating with the nursing staff. This was ranked last (5th) in the questionnaire and was not seen as important as the other 4 factors for having good communication.

Despite this there were some positive comments in respect of Nursing Forums.

> *All nurses should have an equal opportunity to express views, express concerns, etc. So forums at all levels, although probably difficult to establish initially, are very important.*

They therefore may form one aspect of communication Senior Nurses might like to consider when developing their internal communications strategy.

Service Quality Assessment and Monitoring
The following statements were ranked:

26   The 'Fundamentals of Care' are implemented and then audited on a regular basis.

27   There are systems for reporting and learning from incidents.

28   There is active audit of nursing practice.

29   The nursing service invests in the development of champions to drive forward nursing research.

30   Nurses listen and learn from patients' complaints and comments.

31   Nurses are encouraged to improve the standards of their record keeping.

32   Care decisions are based on evidence gathered through the use of nursing assessment tools, e.g. falls, nutrition, pressure areas.

Table 6 shows the rankings of the statements above:

Question Number														
Rank	**26**		**27**		**28**		**29**		**30**		**31**		**32**	
	n =	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**	**n =**	**%**
1	22	*54%*	13	32%	11	27%	5	12%	18	44%	10	24%	10	*49%*
2	5	12%	9	**22%**	9	**22%**	6	14.6%	9	**22%**	1	2%	8	**19.5%**
3	5	12%	8	**19.5%**	6	14.6%	2	5%	3	7%	5	12%	5	12%
4	5	12%	7	**17%**	4	10%	3	7%	2	5%	2	5%	5	12%
5	0	-	2	5%	5	12%	4	10%	7	**17%**	7	**17%**	2	5%
6	0	-	2	5%	2	5%	14	**34%**	2	5%	7	17%	1	2%
7	4	10%	0	-	4	10%	7	17%	0	-	9	**22%**	0	-

Two statements were clearly ranked 1st. Both numbers 26 (fundamentals of care are implemented) and 32 (care decisions were based on evidence, using nursing tools) were seen to be very important factors.

The standards set in 'Fundamentals of Care' (WAG 2003) were cited by respondents as being key to nurses delivering a high quality service to the patients.

> *The Fundamentals of Care are just as it states, Fundamental. They clearly set out the expectations for the quality of care patients should receive and if we implement them then the service should be good.*

The use of policies as part of implementing the Fundamentals of Care was discussed, as it was considered that implementation can be hard to achieve with all the competing priorities. By having policies in place this helped to reinforce the importance of good standards of care for patients.

> *Overall policies can be difficult to interpret at clinical practice level and you can feel that it is just another thing to do. Nurses need to understand the importance of policies and how they fit into improving patient care.*

There was a very positive response to the use of assessment tools to steer the decisions nurses make regarding patient care planning.

> *Nursing assessment tools are one aspect on which to base decisions, as is professional judgement and the wider assessment of the multi-disciplinary / multi-professional team.*

It was also suggested that the use of these tools supported evidence based nursing care and improved the knowledge base of the nursing staff.

> *If evidence based practice is the norm it supports a learning and development culture.*

Three statements were then ranked 2nd, 27 (learning from incidents), 28 (nursing audit) and 30 (listening and learning from patients). One respondent summed up the importance of all three statements when they wrote:

> *Nurses need to be able to critically evaluate their work and understand why they do things. To improve we must always evaluate what we do.*

The involvement of patients in improving nursing care elicited several comments and clearly there was a view that the patient had a significant contribution to make to a high quality nursing service.

> *There is also a need to proactively listen to patients and their carers when making care decisions. Patients and their carers are often the 'experts' in their health condition and what they need, but do we really include them as fully as we should in the assessment and care planning process?*

A further comment was made that:

> *We should listen and change practice and if we involve the patient this could provide nurses with the true measurement of the patient experience.*

Nursing research was ranked 4th, not because it was felt to be of little value, but rather because the other statements were considered to be underdeveloped and should be a priority for improvement before there is an investment in research.

I have ranked research low and feel uncomfortable with it, but I felt it was hard to rank in this category. I think nursing research is vital but compared to ensuring the Fundamentals of Care is introduced, it gets a lower ranking.

The lowest ranked statement was record keeping and one comment explained why.

The importance of good record keeping in nursing is increasingly being overlooked, but I put record keeping last only because it is already a statutory requirement and they should need no encouragement.

It was assumed record keeping happened and therefore did not need the focus of nurse leaders and was not an important area for them to act on.

Several people thought that all the statements were important:

Difficult not to rank all 1 as they are all vital components of a high quality nursing service. And that the Nurse Directors should ensure they happen: *all these are important and Directors of Nursing should have actions in place to ensure all of these happen.*

Conclusion

The questionnaire process was a valuable exercise in prioritising the views expressed by the nine interviewees. It has provided this study with the opinions of a much wider (41) cohort of Senior Nurses. Their scoring and comments add validity and rigour to the development of the final list of key factors seen by the senior staff within the nursing profession as important in delivering a high quality nursing service.

Chapter 5

Analysis of Results

Introduction

This chapter analyses the results described in chapter 4, developing them to produce the key elements of the Senior Nurses' framework presented in chapter 6. The focus of the analysis is to identify the key factors that are missing from the nursing service when things go wrong, and what should be in place in the nursing service for it to be successful in ensuring patient safety and service quality in the future. Chapter 5 further provides a greater understanding of the application of these key factors by reference to the evidence from the literature review.

The Staff and their Role in the Nursing Service

By cross referencing the three areas of work; Magnet factors (McClure et al 1983), staff nurses' essentials of magnetism (Kramer and Schmalenbery 2001) and the current study, similarities were identified though there were also key areas that had been omitted from the work undertaken in the USA. These are now discussed below.

High quality nurse leadership was a significant priority in Magnet hospitals and also for the Senior Nurses in Wales. The nurses in Wales through a critical nursing science (CNS) approach (Berman et al 1998) went further and described the importance not only of Senior Nurses involvement in setting direction and expectations for the service, but also in them having a strong voice at ward level and the Management Board, so that nursing issues are heard, recognised and acted upon and for the Nurse Director to have influence. In support of this leadership theme, all three studies identified the need for a good management structure that provides sound supervision of the delivery of patient care and a style of management that is supportive.

Through a critical nursing science (CNS) reflective approach, empowerment of nurses, particularly those in senior roles, emerged as one of the major factors for the success of the nursing service in this study. The other two studies speak of nurses having autonomy within the clinical team, being seen as an equal and having control over their own practice and the environment in which they work. This is the same empowerment sought by ward sisters in Wales, who now have the strategy 'Free to

Lead, Free to Care' (Welsh Assembly Government 2008) to support them in their quest for control. While the American studies focused predominantly on empowerment at the bed side, neither recognised that this has to go hand in hand with empowerment of nurses at all levels of management, especially at Board level, which was a significant factor stressed by nurses in the current study.

Issues regarding the nursing staff emerged as a theme within all three studies. One area of focus, that was fundamental to providing a high quality nursing service, was having the right number of staff with the right skills for the job (Procter 2000, Rafferty et al 2007). Senior Nurses participating in the current study put staffing levels as a high priority. In the USA research the staff nurses ranked this 7th, giving it a lower priority, which may be due to the fact that low staffing is not such an issue in the USA as it is in Wales.

The other main area of overlap between the findings of two US studies and the current study was in relation to the education and development of nursing staff. Though all identified this as a key factor involved in the delivery of a nursing service, the staff nurse study put this factor 6th out of 8, fairly low down the priorities. In contrast the current research, though ranking it higher, did not place this factor as the highest priority. There are greater risks to the delivery of the service if the staff are not educated and skilled to deliver it (Rafferty et al 2007). These risks do not seem to be seen as important in the US studies, when compared with the much higher prioritisation in the research.

There appears to be a fundamental difference between the American studies and the findings of the current study. The US work focuses strongly on the social aspects of working as a nurse. They very much prioritise areas that are seen to make the nurses happy. Such things as good working relationships, team work, the ability to make your own decisions in your work and supportive management, were all important to the nurses. The research as well as identifying similar social issues, further identified factors which would improve the nursing service system and the environment in which it operated, so ensuring a high quality nursing service from a patient's perspective, as well as from a nursing one. The current research, which used a critical nursing science (CNS) approach to enable the Senior Nurses to be reflective, has provided knew knowledge and identified factors not considered in the USA studies that have an impact on the quality and safety of patient care.

Will these Factors Prevent Failure?

The original motivation for this research was to prevent failure of nursing services in Wales. Even as the thesis is being written further press reports of deaths in hospitals due to poor nursing care are being reported (Health Services Ombudsman 2011). Significant differences have been identified between the two types of literature reviewed and the results of the current study. The nursing literature supports the views of the Senior Nurses, but the general literature on health service failure pays little attention to the front-end delivery of quality care by the nurses. Rather it focuses on higher level systems, processes and targets.

Since this current study identified a larger range of factors than just those that directly benefit the staff, the remainder of this analysis considers these factors in greater depth. As discussed earlier this research has led to the development of the first comprehensive list of factors that could if implemented prevent failure in the nursing service. It has taken an approach that explored the key components of the nursing service system within the Welsh Health Service.

The literature reviewed focused on either particular components of the delivery and organisation of the health service or specific aspects of the nursing service. It was considered by the researcher that there was potentially something fundamental about how the nursing service is organised and its systems work, which when these factors combine together lead to the service failing. None of the previous work looked at the whole process involved in delivering the nursing service; rather it had a fragmented approach. Further it did not utilise a CNS method to obtain the considered views and opinions of Senior Nurses themselves.

Ethos and Leadership

There are overlaps between the current study and issues raised by the various literature reviewed earlier in chapter 2. As previously recognized (pp30) leadership was seen as lacking in failing organisations and nursing services, but leadership encompasses many factors and needed to be further dissected so the factors are clear.

Filochowski (2004i) and Jackson (1998) both describe the importance of having a vision and outlining what the expectations are for the staff to deliver the vision. The Senior Nurses in the study also emphasised the importance for the nursing service to

be clear on its expectations and that the Nurse Director should articulate a clear vision of where the service is going.

Filochowski (2004i) further feels that clinicians should be involved in the leadership of the organisation. The Senior Nurses in the study go further with their views that clinicians are often interpreted as Doctors, whereas to prevent failure nurses must be involved, as an equal. The Audit Commission (2006) identified that failing organisations lacked Board leadership. If the nursing service is to thrive then the nurse on the Board must have an equal voice and be involved in decision making (Procter 2000). This involvement in decision making was identified as a most important factor in the prioritisation of the leadership/strategic factors. This did not achieve this level of priority in the general literature, but was a factor in the nursing literature, being the first point identified in the Munich Declaration (2000). Non-nurses do not appear to recognise the advantages of giving nurses the power to make decisions, though nurses themselves using a CNS approach have identified this as a key factor. This issue is explored further in chapter 7 as part of a professional debate.

Mannion et al (2005) builds on the issue of clinical involvement in the running of an organisation. They develop this theme further by stating that a pro-professional culture that gives power to one professional group can also lead to a poorly performing organisation. This supports the Senior Nurses' views that in strengthening the medical profession in an organisation, this acts to reduce the influence of other professional groups, such as nurses and ultimately can lead to failure. The nurses asked to work in a culture where they have an equal voice and influence (Procter 2009), the same as other professional groups. Through the semi-structured interviews, the Senior Nurses had time to reflect on the nursing service and as a result of this, identified one of the most important factors to be 'empowerment' of nurses. Without empowerment many of the other important factors could not be implemented.

High visibility of Senior Nurses in the nursing service, which listened to the staff and acted on their concerns, were all identified as important factors in the research. Many of the writers on the subject of healthcare failure identified senior management being seen as remote and disconnected from the real world which was a significant factor in failure (Mannion et al 2005, Yourstone and Smith 2002, Mory 1994 and Vincent and Barker 2005). In addition the writings of Faugier and Woolnough (2002)

emphasise the importance of the nursing workforce being listened too, given a voice and their concerns acted upon.

Fundamentally if you do not have the correct number of staff to provide the nursing care, it will fail. This was identified by Filochowski (2004i), Faugier and Woolnough (2002), Mariner and Tomey (2008), Rafferty et al (2007) as an important factor. Likewise an overwhelming number of Senior Nurses in this study reinforced this view. Without sufficient nurses, there is not only insufficient time to do the work, but there is no time to learn new skills, reflect on practice or gain further academic qualifications. Again this is identified by Mannion et al (2005), the Munich Declaration (World Health Organisation 2000) and the Burdett Trust (2006).

The Quality of the Nursing Service

It goes without saying that the ultimate goal of the nursing service is to deliver high quality and appropriate care to the patients. The Senior Nurses identified that having clear expected standards of care, such as those outlined in the 'Fundamentals of Care' (Welsh Assembly Government 2003). This should be supported by the use of clinical assessment tools and followed by responsive clinical audit to assure the nurses that they are delivering effective and high quality care to their patients. Faugier and Woolnough (2002) also state the importance of such an approach, as does the Burdett Trust (2006).

In the current study the involvement of the Senior Nurses using a CNS approach has resulted in the development of the key factors that contribute to attaining a successful nursing service. They made comments from their own lived experiences and learnt practices in the health service using a narrative (Berman et al 1998). This is similar to the findings revealed by the review of the nursing literature, where the nursing perspective was also utilised. In contrast the general literature on health service failure is written from a management consultancy point of view, of someone looking from the outside into a situation, rather from being part of it. This external perspective has lacked depth in truly understanding what factors make for a high performing nursing service and in some areas are quite superficial. The nursing literature does show a greater insight and gets much closer to identifying similar factors (McClure et al 1983, Rafferty et al 2007, Burdett Trust 2006) to those in the current study. This literature does however fail to consider how these factors interact with each other or the influence on them of external matters. No literature to date

identified a comprehensive collection of the important factors for a high performing nursing service.

Organisational Theory

An interesting aspect of the research was the overwhelming consensus of comments received both from the interviewees and the questionnaires. These Senior Nurses explained their views from a traditionalist or classical organisation theory basis (Taylor 1917). It could be concluded that they based their comments on the need to find the one best way to do something, rather than there being a variety of approaches to suit a changing, chaotic (Girlin 1999) environment that we find in the NHS today. They identified the need for each worker to have a clear role and responsibility based on their skills; that these nurses have to be closely supervised to ensure they deliver the correct service and that their role as senior managers is to plan and control the work of the nurses delivering direct care. Similar to the research, Taylor (1917) identified key factors which had to be combined to produce the right results in the delivery of a service or product. Further the Senior Nurses also reflected the views of Weber (1947), when they considered it to be important to have clear lines of accountability, a clear management hierarchy, with clear rules by which staff work. It would be concerning if the Senior Nurses comments did not go beyond theories such as these, but they did expand into the area of the neoclassical (Mayo 1933) aspect as well. By exploring the neoclassical area they considered the human and emotional aspects of delivering the service, such as good communication and working environment. Further the Senior Nurses' discuss the need for the leader to create an environment where there is agreement on the values and purpose of the nursing service (Barnard 1968) and where there is also a system of coordinated activities. These two types of organisational theory both use the requirement to keep the service in a state of equilibrium and to do this the management need to control and manage the working environment of their staff.

The Senior Nurses predominantly expressed their views in the more traditional approach to organisational management. This being an interesting juxtaposition with the respondent's comments being more about the need for a leadership style that was transformational rather than transactional. It could be considered that though they feel they should have a transformational approach, which stimulates change innovation and empowerment to make decisions. The world they describe and lead was focused on rigidity and protection of the status quo. With further reflection, the fixation of their own organisations on the achievement of balanced budgets and targets is what appears to drive the Senior Nurses' leadership style. The

respondents consistently state that there is a need to be transformational (Wong and Cummings 2007) if services are to be improved, when in fact they operate a traditional, transactional leadership style (Bass and Avolio 1985) which has the potential to be detrimental to nurses and the service. As Sellgran et al (2006) explain in their study, what the Senior Nurses need to develop within the service is a leadership style that combines the two styles. Further Ekvall and Avonen (1994) describe three dimensions; giving clear structure and direction to the nurses; understands the nurses' needs and values them and allows them freedom, encouragement and empowerment to innovate and make decisions for changes to the service. This mixture of styles has the potential to improve the quality and safety for the patient as well as job satisfaction for the nursing staff.

In general the Senior Nurses failed to go beyond this to a modern theory of organisation, considering the nursing service as a whole system (Senge 1990) rather than independent actions. Had they done this they could have identified the interrelationship between the factors identified and how changes in one factor can directly or indirectly affect another and so either weaken or strengthen the working of the nursing service system. It would be interesting to explore in a future study why Senior Nurses in Wales express a management style that is more suited to a ridged, centrally controlled approach, rather than today's health service which has to constantly change to meet new demands and is a true learning organisation as described by Senge (1990). The nursing service and the Senior Nurses working in it need to be proactive rather than the more common reactive style and should recognise the increasing influence of the environment in which they operate. The study explicitly used an elite sample of participants, due to their experience. It could be that this seniority also led to participants who had become more fixed in their views, based on the length of their NHS service. This is as well as the focus on the environment of targets and risk aversion, which has made the Senior Nurses' leadership approach transactional when it should be transformational, if service quality and safety are to be improved.

Conclusion

The motivation for the research was the publically reported failings in the health service and particularly those relating to the failure of the nursing service to adequately care for and protect patients. The particular geneses of the study were incidents and serious errors and the inability of the Nursing profession to learn from

these mistakes (Dixon-Woods 2010). This led to some serious failures in the nursing service.

Though such errors, particularly those that have had serious consequences, are independently investigated and public reports are produced e.g. Audit Commission, Healthcare Commission, Commission for healthcare Improvement, Healthcare Inspectorate Wales, none of these really focus on the nursing service in any depth. The unique feature of the research is that it is conducted with a focus on the nursing service by listening to experienced nurses (Marshall and Rossman 1999), using a CNS approach (Berman et al 1998). The nursing service is examined as a system within the health service. The research was an opportunity for Senior Nurses to express their professional views on why things go wrong (Berman et al 1998). These Senior Nurses told it as it was, some comments were shocking to the reader, but this frank approach provided valuable information for the research (Latimer 2003). They explained what should be done within the nursing service and the whole organisation in which it functions, to stop things going wrong and deliver high quality services to patients.

Though they identified and prioritised 35 factors, it was the drawing together of these factors into a framework that could make a difference to the quality and safety of the nursing service. But this was not the totality of their views. Through a CNS approach which allowed the Senior Nurses to reflect on the nursing service, they identified that these factors alone would not make a difference, but rather the empowerment of nurses at the Ward and the Board had also to be in place for the factors to be effectively implemented.

The next chapter provides an explanation of the Senior Nurses' Framework and further in chapter 7 the issues surrounding the implementation of the framework are explored.

Chapter 6

The Senior Nurses' Framework

Introduction

The current research has provided significant insight and knowledge into the thoughts and views of the Senior Nurses in Wales. The factors they identified and prioritised were those they considered could make a positive difference to the nursing service if implemented (Schiemann and Morgan 1983). The chapter that follows begins with assembling these 35 factors into a framework, so the Senior Nurses can then use this 'tool' as a checklist to undertake their work. By operating within this framework the Senior Nurses are provided with the opportunity of delivering a high quality, safe nursing service. The chapter then offers a thematic discussion of each factor, explaining in more detail the background to this factor and why the Senior Nurses in this research study considered it to be important, therefore justifying its inclusion in the framework.

The Framework

Leadership and Direction

1.	Regular reports to the Board by the Nurse Director on the standards of care, identifying the actions required and progress reports on implementation of necessary action plans.
2.	The Nurse Director is able to comment on the wide range of issues presented to the Board.
3.	The Nurse Director has an equal voice with the other Directors.
4.	Sisters / Charge Nurses are empowered to fully manage their clinical area and are free to make decisions relating to patient care and the environment of care.
5.	Nurses are represented at all key decision-making meetings and fully participate in the decision-making processes.
6.	Senior Nurse development programmes are in place to support future nurse leaders and strategic thinking.
7.	Nurses are involved in and influence future service and capital planning processes.

8.	Nurses should have a clearly documented strategic direction, which has milestones and timetable for delivery. Periodic evaluation and review of the strategic direction should be included in the process.
9.	There should be clear and explicit standards for the Nursing Service. The implementation of 'Fundamentals of Care', supported by an audit process is important in the delivery of high quality care, and identification of service failure / gaps.
10.	Nurses should both accept responsibility for their actions, as well as being held accountable for their service to patients.
11.	Nurses are given the opportunity to shadow experienced nurses to gain first-hand experience of the senior nurse role.

Fit for the Job

12.	All nurses have annual personal development plans and objectives, which are reviewed at least twice a year. The objectives are linked to the Nursing Service strategic direction.
13.	There is a budget available to support education and training of nurses, which is based on a training needs analysis undertaken annually.
14.	All Nursing staff undertake mandatory training.
15.	All Nurses have annual registration checks.
16.	All nurses have regular times set aside to reflect on their work through a system of clinical supervision.

The Staff

17.	A robust system is in place to assess the nurse staffing requirements for each clinical area.
18.	There is a rostering system that ensures the best utilization of the Nursing workforce resource.
19.	Reports are presented to the Board on nurse staffing levels, absenteeism, turn-over rates and training undertaken by each clinical area.
20.	There is a strong commitment to a systematic and robust approach to workforce planning.
21.	There is a simple management structure, which has few tiers of responsibility and clarity as to who reports to whom. The structures should be changed as little as possible over time to ensure continuity.

Communication

22.	There are effective systems of two-way communication throughout the nursing service.
23.	The Nurse Director and Senior Nurses have high visibility in the service and are regularly seen in the clinical areas.
24.	Nurses in the service are able to identify their Nurse Director and the senior nursing team are known to nursing staff.
25.	The Senior Nurses are approachable, listen to the views of nurses and demonstrate positive actions to address issues raised.
26.	There is an open sharing of information throughout the nursing service.
27.	Adverse events are reported and such reporting is encouraged and supported by Senior Nurses and management, as a learning opportunity.

Culture and Ethos

28.	The Nurses are empowered and trusted to make decisions and have autonomy over the care they provide, the environment of care and their professional conduct.
29.	There is a positive plan being implemented to empower Senior Nurses, with particular focus on Sisters / Charge Nurses
30.	Nurses are full and equal members of the healthcare team
31.	Nursing innovation is encouraged and supported, with evidence of changes to service delivery, which improve the quality of care.

Service Quality

32.	Reports on service quality have equal time and place on the Board agenda.
33.	There are robust systems of data collection and analysis that provide an assessment of the quality of care provided to patients.
34.	Care standards are set, assessed and measured. Action plans are available and regular reports on the process and outcomes of care are produced and widely disseminated for comparison purposes.
35.	Nursing assessment tools are used and patient's care is planned and implemented based on assessed need.

Thematic Discussion of Each Factor for the Framework

The above framework has been derived from the Senior Nurses' interviews and questionnaires. The discussion below provides the background to the factors and the reasons why they were considered by the participants to be important enough for them to be included within the framework.

Leadership and Direction

The first theme explored the role of leadership. The main focus being the Nurse Director and the Sister/Charge Nurse, as well as the contribution (or otherwise) made by other Senior Nurses within the nursing structure. Also briefly explored was the leadership role played by other senior team members, particularly the Chief Executive and Medical Director. The last section of the analysis of results chapter explores the leadership style of Senior Nurses today. It explains how their leadership style should be mixed, both transactional and transformational (Sellgran et al 2006). This approach would be beneficial to support the enhancement of the nursing service to the benefit of the patient. The research was not designed to focus on nursing leadership in detail; this has previously been examined in depth by others (Riley 2009, Rouse and Kaplan 2008, Robinson 1991, Sellgran et al 2006, Ekvall 1992, Manojlovich 2005), but rather to explore the aspects of leadership, the factors that are thought to be important in the context of the research.

The Nurse Leader's Role at the Board

A theme from the three stages of the research was the lack of the Nurse Director's voice in the Board Room. When this happens the Board are less likely to know what is going on with the clinical services and are not in a position to intervene early to prevent failure (Burdett Trust 2006, Health Care Commission 2009).

Senior Nurses, especially the Nurse Director, needs not only to have a voice, but also influence at the Board. In fact the questionnaire revealed that though nurses considered that there were several factors that were important in this section; these could only be facilitated into action if the Nurse Director at the Board was strong. *'It is important that nursing is a significant agenda item for the Board.'*

Therefore an important factor was considered to be having a Nurse Director who has influence at the Board and the Board listens to their views and advice (Procter 2000).

This was supported by the Board meeting agenda being balanced between finance, performance (meeting targets) and the clinical care of patients. The Nurse Director presenting regular reports to the Board on the Standards of Nursing care, which were appropriately acted upon (Burdett Trust 2006).

The Nurse Director has to have a presence in the Board room; they must feel empowered and confident in understanding the importance of their role (Burdett Trusts 2006). The dominance of certain directors, in particular the Finance Director, in the top team appears to dilute the role of the Nurse Director to being second order. This is further reinforced by the differentials in pay, so emphasising the importance of financial management over the delivery of clinical care (Procter 2000).

The interviewees expressed the need for Nurse Directors to 'fight' for their recognition on the Board. Are Nurse Directors 'Bored on the Board'? Well many probably are as the other members of the senior team fail to optimise the contribution they can make. The sense of frustration in current Nurse Directors was very strong in this research. Though they frequently tried to be heard they felt overlooked (Latimer 2003). They either continue to fight to raise their profile or resign themselves to 'playing second fiddle'. When this situation occurs, the evidence from the interviewees and the review reports clearly show a decline in the performance of the nursing service (Latimer 2000, Page 2004, Aiken et al 2000) and ultimately patient care and outcomes (Mannion et al 2005).

Both the interviewees and the questionnaires described a similar situation faced by the Sister/Charge Nurse, a role identified by the participants as of equal importance to that of the Nurse Director. Consequently the word empowerment was frequently used (Manojlovich 2005). Sending a clear message that nurses at ward level felt disempowered over the management of the nursing service (Faugier and Woolnough 2002). Again a sense of frustration and exhaustion was expressed with a feeling of loss of control whilst still being professionally responsible for the service and patient care (Burdett Trusts 2006). A similar conflict faced by the nurses at the top.

Influence and Decision-Making

Building on the above theme of having a 'presence' in the organisation, the Senior Nurses in Wales emphasised the need for full involvement in the decision making processes in their organisations (World Health Organisation 2000). This feeling of being 'done-to' rather than involved was emphasised. Clearly this lack of

involvement of nurses at all levels in the organisation in decision making, added to the frustration and in the view of the Senior Nurses, one of the reasons as to why the services fail. The view was that nurses were excluded from this process due to the dominance of 'general management' and 'Doctors' in the process (Latimer 2000). Nurses were viewed as 'doers' in the system and not those that had influence in the direction of the system. Even Senior Nurses expressed the view that they were low down the hierarchy of dominance in the decision making process. Without this involvement and influence they considered things would continue to go wrong with patient care. The nurses appeared to play the role of the 'child' in the NHS family and as such their views were not sought and often not listened to (Cohen and Bailey 1997, Procter 2000, Tucker and Edmondson 2002). A view was also expressed that for the delivery of high quality nursing care, nurses need to accept accountability for their actions. With the apparent erosion of their power in the health system, nurses have also abdicated responsibility and therefore accountability for their actions (Faugier and Woolnough 2002). If they are not included in making decisions, they are not prepared to be accountable for the consequences. This has resulted in a 'passive' state with nurses being ambivalent to their contribution to the health care delivery system (Gaddis 2007). They know their place and stay in it.

Vision and Strategic Direction

Nursing is a practical, hands-on job, looking long term is not the usual role of the nurse, so is it surprising that a common symptom of a failing nursing service is a lack of direction and vision (Jooste 2004). Senior Nurses require development into the leadership roles if they are to be successful (Skytt et al 2007). As part of this development process they have to change the mind-set of dealing with the 'here and now' to having a view of the future service needs and how the nursing service must change and adapt to address both internal organisational demands and pressures, as well as changes in society and the external environment in which the service operates (Robinson 1991).

There was a majority view, which many may feel is controversial, in that there is limited value in having a 'strategy' document to guide the nursing service. A strategy was not dynamic enough to have a place in a rapidly changing health service (Gerlin 1999), which has strong political influences. Rather Senior Nurses expressed the need for there to be clear expectations and standards for the delivery of the service (Mannion et al 2005, Jackson 1998). These needed a high profile so nurses knew

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about them and what was professionally expected of them (Filochowski 2004i). An overwhelming view was that universal implementation of 'Fundamentals of Care' (Welsh Assembly Government 2003) would negate the need for a strategy as this would focus nurses on delivering high quality care and ensure they had the enablers to do it.

Mentorship

The literature review describes mentorship as a risk to the ability of the nursing service to evolve and change to meet patient requirements (Cook 2001). For aspiring senior nurses learning a leadership approach that maintains the status quo by copying the existing nurse leaders may not be a solution to improve today's service. The Burdett Trust (2009) does consider that development programs have a place in preparing nurses for leadership roles but the participants' view was that this was only part of what was required. What was needed was a greater chance for nurses to 'shadow' and experience first-hand (Manojlovich 2005) what you have to do to lead a large profession such as nursing and this was frequently referred to as 'sitting by Nellie'. This form of development is far more acceptable to nurses who, despite the greater focus on academic based education of nurses, they still learn their clinical practice at the bed side. This method of 'indoctrination' in educating nurses may be considered to work best when developing our leaders, as this is the method nurses are most used to and through this previous experience is most effective for them to learn new skills and knowledge (Aiken and Patrician 2000). What this discussion has described is the requirement for a mixed approach to nurse leadership development, with mentoring combined with a broader range of non-nursing leadership experience.

Fit for the Job

The next theme exposed by the interviews and explored further by the questionnaire was in respect of the staff delivering the nursing service. This examined how they undertake their work and what should be in place to ensure their work is appropriate and meets the expected standards.

Education

The need to have nurses with the correct skills and knowledge was identified if patients were to get the right care for their condition. This lack of opportunity for education and development was identified as a reason why nurses fail to provide high standards of care. They do not have the knowledge and skills to do the job,

neither are they able to identify when things are going wrong and have the ability to put things right (Mannion et al 2005, Scally and Donaldson 1998). It was considered to be a false economy not to invest in the development of staff. This lack of investment has the potential to lead to poor care and serious consequences for patients (Rafferty et al 2007). In these days of litigation, patients and their relatives may well sue for those failings and ultimately the costs are far higher to the health service than if they had invested in educating their staff (Mannion et al 2005).

Again the Senior Nurses considered that the dominance of 'finance' in the running of the health service meant that education budgets had been cut and therefore some nurses no longer had the necessary skills to do the job. This clearly links to the previous theme where the nurses feel unable to articulate their views in decision making and therefore decisions are made to their detriment.

Objectives and Review

The first theme identified the need for the Nurse Director to set the expectations for the service, it was therefore important to ensure that these are delivered at the bed side. Senior Nurses thought that the best way of ensuring nurses do what is expected, is to set them annual objectives which are periodically reviewed to ensure progress (Scally and Donaldson 1998).

This seems a very straightforward exercise, so why does it not happen already? The interviewees repeatedly reiterated that there was a lack of time to do what had to be done to do the job properly (Mannion et al 2005). Trying to balance the pressures of delivering care to patients against setting time aside for the staff to discuss objectives was a constant conflict nurses faced. Nursing is a practical profession and delivering care always takes precedence, even though it might be the wrong care. Setting time aside for reflection is not valued as time well spent; there is the need to have an approach which encourages reflective practice and learning (Urden and Monarch 2002). Time spent in this way prevents failure, though it is hard for many nurses to see the value of thought over action (Albert and Siedleck 2008).

Supervision

If nurses are obsessed with 'doing things' to people and spend little time on reflection, then there needs to be other checks and balances in place to prevent failure (Jooste 2004). The interviewees and questionnaires saw the value in increased supervision and mentoring of nursing staff. Keeping an eye on what was

going on in the clinical setting increased the chances of the service provided being effective and provided the opportunity for nurses to learn from their mistakes (Faugier and Woolnough 2002). The culture of the tyrannical ward sister as described by one of the interviewees is not considered appropriate for today's profession, but maybe this attitude of close scrutiny of staff and their actions has some place if service quality is to be maintained. The art now is for nurse leaders to find the happy medium between scrutiny and autonomy for the nurse (Laschinger and Havens 1996). A balance which can be hard to achieve in the dynamic clinical environment, but supervision of nurses and the care they provide has to be high up the nurse leaders agenda if failure is to be reduced (Gaddis 2007).

The Staff

As identified by the 'Magnet' hospitals, the staff are a key component to having a good nursing service. There were several aspects relating to the nursing staff that the participants considered being of value in the framework.

Staffing Requirements

There is no point in having the skilled staff if you don't have enough of them to do the job. A strong theme from all three stages of the research was care quality deteriorates if you don't have enough staff (Rafferty et al 2007). This may be common sense, but from the comments made by the interviewees, an area which is often ignored (Klein 2006).

The research identified that nurses constitute over 50% of the NHS workforce in Wales and therefore makes up a significant amount of the expenditure of delivering the service. When there is the need to make savings the nursing service is often seen as the place to find the money (Procter 2000, Tucker and Edmondson 2002). Constant pressure on the nursing service to get more for less leads to the nurses working harder and as interviewees explained, that's when things go wrong (Filochowski 2004i). There is only so much nurses can do in their shift, they don't go out to provide poor care, but end up compromising. The nurses at Maidstone and Tunbridge Wells NHS Trust (Healthcare Commission 2007) did not start their day with the intent to spread infections due to poor hygiene, but there were not enough staff to do the job, so they cut corners and in this instance spread the infection from patient to patient resulting in deaths.

In the failing organisations examined in Chapter 4, nothing was reported to their Boards about staffing levels and the effect this was having on patient care, the focus on money and targets occupied their agenda. Nurses again are the silent majority (Faugier and Woolnough 2002), getting on with the job as best they can, given the resources available. They protest very little and too often Senior Nurses keep quiet on the matter (Burdett Trust 2006). They feel there is little point in raising the issue as they know there is no money to improve staffing levels. Nurses are expected to just muddle through, the only protest they make is to leave the job or go to a different organisation (McClure et al 1983). It was this exodus of nursing staff that stimulated the development of the Magnet hospitals in the USA. If there is to be good nursing care then the nurses have to be content in their work (Rafferty et al 2007) and one factor in achieving this is to have sufficient staff – obvious to some but not necessarily to those who have influence.

Planning for the Future

Addressing the demands on the service has to be a priority for Senior Nurses. Planning for the future staffing needs have to be near the top of the list of things to do for Senior Nurses (Scally and Donaldson 1998, Mannion et al 2005). The service is not static but has to constantly change to meet advances in technology and treatments. It also has to respond to environmental and demographic changes (Gerlin 1999). An increased birth rate means the need for more midwives; an ageing population means chronic diseases requiring specific nursing care to support the people at home, and so on.

There was a unanimous view that workforce planning was poor in the nursing service (Procter 2000) and without improvements in this area the Senior Nurses had no ammunition to use to present an argument for more nursing staff, let alone what type of nurses they need (Burdett Trust 2006). The lack of robust workforce planning was seen as a fundamental flaw in the aim of improving the working conditions for today's nurses and ultimately the care they provide (Journal of Nursing Management 2005, McClure et al 1983). In addition sound rostering systems were thought to be of value in ensuring the best utilization of the nursing staff resource (Yourstone and Smith 2002, Filichowski 2004i).

Change and Stability

The constant change in management structures in the NHS comes in for much criticism (Filochowski 2004i, Skytt et al 2007). The value of stability in the

management structure of nurses was considered to be necessary to ensure everyone knew where they sat in the hierarchy and therefore what was expected of them (McDaniel 1997). The constant structural changes leads to confusion regarding the individual nurses' place in the system and what role they were supposed to play, and what accountability they have in contributing to the success of the service (Skytt et al 2007, Manjlovich and Ketefian 2002).

Nursing has its roots in the military with the establishment of the role by Florence Nightingale during the Crimean War in caring for injured soldiers. These military roots have instilled a need for order and discipline in the profession. The importance of hierarchy and clarity of who is in-charge (Nightingale 1859) is inbred into the nursing service even after so many years. When this stability is changed or worse missing, the nurses lose their sense of order and direction (Skytt et al 2007). They become confused about their role and purpose with this lack of order to their work, they become dysfunctional as a team of staff (Cohen and Bailey 1997), there is a breakdown in communication within the service, delegation of work becomes unclear and staff feel abandoned.

In this scenario, the nursing service at best treads water, unable to move forward and adapt to changes (McDaniel 1997). At worst the service starts to fragment, becomes disorderly and direct patient care deteriorates as no one knows who is in charge or responsible (Tucker and Edmondson 2002).
Getting the structure right with few tiers of management improves the flow of information and provides a direct connection between the top of the organisation and the nurses working at the bedside (Urden and Monarch 2002). It also reduced the likelihood of confusion in expectations of the service to be delivered and creates clarity on who is accountable for what (Manjlovich and Ketefian 2002).

Communication

Throughout this research communication between nursing staff has been a fundamental theme. The earlier reviews of the investigation reports revealed the failure of communication being a thread running through poor performing nursing services (Filochowski 2004ii). The role played by the Nurse Director in establishing effective systems of communication was considered vital if communication is to work

(Burdett Trust 2006). The participants in the research presented many tried and tested solutions that would enhance the communication process.

Visibility

In the large health service organisations of today, the Nurse Director can be a lonely figure at the top, isolated from the nursing service. This isolation is an easy situation for the Nurse Director to fall into. In large organisations the executive offices are often on a remote site, away from the main service areas, keeping the Nurse Director away from the action (Mannion et al 2005). In addition the participants considered it to be important for the Nurse Director to be located with the other Directors rather than their nursing team who are positioned elsewhere. There are the positive attractions of this, as it ensures the Nurse Director can influence the thinking of the other Directors, hopefully helping them to link finance and targets to the delivery of patient care (Latimer 2003). Unfortunately this form of location does isolate the Nurse Director from their service (Upenicks 2003). If they are isolated it has to be questioned what they are communicating to their executive team and without 'live' information about the service their contribution to the top team is diluted (Manjlovich and Ketefian 2002).

Clearly the Nurse Director has to work at developing systems of communication which satisfy both informing the top team whilst keeping in touch with the workforce delivering care. The Nurse Director's jobs are busy and complex; they comment that due to a high workload there is just no time in their day to find out what is really happening in the nursing service.

Despite the above constraints, high visibility of the Nurse Director was identified as a key to a successful service (Upenicks 2003). Failing services did not know who their Nurse Director was let alone what they looked like, they were remote and disconnected (Mannion et al 2005). The concept of 'walk-abouts' mentioned by some participants has also been identified through the 'Safer Patient Initiative' (The Health Foundation 2009) to be an effective way for executives to find out what is going on in the service and therefore initiate action to correct failure. To perform this role the Senior Nurses have to have confidence to enter areas that may be hostile to them and be prepared to have open minds to what they hear and see if these activities are to add value.

Listen and Learn

Senior Nurses in this study stated that they found it easy to tell staff what was going on and what they want them to hear (Jackson 1998), though they recognised that many found this difficult. The art to maximising these 'walk about' activities is to listen and more importantly take action to address issues raised. It therefore was identified as essential if true communication is to happen, that the Senior Nurse is approachable and has an attitude with their staff that promotes openness and information sharing (Vincent and Barker 2005). If the Senior Nurse demonstrates actions in response to the communication, the staff are able to develop trust in the process and the cycle of communication improves (Filochowski 2004i).

From the research, trust appears to be a fundamental part of the communication process for it to be effective. Without trust there is no openness, with a closed system of communication within each tier of the hierarchy (Vincent and Barker 2005). In failing organisations there was no trust of senior staff resulting in a failure to share information (National Co-ordinating Centre 2006). This is seen in the poor reporting of untoward events in failing organisations. Nurses fear that telling people when things go wrong would lead to punishment (Mory 1994). This lack of trust prevents the communication of mistakes and no one can then learn lessons from the error and prevent it happening again (Dixon-Woods 2010). The break in the circle of trust has direct implications for the safety of the patients (Yourstone and Smith 2007) and the confidence and reputation of nurses in the organisation (McClure et al 1983). If we don't trust each other then our patients will not trust nurses either. Also it was considered by the participants that if the nursing team cannot communicate effectively between its members, it is likely that the communication with the patient will be negatively affected (Burdett Trust 2006), as well as with other members of the healthcare team.

Culture and Ethos

The culture and ethos of the organisation was identified by the participants to be a further element that contributed to or detracted from the delivery of a high quality nursing service. Within this there were some specific factors that they considered worthy of inclusion in the framework.

Empowerment

Throughout the research a word was repeatedly used by both the interviewees and respondents to the questionnaire. That word was 'empowerment', but what exactly do they mean by this important word and how does this relate to the culture in which the nursing service operates?

The chambers dictionary (2003) defines empowerment as giving authority, to give individuals power to take decisions in matters relating to themselves and to provide self-development.

In reflecting on the comments made by the Senior Nurses in the research, the above statement probably does sum up their feelings as to what they need to do to stop things going wrong. They wanted control over their service (Sieloff 2004, Fletcher 2006), which they overwhelmingly feel had been eroded by other members of the health care team (Latimer 2003). If authority and control were given to nurses, then there is a greater chance that the right decisions would be made (Jackson 1998, Procter 2000) regarding patient care and the nursing service and the overall quality of the service be improved (National co-ordinating centre 2006, Yourstone and Smith 2002). The nurses are clear that the medical and managerial dominance (Noad and Jermier 1992) has left an unequal balance in the healthcare system, with nurses seen as second order members of the team (Latimer 2000). They feel unable to think for themselves, lack confidence and are prevented from being involved in decision making at all levels. Other professionals act to reinforce the position of nurses in the hierarchy and by disempowering them, keep them in their place (Manojlovich 2007).

The fear of other more dominant staff is that by giving nurses a voice and control over their area of service, aspects of service need and patient risk will be exposed and they will themselves lose control (Noad and Jermier 1992). This could potentially result in the non-achievement of financial and management targets, which would be detrimental to the assessment of performance of the whole organisation (Mannion et al 2005). Management by the 'ignorance is bliss' method could be destroyed if nurses are given back their power, with senior staff having to face up to the unpalatable aspects of the service and having to deal with them. It is far easier for others in the team to keep nurses in their place (Noad and Jermier 1992).

Again the word 'trust' is used by participants if nurses are to be empowered and given back control of their service (Filochowski 2004i). A high performing nursing

service has mutual trust between nurses and other members of the team. In this situation doctors and managers recognise the value of the nursing contribution and through this empowerment nurses can play a valuable part in solving the corporate problems faced by the organisation.

Innovation

When nurses are empowered they feel free to innovate (Upenieks 2003), try out new things and are prepared to take managed risks to improve patient's care, preventing errors, which might lead to service failure (Laschringer and Havens 1996). They also have the confidence to challenge current practice, not just in nursing but in other areas of the service (Tucker and Edmondson 2002). Underpinning this were the views of the participants that nurses are waiting to be given permission to make their own decisions and are keen to take on this new role if they are authorised to do so (Procter 2000). An interesting fact is that nurses want to be empowered, but are frightened and reluctant to take the initiative themselves. Rather they are waiting for others to give them permission (Sieloff 2004, Fletcher 2006). If the nursing service is to be empowered to deliver a high quality service, they have to grasp the initiative rather than waiting for others to let go. They have to break free from a culture of repression, to being one of equal partners if they are really going to succeed (McNichol 2002, Laschinger and Havens 1996).

Targets

There was a strong feeling held by the Senior Nurses involved in the research, that the focus on targets and finance had a detrimental effect on patient care, particularly in relation to the quality of service they receive (Yourstone and Smith 2002). This lack of a quality focused ethos in an organisation was considered to be a contributing factor to both the failure of the nursing service and the organisation (Walshe and Higgins 2002). It was also considered to be important to have a service focused on the patient and one that listened and learnt from the patient's views. A Board that failed to take account of the quality and outcomes of the services it provides has a greater risk of failure and poor public reputation (Burdett Trust 2006, Filochowski 2004i).

Service Quality

This focus on the service quality was considered by the participants to be essential for a high performing service, but it was thought by them that in today's health service the profile of service quality was too low.

The Board's Role in Quality

Engagement and ownership by the senior team and Board was essential if quality was to have a high place on the agenda of the organisation (Burdett Trust 2006), but the concern was how to best engage the Board. It was easy for the Finance Director to produce reports with graphs and charts that clearly show the financial position (Noad and Jermier 1992). With qualitative information usually available from monitoring service quality, it is not so easy to present to the Board in a meaningful way (Filochowski 2004i). The participants talked about the trend in using 'Patient Stories' to give a real life view of the service and was considered to be the most appropriate and effective way of getting the quality message to the Board (Berman et al 1998). The poignancy of hearing what the experience of the service was really like for the patient can be a good method of raising the profile of the nursing service and the issues it faces to the Board, as well as raising the overall quality and outcomes of patient care.

Service Standards

Senior Nurses suggested that clear standards for the service should be articulated and systems developed to monitor them (Mannion 2005). Following on from this, Board presentations could be prepared. The use of the standards set in Fundamentals of Care (Welsh Assembly Government 2003) was agreed by the participants to be the benchmark that should be used across Wales. These standards were well researched and would allow for comparisons between nursing services across the whole country. An audit tool had also been developed which would support the implementation of the standards. This would also assist in the assessment of the patient's needs and benchmark the implementation of standards. This would enable changes to be made where necessary to improve the nursing service to patients.

Conclusion

The research has, through listening to the Senior Nurses, identified what the key factors are to having a successful, high performing, quality nursing service. The aim

of the research has been achieved, in that it has identified the list of factors that have the potential, if implemented, to prevent failure of the nursing service. When combined together these key factors form the Senior Nurses' Framework. The next steps have to be how can the nursing profession take this framework and use it to create a successful service? In Chapter 7 this is explored further with a professional debate which examines why the profession seems unable to have control over its own service and what it can do to become empowered, which is necessary if the framework is to be successfully implemented. By taking on the challenge outlined in the research and assuming power over their services, nurses can use the framework to develop their service to improve patient care and prevent future failures.

The diagram in Figure 2 showing the position of the nursing service in the NHS organisation system identifies the nursing service as a discrete item in the system. The framework above has factors that nurses are able to apply when working not only in the nursing service but also the multi-disciplinary team and at Board level. It is suggested that the nurses in senior clinical, management and Director roles can now take forward the research to the implementation stage, having influence at all levels in the NHS. The use of a critical social science / critical nursing science approach by these nurses would assist them in gaining the power they need to effectively deliver the nursing service. They can have their voices heard throughout the organisation, particularly at the Board and be a key player in organisational decision-making (Procter 2000). Nurses are well positioned to provide leadership in the development of the use of stories and numerical information to drive forward their agenda of empowerment and change. It is within their control to make things happen, and through their stories as told in the research they need to act to improve the situation they find themselves in. They can if they act, have a voice amongst the elite in their organisation and the power they need to improve the nursing service and prevent failure.

Chapter 7
Professional debate

Introduction

As the research progressed it became evident that a main factor influencing failure in the nursing service was that of 'repression' of the nursing workforce and particularly those in more senior management roles – Ward Sister / Charge Nurse and above. This is referred to as the **Theory of 'Repression Failure'.** In this, key groups of staff are repressed by others, who fear that by giving them power they themselves lose control (Noad and Jermier 1992). This act of repression not only reduces power in the staff group, but also removes their confidence in themselves and their profession. The act of repression limits communication, innovation and the ability of the repressed group to act effectively (National co-ordinating centre 2006). This combination of factors which result from the repression, directly contributes not only to the failure of a specific service area, such as nursing, but inevitably to organisational failure as well (Filochowski 2004i). The research has directly linked the repression of nurses to the failure not only of the nursing service but ultimately the whole organisation, since nurses make up such a significant portion of the workforce and play such a vital role, as described in the introduction (Latimer 2000, Procter 2000).

The question now has to be posed as to how nurses can overcome this repression and as they repeatedly stated in this research, regain power over not only their own area of service, but across the organisation as a whole. It would be straight forward to state here that if the framework in chapter 6 were implemented then there would be a high performing nursing service. Of course this framework would be of benefit and many of the participants suggested it, but is this the real solution to the prevention of failure in the nursing service?

Exploring the literature revealed writings which examined oppression and are directly applicable to the research findings. Commentators such as Noad and Jermier (1992), Kanter (1979) and Wright (1985) focused on how oppressed groups of staff, such as nurses, could develop a greater understanding of exactly why they are powerless and therefore what actions they need to take to gain a position of control over their own service and have influence over how it is run. The method that most suits the situation nurses find themselves in, as revealed in this research, is that of 'critical

social science' (Sayer 1992), which has been developed further by Berman et al (1998) to a Critical Nursing Science.

Critical Nursing Science (CNS)

What the research has done through the interview and questionnaire process is to enable the nurses to have a voice, an outlet to express their feelings and opinions. The participants frequently stated that no one listened to their views, they were ignored and as a consequence things were wrong. The research should be seen as the first stage in the critical nursing science approach as proposed by Berman et al (1998). It allowed both the participants and the researcher to reflect and consider the social situation in which the nursing service operates. It has allowed all involved in the study to explore alternative ways of viewing the nursing service and its place in the organisation and the wider society. It further revealed basic assumptions and ideologies about the nursing service from the perspective of the Senior Nurses working in it. A fundamental finding revealed by the research was the unspoken role power plays in the success or failure of the nursing service (Lukes 1974). The recognition of the influence of other's power and nurses' lack of power in the health service (Noad and Jermier 1992), as well as in society as a whole, can be explored using a critical nursing science approach.

The participants and researcher came to the process holding assumptions regarding their own place in society based on custom and practices, which was reinforced by the nurses' behaviours. This was then articulated as the real life situation and how they saw themselves as nurses in the hierarchy of the organisation. Though their feeling of being powerless was often invisible to others outside the profession (Latimer 2003, Allen 2004), to the nurses it was self-evident that others and not themselves were 'pulling the strings'. The CNS process used in the research has now made these assumptions and feelings explicit, so they can be openly discussed. By doing this it may be possible for this repressed group to gain power and influence over the nursing service. Through the research the nurses involved have generated knowledge which can contribute to emancipation, empowerment and gives rise to the potential for change (Berman et al 1998).

Dimensions of Power

Lukes (1974) described three dimensions of power. The first one being 'overt', where those in the élite position of power bring other things to the table, which

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suppress the issues of the less powerful. The second is similar but the less powerful individuals' issues are weakened through negotiation or compromise. Finally the third dimension is covert where the alternative view or issues do not even reach the table and are ignored and not discussed. The 'real world' of the nursing service that nurses would want to bring to the table, such as staff shortages, infection rates etc., simply gets ignored and no space is given for them to be discussed. It is an insidious dimension of power, as it is invisible to others in the organisation, though often recognised by the Senior Nurses themselves.

Though all three of these dimensions can be seen in the repression of nurses and therefore their exclusion in decision-making processes and control of their own service, the last dimension is the one most commonly described by participants in the research. This is further reinforced by the work undertaken by the Burdett Trust (2006).

Why Nurses Lack Power

In further examining the writings in critical social science (CSS), the chapter by Noad and Jermier in Critical Management Studies (1992) provides an insight into what the factors are with the nursing profession and the service it provides, that hampers their empowerment.

Nurses are not seen as one of the élite management group, as it is more usual for élite managers in the structure to be focused on 'hard' criteria for success. Power has been viewed as an outcome of masculinity, this is in direct opposition to caring, which is seen as the essence of nursing (Rafael 1996, Procter 2000). Noad and Jermier (1992) comment that this could be seen as a product of institutionalisation, with the élites' interests driving the way of thinking in the organisation. These élite managers use their power to influence organisational goals and the allocation of resources, they also have narrow corporate interests, such as finance, which are easy to articulate and easily understood by the listener (Noad and Jermier 1992). Since nurses' work is invisible in nature (Procter 2000, Latimer 2003, Allen 2004, Fletcher 2006) and their skills, experience and knowledge often go unrecognised (Allen 2007), they often work to demonstrate their understanding of management and finance to gain recognition as professionals (Allen 2004, Latimer 2003).

In contrast to this, nurses are focused on public welfare issues, which have a broad sociological base (Noad and Jermier 1992) and work within the organisation in the interest of the patient (Allen 2007). Their focus and drive is at conflict with the 'hard' focused managers, as they are driven by social ideologies and are in conflict with the élite group regarding corporate conduct. This conflict acts to threaten the élite group of managers and leads them to take action (as described above) to repress the powers of nurses in the organisation, particularly at a senior level.

A nurses' work is predominantly undertaken in private, behind drawn curtains (Wolf 1989, Lawler 1991), their work cannot be seen (Fletcher 2006) and therefore is invisible and unrecognised in its contribution to healthcare (Procter 2000, Benner 2001, Allen 2007). Their work is not easily identifiable, so their visibility is extremely difficult to accomplish (Latimer 2003). This invisibility is one of the reasons why nursing has a low social status and lower value than other health professionals which has implications for their lack of power. To maintain visibility and identity, nurses align their work with the technical and heroic clinical work, which will gain them recognition by doctors. In doing this they devalue their role in addressing the personal and social needs of patients (Latimer 2000, Procter 2000). The lack of power may be reinforced by a reluctance to discuss openly the issue of power and acknowledge its influence over the position of nurses and the invisibility that works to control their practice (Kanter 1979).

Wright (1985) identified other specific factors that make individuals and some professional groups more likely to be oppressed by the élite group of staff. These key factors were identified as age, stage in their career, gender, race, social class and educational achievement. These differentials create a hierarchical group with people from different professional groups, though seen at the same level in an organisation being actually victors and victims (Schiemann and Morgan 1983). These factors are those that create diversity in society as well as in the work place. Society has people that are more dominant than others and therefore the same dominance can also be seen in the workplace. In health care, nurses continue to be seen as subservient to the doctor and not to have a relationship as equals (Latimer 2000, May and Fleming 1997).

Senior Nurses in the current study described this subservient position and further commented that they find it hard to communicate with the élite managers. This is not only because of their feeling of inferiority, but more because their interests are

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different and the élite either do not want to listen or do not understand what they hear (Noad and Jermier 1992).

When these discriminatory factors are examined it is evident that many of them can be found in the nursing profession. Firstly the profession is predominantly female. Traditionally nursing has a problematic identity because of the association between nursing and women (Rafferty 1996, Procter 2000), with 95% of nurses being women (Spratley et al 2000). There are both social and cultural factors that influence nursing power, which have their roots in the view of society that nursing is woman's work (Wuest 1994). Nurses tend to come from a lower socio-economic group than that of doctors and accountants and are less likely to have academic qualifications at degree level and above (Prescott and Dennis 1985), though this is being addressed due to the profession now being degree entry. They are seen as less well-educated than others within the hospital, which puts the nursing service at a disadvantage in organisational politics (Prescott and Dennis 1985).

Empowerment – How Critical Nursing Science (CNS) can be used by the Nursing Profession

CNS can be of benefit to managers such as nurses in gaining control and competing equally for resources and power in the organisation (Berman et al 1998). It helps them achieve corporate interest in their professional field of work. CNS can offer repressed managers and nurses a method so they can understand their own position in a critical way and why they lack the power they want. It has the potential to create knowledge that can produce change through personal and group empowerment. By developing this understanding (May and Fleming 1997), they can start the journey of discovery and take appropriate action to improve their situation and standing in the organisation.

Manojlovich (2007) describes the three types of power nurses need to have if they are to have influence, these are control over their own practice, control over the environment in which they work and control over the competence of nursing practice. This last factor is often ignored as an area for empowerment, but Manojlovich (2007) emphasises its importance as nurses frequently are unable to use their professional training to support their autonomous practice and clinical decision-making. They are undermined and powerless relative to doctors and managers. Dingwell, Rafferty and Webster (1988) considered that for the future of the nursing profession, it must have autonomy, supported by the unique skills, knowledge and judgement of the qualified nurse.

So CNS can be an emancipatory tool and assist the nurses towards enlightenment. In this process nurses' knowledge is valued as they are seen as experts in their own field and as such are important stakeholders in resolving issues they face (Berman et al 1998). How can the nurses now use it to address their frustrations and enable them to take forward the actions necessary to implement the findings in the research and reduce the incidence of failure in the nursing service?

The research has given Senior Nurses a vehicle to voice their views, opinions and concerns as well as expressing their frustrations. They have been given the chance to be reflective, something they fail to make time for in their day to day work. They have provided a nursing narrative that has explored the participants' lived experiences and developed a professional identity (May and Fleming 1997). If they did this regularly, it could provide great insight into their position and problems and facilitate their solution. It would put them in control of the nursing service and decisions made about the way it is run. It could also help them get their voices heard at the Board.

The process of facilitating empowerment starts with assisting individuals to gain a critical awareness of their situation (Berman 1998). A valuable tool Senior Nurses could use, as well as being reflective, is 'nursing narratives' (Allen 2001, May and Fleming 1997, Manning and Cullum-Swan 1994). What the research has collected from the nurse interviews, are nursing stories or narratives, many of which have similar themes. These stories allow the voices of the participants to be heard, they provide access to information which might otherwise be difficult to obtain and can also identify barriers nurses face in changing their working lives (Wright 1985). It can also provide an opportunity for them to identify what can be done to make improvements (Berman et al 1998). Presenting these stories not just in a peer situation with other nurses, but to other staff and managers, can wake them up to what is really happening to the service and the patients (May and Fleming 1997). These stories can capture the attention of non-nurses and help nurses on their journey of empowerment.

But who gives nurses the authority to take forward the above approaches? If the élite group are seen to facilitate these actions, it could be thought that they are yet again having power and control over nurses (Deetz and Murphy 1990). Therefore nurses have to be seen to take the initiative for themselves. Senior Nurses have to

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have a champion for their cause, who is not one of the élite group and who people in positions of power will listen to. The Senior Nurses in Wales achieved the establishment of the 'Free to Lead, Free to Care' (2008) strategy and action plan by gaining the attention of the Minister for Health and Social Services. Through a process of 'story telling' to the Minister, the nurses in Wales were given the resources to take forward their project to develop empowerment for the Ward Sister / Charge Nurse. This is unlikely to have happened if the narrative had been heard by the élite group of NHS managers, as it would have been seen as a threat to their authority within the organisation.

Some of the other emancipating factors as described on pp152 (Prescott and Dennis 1985) are beyond the control of the nursing profession. They have though taken the initiative in recent years to raise the educational level of achievement required by nurses. All nurses in Wales have been educated to degree level since 2004 and with the introduction of the role of nurse consultant with a requirement of a Master's Degree qualification, has acted to reinforce the higher educational attainment of nurses and for them to be seen as equals with other professional groups in the health services.

Though gender remains an issue within the nursing service (Davies 1995, May and Fleming 1997, Rafferty 1996, Spratley et al 2000), it is likely this will continue to be an issue. This is because the caring professions are seen as a more suitable activity for females (Procter 2000) and more attractive to them for work. Despite this we are seeing more men entering the profession, which in years to come may be beneficial.

Conclusion

This chapter has taken the opportunity to explore in detail the repression of nursing and the implications this has on the success or failure of the nursing service. This chapter uses a critical nursing science approach to consider what actions the Senior Nurses can take to empower themselves, so that failure is prevented and their voices heard in the future. This chapter will also assist the Senior Nurses to effectively implement the Senior Nurses' Framework.

Chapter 8
Conclusion

Reflection on the Research

Limitations

All research has its limitations and further areas could have been explored given time. It has to be recognised that there are limitations to a professional doctorate research thesis due to the word constraints, but this does give opportunities for the researcher or others interested in this field of study to explore the research further. Below are some suggestions the reader may wish to follow up.

The most obvious limitation to the research is that it was only undertaken in Wales. It could be that since the healthcare system in Wales is run differently, has different organisational arrangements and political influences, the views of nurses in respect of what would make a high performing nursing service could be at variance to other parts of the UK. As well as this, clinical practice can vary between countries an example of this is the difference between the Welsh Fundamentals of Care (Welsh Assembly Government 2003) compared with the English Essence of Care (Department of Health 2010) standards for practice. However it could be argued that these findings are transferable to the wider debate of healthcare across the United Kingdom, since the principles underlying nursing care are universally recognised (McClure et al 1983 and Rafferty et al 2007).

When you consider the sample of nurses used for this study, it focused solely on an 'elite' group of Senior Nurses. The choice of this group was because it was thought that they had the most experience of working in a nursing service to provide the best information for the study. This experience might, though, add bias to the research as this length of service could give them a jaded view of the health service. They may look back on the old days with rose coloured spectacles, wishing things were as they used to be. Maybe things were not so good and in fact the study of investigation reports shows that things have gone wrong for over 4 decades. A nurse with less experience and only having knowledge of how things are today may see things differently and have less bias. Their views and therefore the results might have been different with this group, providing a fresh view on the problems faced by today's nursing service.

The main part of the research involved a sample of nine Senior Nurses. Some may question that this sample was too restrictive and should have been larger. The fact that all those interviewed provided similar and consistent information does indicate the validity of this sample and that it is likely that a larger sample would not provide any more information than this sample provided. Further measures were taken to ensure the information was valid, in that the questionnaire had a good response, n= 41 Senior Nurses had the opportunity to challenge and comment on the themes and sub themes identified from the interviewees. Their views and comments were of great value in determining what the factors should be and also why these factors were important to the successful nursing service.

Though the n= 41 returned questionnaires were considered to be acceptable at 63% response rate, it could be questioned whether a larger response rate would have provided a greater amount of information and provide the ability to generalise? The methodology had to balance the preservation of participant's anonymity against the opportunity to follow up non-respondents. It was considered that there was more benefit in providing anonymity in encouraging people to respond than having the ability to chase responses. This was shown by the volume of comments received on the questionnaires, where people were open and honest in expressing their views, which might not have occurred if the respondent was identifiable. The response rate might have been lower had anonymity not been assured.

A final limitation was that all those involved in the interviews were female. This lack of male interviewees could have created a bias in the study as they might have had differing views and attitudes to the subject being studied. The questionnaire could have helped to correct this bias as it was sent to all Senior Nurses in Wales, which include male participants. It has to be noted that very few males occupy Senior Nursing positions in Wales. At the time of this study a total of 8 out of the sample of n= 65 who were sent the questionnaire were male. Therefore, the likelihood of the male view correcting any bias created by the female view through the third stage of this research was unlikely, due to the small number of males at a senior level in the profession.

The study was part of a professional doctorate and was therefore limited by a word and time constraint, as well as the researcher being fully employed as a Nurse Director whilst undertaking this study.

Areas for Further Research

The most obvious of these expansions on the research is to develop a research proposal for a study covering the other 3 countries, Northern Ireland, Scotland and England. Then each of these could be compared and contrasted across the United Kingdom, to develop a framework of factors that are common to all. An international comparison would be very insightful in strengthening the knowledge in the delivery of the nursing service, particular in understanding the cultural attitude to nurses and their position in the healthcare hierarchy in different countries. It might also reveal how the different political influences reinforce or otherwise the role and position of nurses in the healthcare system.

As identified in the limitations of this study, there was a gender bias towards females. It would be most interesting to replicate this research using only male Senior Nurses (though in Wales the sample would be small) and compare these results with the female participants. It would be particularly interesting to examine if there were differences between the prioritisation of factors by the male and female Senior Nurses. This may explain any differences in the management style between the two sets of nurses. If the research was expanded to include the other countries in the United Kingdom this could provider a larger sample of male participants that could act to reduce any bias.

As explained earlier, this study focused on the opinions of expert, 'elite' nurses, who have considerable experience in healthcare systems. It would be very interesting to explore whether there are different opinions as to what are the key factors for a high quality nursing service, between the Senior Nurses and nurses at different stages of their career. Do nurses get more jaded the longer they are in the health service or are these opinions evidenced in less experience nurses? Do nurses working in roles closer to the patients, such as staff nurses, have a different list of factors that they feel are important? If there are differences, at which point in their career does their opinion change?

A different approach to the suggestion above would be to compare nurses working in different fields of the profession. Though this research did sample interviewees from a variety of clinical backgrounds, the study did not examine the differences in their opinions dependent on their backgrounds. This research could be repeated but using a sample, both at interview and questionnaire stage, that identified the clinical

background of the respondents. It would then be possible to analyse the variation in responses by professionals from different areas of practice, e.g. mental health, midwifery, etc. This again could indicate a difference in the culture of the environment and organisation (or part of) in which they work.

Of course other professional groups working in the healthcare system may like to repeat this research to explore whether their profession also experiences the same problems as those faced by nurses. It would be even more interesting if the study was repeated amongst medical practitioners, since their dominance was identified by nurses as a specific problem for the nursing service. Do Doctors think they are dominant or do they feel the same as other professional groups, regarding their position in the healthcare system and whether this has an effect on the performance of the organisation?

Further to this, the original study could be repeated but this time involving non clinical staff. It would be interesting to understand their views as to what makes a successful nursing service. Do they have similar opinions to the nurses or are they quite different. If there was a significant difference in views then this would add a greater understanding as to why nurses, particularly those in senior positions, have to fight to obtain a service they are proud of.

Finally it would be of value to expand this research to cover the whole organisation and not just the nursing service. Are the factors identified in this study just as relevant to the running of a successful organisation or are some or all of the themes only relevant to the nursing service?

Summary of Recommendations for Further Research
- Undertake a compare and contrast study across the 4 nations of the United Kingdom.
- Compare the responses with male and female participants.
- Comparison of the responses between nurses and midwives working in the different fields of the profession.
- To explore whether these factors are transferable to other healthcare professions.

What Next – Implications for the Nursing Service?

The research was pursued to improve the quality of the nursing service in Wales and prevent failure, which has a serious detrimental effect on patient care and the outcome for the patient. This now needs to be continued with the Nurse Directors and Senior Nurses taking forward the framework in Chapter 6 and using it to support the delivery of their nursing service. If this was implemented by the Senior Nursing staff along with the actions they could take to become more empowered as described in this chapter, then there should be an increased likelihood that the service will not fail in the future, as was described in this thesis. Nurses in the health service would be more satisfied with the job they perform and the patients' content with the care they receive which would be safe and to a high standard. Overall the reputation of the nursing profession would be improved in the eyes of patients receiving care and the general public.

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Appendix 1

MREC for WALES

Multi-Centre Research
Ethics Committee for
Wales

Pwyllgor
Ymchwil Ethegau
Aml-Ganolfan
yng Nghymru

Chairman/Cadeirydd :
Dr Gordon Taylor

Administrator/Gweinyddles:
Dr. Corinne Scott

Churchill House, fourth Floor, 17 Churchill Way, Cardiff, CF10 2TW
Ty Churchill, 17 Ffordd Churchill, Caerdydd, CF10 2TW

WHTN 6 1909   Telephone enquiries to: 02920 376 829   Fax No. 02920 376 824

MREC website: http://www.mrec.npsa.nhs.uk
e-mail mrec.for.wales.nhs.uk

25 April 2008

Mrs Marion S Andrews-Evans
Regional Nurse Director
Welsh Assembly Government
S.E.Wales Regional Office - DHSS
Block C, Mamhilad House
Mamhilad Park Estate
Pontypool   NP4 0YP

Dear Mrs Andrews-Evans

Full title of study:	What are the high-level Nursing Service performance indicators that can be used for assessment of the quality of the nursing service in NHS organisations?
REC reference number:	08/MRE09/19

Thank you for your letter of 18 April 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites
The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval
The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents
The final list of documents reviewed and approved by the Committee is as follows:

i

Participant Information Sheet

- **The Study - The identification of high-level nursing service indicators that contribute to a quality health service.**

Thank you for considering taking part in my research study. This research forms part of my Doctorate in Health Studies, which is being supervised by Dr Joanna Latimer of the School of Social Science and Dr Christine Smith of the School of Nursing and Midwifery, Cardiff University. Once the study is completed I anticipate that the findings could be of benefit to senior nurses working in the NHS. It is hoped that through this qualitative research study, we can identify, using our collective professional knowledge, what key ingredients are needed to deliver a high quality nursing service to our patients / clients.

- **The Participants**

The participants in this study are all experienced senior nurses working in the NHS, HEI or WAG. As a participant you will currently be in a role as Nurse Director, Deputy Nurse Director or Nurse Consultant in a NHS Trust or LHB, a Nursing Officer in the Welsh Assembly or a senior member of the teaching / managerial staff in a Nursing & Midwifery School of a Welsh University.

- **Your Role**

Your participation in this study is entirely voluntary and you can choose to withdraw from this study at any time. Your involvement should be minimal and for the majority of participants all you will be asked to do is complete an on-line questionnaire.
For those of you who are willing to become more involved their will be the opportunity to participate in one-to-one interviews at the start of the study to help design the questionnaire. Others of you may be happy to assist at the end of the research by joining a one-off focus group to consider and discuss the findings from the questionnaire.

If you agree to participate in either of these activities then you will be asked to give informed consent to be involved.

Any help with my study will be appreciated. I will shortly be contacting you to see if you are happy to be involved and to find out how much you would wish to participate.

- ## **<u>Confidentiality</u>**

I wish to assure you that your involvement will be entirely confidential. The questionnaires will be anonymised, so your opinions cannot be attributed to you or your specific organisation. The only area of identification will be the type of organisation you work for. All data collected for the study will be securely stored for at least 5 years.

Should you be involved in the interview process and during the discussion identify to me serious areas of poor professional practice, then in discussion with yourself, I would wish to act to ensure patients are not put at risk.

- ## **<u>Feedback</u>**

This study takes the form of 'participative action research' which means that you, as the participant, are central to the research and it's outcomes. Therefore all results from this study will be shared with you and you will be sent a copy of any report published from this work. It is hoped that we will all be able to use the results of this study to see how our Nursing Service can be delivered effectively and how we can improve the service we give to our patients / clients. It would be my intention at the conclusion of the study to publish the results and present my findings at workshops and conferences.

- ## **<u>THANK YOU</u>**

Marion Andrews-Evans
Regional Nurse Director
South East Wales Regional Office – DHSS
Block C,   Mamhilad House,
Mamhilad Park Estate
Pontypool.   NP4 0YP
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e-mail: marion.aevans@wales.gsi.gov.uk

Appendix 3

CONSENT FORM

<u>The identification of high-level nursing service indicators that contribute to a quality health service.</u>

<u>Name of Researcher :</u> Marion Andrews-Evans

	Please initial
1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.	
3. I agree to take part in the study.	

_____   _____   _____
Name of participant   *Date*   *Signature*

_____   _____   _____
Name of person taking consent   *Date*   *Signature*

2 copies: 1 for participant and 1 for research file

Appendix 4

Interview Schedule

'The identification of high-level nursing service indicators that contribute to a quality health service'

Introduction

Explain who I am, what the study is and why I am undertaking it. Check that they have received and read the information sheet (if not give them a copy with time to read). Do they have any questions regarding the study before we start?

"I am interested in the identification of high-level nursing service indicators that contribute to the delivery of a quality health service. This semi-structured interview schedule has been designed to ascertain your perceptions of the identification of high-level indicators. The transcript will be anonymous, so please feel free to discuss the issues that arise fully, and in as much detail as you consider necessary. Complete confidentiality will be assured"

PART 1 *The Exploration of Ideas.*

1. Can you tell me about your experience of visiting a hospital? How do you judge what the hospital is like? What would you say makes it good or bad?

2. What things would you do or look for to confirm your first impressions?

3. What do you considered to be the key 'ingredients' that you might find in a good nursing service?

4. From a senior nursing point of view what do you think needs to be in place for the delivery of a quality nursing service?

5. Which of these are the most important and which are not as relevant? Explain why.

6. How do you think you would know if these key ingredients were in place in an organisation? What would you look for?

PART 2 *Organisational Failure.*

7. We often hear of health organisations, which fail for many reasons. What do you think from *a nursing perspective* would be the main causes of such failures?

8. What would you say has the greatest impact on creating poor performance?

9. Have you ever experienced such failures? If so, what were they, why do you think these happened and what would you have done to stop them if you could?

Conclusion

10. Go over the responses to the questions with the participant, checking they are correctly recorded and that they are happy.

11. Are there any other comments they would like to make on the subject of the study?

12. Confirm the participants grade of post e.g. Nurse Director for data collection purposes.

13. Reiterate the assurances that all information provided is confidential and will not be attributed to them. Tell them what the next steps of the study will be and ask if they are happy to continue to be involved. Inform them that they will be given a copy of the report at the conclusion of the study.

14. Thank them for their time and assistance with the study.

Marion Andrews-Evans

What do you think are the key ingredients that are necessary for a high quality nursing service?

Here are some statements for you to consider.
Please rank the statements for **each** section
 with **1** = **most important**.
There is space for further comment if you wish.

Strategic	RANK
1. A local Nursing Strategy linked to 'Designed to realise our Potential' (2008)is in place.	
2. There are clear and accessible policies and procedures to guide nurses in providing and managing care.	
3. There are regular reports by the Nurse Director covering service quality and professional issues presented to the Board.	
4. Nurses have an active role in the making of key strategic decisions	
Comments:	

Role and Fit for Purpose	RANK
5. Nursing staff have clear relevant job descriptions to enable them to perform their role	
6.Nursing staff have annual objectives and performance reviews	
7. Nursing staff have training and development plans agreed regularly	
8. Professional registration checks for nurses are in place	

Comments:

Culture	RANK
9. Nursing staff demonstrate a professional deportment at all times	
10. There is a positive approach to multi-professional team working	
11. Ward managers / Sisters / Charge Nurses having control over their budget (staff & Equipment)	
12. Nurses are empowered and able to make decisions regarding the clinical area they work in	
13. Nurses are free to raise concerns without fear or sanction	
14. The organisation supports nursing staff to be innovative in their practice, allowing risk taking to promote change	
15. There is a learning culture which supports the delivery of a good nursing service.	
Comments:	

Staffing Levels & Management Arrangements	RANK
16. The nursing service has appropriate staffing levels, relevant to the specific clinical area	
17. Dependency assessment tools are used	
18. There are robust workforce plans	
19. Nursing staff have clear lines of reporting in the management structure	
20. Frequent management changes are stimulating and a positive benefit for the nursing service	

Comments:

Communication	RANK
21. The Nursing Director and Senior Nurses have high visibility across the organisation	
22. The nursing service has robust systems of 2-way communication within the management and professional structures	
23. The Senior Nurses / Director listen and respond to the nursing staff	
24. There are Nursing Forums at all levels of the nursing service	
25. The vision /strategy for the nursing service is communicated to the nursing staff	
Comments:	

Service Quality Assessment and Monitoring	RANK
26. The 'Fundamentals of Care' are implemented and then audited on a regular basis	
27. There are systems for reporting and learning from incidents	
28. There is active audit of nursing practice	
29. The nursing service invests in the development of champions to drive forward nursing research	
30. Nurses listen and learn from patients' complaints and comments	
31. Nurses are encouraged to improve the standards of their record keeping	
32. Care decisions are based on evidence gathered through the use of nursing assessment tools e.g. falls, nutrition, pressures areas,	
Comments:	

Please mark 'X' as appropriate:

I am a:

Nurse Director -

Deputy Nurse Director / Senior Nurse –

Nurse / Midwifery Consultant –

I would like to receive a summary report –

My contact details are:

Appendix 6

Thesis Time-Line

Activity No.	Action	Date
1	Ethical Approval and research design	April - June 2008
2	Fieldwork Interviews (9)	July - August 2008
3	Transcribe Interview Notes and analyse results	August - September 2008
4	Write Methodology Chapter	October 2008 - May 2009
5	Design Questionnaire	February - May 2009
6	Pilot Questionnaire	April 2009
7	Issue Questionnaire	June 2009
8	Analyse Questionnaires	August 2009
9	Research & Write Literature Review	March - September 2009
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11	Write up Findings / Discussion Chapter	December 2009 - February 2010
12	Write Conclusion Chapter	February – April 2010
13	Write Introduction	April - October 2010
14	Review Literature Review	November - February 2011
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18	Thesis Submission	March 2012

Feature

Senior nurses' views about factors that lead to service failures

Marion Andrews-Evans reports on a study to explore why things go wrong and consider how the problems identified could be resolved

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Abstract

Significant failures in nursing services have led to numerous recommendations for improvement, yet problems continue. This article reports the findings of a study carried out in Wales to explore the underlying causes of such failures. It also reports how the findings were used to support the development of a senior nurses' framework with the aim of achieving successful nursing services.

Keywords

Repression failure, senior nurses, service improvement

OVER THE decades there have been many health service inquiries following incidents of health service failures. They include the 1969 inquiry into events at Ely Hospital, Cardiff (Parliamentary Report 1969), and the more recent inquiry into Mid Staffordshire NHS Foundation Trust (Healthcare Commission 2009) after a high number of patient deaths.

Consideration of why care goes wrong and what senior nurses, at ward or board level, can do to prevent this happening prompted the study reported here to examine the delivery of the nursing service.

The study involved senior nurses in Wales and focused on the factors missing from nursing service activities when things go wrong. It also examined what influence organisations have on the success or failure of services and also looked at why senior nurses sometimes find it difficult to implement in their daily work the issues identified and why their concerns are not heard. Finally, it explored how problems in nursing services could be rectified to ensure delivery of safe, high quality care.

For the purpose of the study, 'nursing service' is defined as the organisation of registered and unregistered nursing staff and the systems in which they work, and encompasses all tiers where nurses operate, from ward or team level to directors of nursing on the boards of organisations.

Background

The nursing service makes up 52 per cent of the NHS workforce in Wales and provides most direct patient care (Welsh Assembly Government 2009). Nursing, therefore, contributes significantly to both good and bad health care, with evidence suggesting that nursing work is integral to the everyday organisation of health services and delivery of care (Latimer 2000, Rafferty et al 2001, Allen 2001, 2002). However, the studies also highlight that this work can be invisible at strategic level and to non-nursing members of healthcare teams.

The nature of nursing is personal to each patient and, because the activities nurses perform are often intimate or private, they are not always appreciated by other healthcare workers. This means nurses who work outside ward environments do not always recognise the contribution made by front line staff to positive patient outcomes. Questions therefore arise over the link between nursing and the quality of service delivery, particularly in the context of patient safety and service failures.

Combined factors My own experience as a nurse director with a role in monitoring problems left me frustrated that, despite the numerous reports and recommendations to address service failures, problems continued. Although the reports identify specific aspects of failures, such as low staffing levels or poor infection control, I did not feel they explored the underlying causes or the relationship between the failures that led to poor quality patient services.

I concluded that the reasons for repetition of failures perhaps lay in the way the nursing service

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was organised and how its systems worked. I focused on nursing because it is unique, in that nurses undertake specific activities with individual patients and have 24-hour responsibility for patients' wellbeing, the co-ordination of their care and the management of environments in which care is delivered (Dennis and Prescott 1985).

Further, a more fundamental and overlooked aspect of the role of nursing is the 'orchestration' of patient care services (Latimer 2000), which involves not only co-ordinating other professionals and resources, but also communicating with other parts of the healthcare system to access information about the availability of beds and other services as patients move through their care journeys.

Latimer (2000) argues that nurses continuously have to juggle organisational and professional objectives, which can be both complementary or competing. This means that the nursing service is in a constant state of response and adaptation, which can hamper nursing and lead to failures in patient care. But it can also have a positive effect because the dynamic and flexible roles nurses play lead to innovations in care.

Critically, nurses adapt and develop, when allowed, in ways that protect patient safety and ensure quality care. But to do this they require specific skills, experience and knowledge, which are vital to health services but which are often unrecognised (Allen 2007).

If nurses do not get support to gain knowledge and skills, are unable to use them, or are not empowered to 'take charge' of care environments (Nightingale 1859), the risk of 'disasters' for patients increases (Dixon-Woods 2010).

The nursing service occupies a pivotal place in the NHS and when it fails there can be severe consequences. This study, therefore, addressed the relationship between the health of the nursing service and the dynamics of nursing as it operates in the organisation.

Research process

The study involved senior nurses at nurse director, deputy nurse director and nurse consultant levels; their backgrounds included acute and primary care, community services, mental health, midwifery and the third sector. The aim was to achieve transferable outcomes for all sectors of the service.

The information obtained provided a greater understanding of what can be done in practice to prevent disasters in the nursing service, particularly at ward and team levels. It provides areas for action by senior nurses to improve care. The research had three stages, with each stage informing the next, providing validity through reference to the previous stages.

The first stage involved a review of 14 published inquiries covering all clinical service areas, including Mid Staffordshire NHS Foundation Trust (Healthcare Commission 2009), maternal deaths at Northwick Park Hospital, Middlesex (Healthcare Commission 2006), the care and treatment of people with learning disabilities at Cornwall Partnership NHS Foundation Trust (Healthcare Commission and Commission for Social Care Inspection 2006), and the outbreak of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust, Kent (Healthcare Commission 2007). The review identified themes that led to failures in the nursing services and the care they provided.

Stage two consisted of nine semi-structured interviews with senior nurses to gain their opinions about why nursing services fail and what actions can prevent failures recurring. The inquiries cited make recommendations all nurses can learn from. This involves, for example, the importance of the nurse director in reporting service deficiencies or clinical areas that were causes for concern to their board. Although this was seen in the outbreak of *C. difficile* and subsequent deaths at Maidstone and Tunbridge Wells NHS Trust (Healthcare Commission 2007), the reports' authors were also concerned that failures were continuing.

The final stage was the development of a questionnaire based on the main themes and actions that could reduce failure, which were derived from the interviews. These themes were grouped under six headings: strategic leadership, the nurse's role and fitness for purpose, culture, staffing and management arrangements, communication, and service quality monitoring.

The senior nurses were asked to rank the factors in each of the six areas according to how important they considered they were in preventing failures in the nursing service.

Sixty five questionnaires were emailed to nurses, with 41 returned (63 per cent). The free comment section contained many comments and showed that senior nurses were keen to contribute their views about why services failed and what can be done to prevent failures. Many nurses commented that their concerns were rarely heard or acted on, making the failures inevitable.

Nurses who work outside ward environments do not always recognise the contribution made by front line staff to positive patient outcomes

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Voice of senior nurses

The semi-structured interviews and questionnaires produced similar findings, and comments across the range of nurses were consistent. These and the factors identified by the research were grouped in six themes:

- Leadership and direction.
- Culture and ethos.
- Communication.
- Staff.
- Fitness for the job.
- Service quality.

These themes were subsequently used to form the basis for developing the senior nurses' framework.

Leadership and direction Senior nurse participants first considered the usefulness of nursing strategies in guiding the nursing service. They felt strongly that strategies 'sat on shelves' and were not particularly relevant to staff in direct contact with patients. They also believed it would be more helpful to have an annual strategic direction document. One nurse said: 'The strategic document needs clear milestones that can be measured to assure it is achieved, with the board owning it and being involved in monitoring its implementation via board reports and presentations by the nurse director and other senior nurses.'

There was concern that strategies alongside many organisational policies could be too restrictive on nursing practice and stifle innovation. Another participant said: 'Too many policies lead to transactional staff rather than transformational staff. We need nurses who challenge the status quo, try new things and adapt to changes, nurses who are not driven by a culture of rules, of "doing as you are told". By taking this approach we lose our professional control and authority.'

Next, participants identified the need for senior nurses with vision, who are open towards followers and give clear direction. This was expanded further, with some participants expressing the need for good succession planning to develop future nurse directors. One nurse said: 'Some senior nurses are selfish creatures and do not develop others; they see them as some sort of threat… If the service is to develop, we need to let junior staff have the opportunity to watch more experienced colleagues and learn from them.'

Participants overwhelmingly believed that nurse directors and other senior nurses had to be clear about their expectations of the service and the quality of care; they needed to follow this through by having a high profile and being seen out in the service, to help them understand the issues facing nurses providing care, and to relay these to the board.

One noted: 'The nurse director must be in contact with what is going on throughout the organisation.

You need to see reality, so you can present the real picture to the board. You can then translate the reality of the patient's experience into a language the board can understand, such as information about complaints and serious incidents, which sometimes they don't want to hear.'

Culture and ethos The responses indicated that the culture and ethos of organisations could make or break a nursing service, and subsequently the care nurses give to patients. As one senior nurse commented: 'Organisations have a responsibility to ensure staff are empowered and given the tools to do the job properly, able to work as equal members of the health team. There has to be good working with other members of the multidisciplinary team, as well as good working relationships within the nursing team. Nurses should not be treated as junior members of the team, if you are going to get effective working and care of patients.'

Further comments included what nurses believed represented a 'good' culture in the nursing service, for example: 'A calm atmosphere, staff look professional, act calmly and with purpose, like a well-oiled machine, the place has a sense of order. There is clear evidence of someone being in charge and in control.'

There was a strong view that nurses needed to be free to run the service and able to take risks that could improve patient care. One respondent said: 'The nurses must be free to think independently… if they are [free], they will innovate and be creative in… finding solutions. Senior nurses must welcome innovation… If they don't, the service will stagnate. It is usually worth trying something new, as you may find you make great gains in service provision.'

Communication This was considered another key factor for success. One participant pointed out: 'If you have nursing staff who communicate well with the patients, they usually communicate well as a team, and this is set as an example from the top of the office as well. We must have good relationships with each other, which aids communication and improves our job and the care of our patients.'

There was a strong message about the visibility of senior nurses, including the following comment: 'You have to engage the staff, not just by using emails, newsletters or the phone, but face to face, to get out and see them. Senior nurses need to be out and about to pick up what is going on. You need visibility, so staff can talk to you. And don't forget to congratulate them as well.'

The senior nurses also recognised the need for a good communications network and the role played by nurses at middle management level. One said:

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'It is the group of staff above ward sister who can make the difference. They often sit between the nurse directors and front line nurses and can either facilitate or block communication up and down.'

Staff The workforce and the way it is organised have been the subject of much research. Participants considered good organisation to be an important factor for success, with one senior nurse saying: 'Not only do you need staff with the right skills, but you also have to have the right number of staff to do the work. A poor skill mix leads to poor care, which to me is a false economy as poor care costs more due to mistakes that happen and complications for patients.'

Another participant noted: 'Establishments are very traditional and do not reflect changes and innovation in nursing care and nurses' roles. We just have to change the way we look at nurse staffing today so we can cope for the future.'

Participants said that, although financial constraints often affect staffing levels, a lack of good workforce planning meant that they were unable to build a case for increasing staff numbers. One senior nurse said: 'There is a lack of systematic planning processes linked to the organisation's strategic aims and the ability to scan the horizon to predict future nurse staffing requirements. Workforce planning is essential, but most organisations don't really get it right and, although there could be great value in doing it right, we don't make the most of it.'

Fit for the job Ensuring staff are fit for the job follows on from ensuring that the right number of staff is in place. One participant commented: 'Do all staff have good role descriptions and objectives? The senior nurses need to know they are accountable and shoulder responsibility for the service. We need to be sure that nurses are clear about their roles and responsibilities and that they are prepared for new roles. Training plans are important. Without a good understanding of their roles and what is expected of them nurses do not feel empowered, nor will they accept accountability for their actions. This is asking for trouble, and then things go wrong.'

Some participants identified that senior nurses have specific roles in ensuring nurses work within their competence and are developed appropriately. One said: 'The ward sister or charge nurse provides the clinical supervision essential for good care, while the nurse director sets the expectations and vision for the service, but they can only fulfil these roles if they are allowed to do them as they feel is appropriate. There are too many people trying to tell nurses how to do their job.... Give us our power back!

Without a good understanding of their roles nurses do not feel empowered, nor will they accept accountability for their actions

Only then will we take on the accountability for the service we provide.'

Participants referred to the need for an organisational culture in which learning is supported and which creates a hunger for developing knowledge and skills. They thought this was essential to ensure services are kept up to date.

Service quality While participants agreed the nursing service should aspire to providing the best and safest care possible, they identified the need for assurance processes to monitor quality and ensure continuous improvement. One nurse said: 'There should be sound audit of the service, so you know what the quality of the nursing service is like, so you can pick up problems and put them right as quickly as possible.'

Participants focused on serious incidents and the importance of learning from mistakes. For example, one senior nurse noted: 'Having systems to learn from incidents is vital if the nursing service is to manage clinical risk and improve patient safety. Nurses need time to reflect when things go wrong.'

They also considered the importance of seeking external advice and learning from others, as well as listening to patients. One nurse said: 'If independent patient surveys are used and we review complaints and incidents, we can present information and trends to the board. This provides a system of feedback to the people in charge on how good the service is and where improvements are needed.'

Framework

Many of the senior nurse participants said it would be helpful to have a framework to guide their work. One responded: 'I am new to my post as nurse director and it would be helpful to have a checklist to help me get things right.'

The study provided insight into the beliefs and views of senior nurses. The factors they identified and prioritised were those they considered could make a tangible difference to the nursing service if they were implemented. This information was subsequently used to produce a senior nurses' framework; this contains the 36 'factors for action' that participants said were a priority for a successful nursing service. Box 1 (page 30) illustrates some of the points covered by the framework.

While the factors identified in the framework are not new, implementing them can make the difference

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Box 1 Extract from the senior nurses' framework

Leadership and direction
- Regular reports to the board by the nurse director on standards of care, identifying actions required and progress reports on implementing action plans.
- Ward sisters/charge nurses are empowered to fully manage their clinical area and are free to make decisions relating to patient care and the environment.

Culture and ethos
- Nurses are empowered and trusted to make decisions and have autonomy over the care they provide, the environment of care and their professional conduct.
- Nursing innovation is encouraged and supported, with evidence of changes to service delivery which improve the quality and safety of care

Communication
- The nurse director and senior nurses have high visibility in the service and are regularly seen in clinical areas.
- Adverse events are reported and this is encouraged and supported by senior nurses and management as a learning opportunity.

Staff
- A robust system is in place to assess the nurse staffing requirements for each clinical area.
- Reports are presented to the board on nurse staffing levels, absenteeism, turn-over rates and training undertaken in each clinical area.

Fit for the job
- All nurses have annual personal development plans and objectives that are reviewed at least twice a year. The objectives are linked to the nursing service strategic direction.
- All nurses have time set aside to reflect on their work through clinical supervision.

Service quality
- Care standards are set, assessed and measured. Action plans are available and regular reports on the process and outcomes of care are produced and widely disseminated for comparison purposes.
- Reports on service quality have equal time and place on the board agenda.

between success and failure. As a rule, organisations tend to focus on tackling just one problem area of nursing services, such as staffing levels or lack of focus on untoward event reporting; it is rare for 36 to be considered concurrently. To implement the framework and support delivery of high quality, safe care senior nurses can take a range of actions.

Leadership and direction Nurse leaders, particularly nurse directors, need a voice at board level and the ability to influence the board. The framework identifies 11 factors under the heading of 'leadership and direction', but these can be acted on only if nurse directors on the board have a strong voice. Nursing has to be seen as a significant item on board agendas and it is nurse directors' responsibility to ensure the nursing contribution to the delivery

of care is understood (Burdett Trust 2006). Nurse directors should, therefore, present regular reports on the status of care, such as infection control, tissue viability, nutrition and falls. Results from this study showed that when such reports were not available to the board the performance of the nursing service and quality of care fell.

Another action for senior nurses is to be visible, to make time to visit clinical areas regularly, not only to observe care provision and the environment, but also to listen to nurses' concerns and ideas and to act on these to make service improvements.

Culture and ethos A high quality service encourages innovation in nursing practice so senior nurses have to demonstrate their support for staff wishing to try new ideas and share them with others. Nurses also need to have confidence to challenge practice and take on new roles and responsibilities; for example, they should not fear complaints from patients but instead use them to improve services. Good information on complaints and serious incidents should, therefore, be easily accessible so nurses can identify trends and learn from mistakes.

Empowering nursing staff, particularly at sister or charge nurse, and nurse director level was discussed at length by participants, both in the interviews and the comment section of the questionnaires.

Communication Alongside visibility, senior nurses must ensure that robust systems of communication are in place throughout the nursing system. Many examples of supporting communication emerged from the study, including walkabouts, discussion forums and newsletters.

The use of newsletters came with caveats, however. They should not, for example, be a substitute for face-to-face interaction, and they should publish not only news about the organisation, but also its vision and aims, practical information for nurses, such as lessons learnt from serious incidents, changes in personnel, nursing initiatives and examples of good practice.

Staff Senior nurses and human resource staff must improve workforce planning and ensure the right number of staff is available to meet future care needs. Nurses need to express the need for sufficient staff, so good systems for assessing staffing levels, as well as effective rostering systems, must be in place to enable them to do so.

Fit for the job At a time of organisational change and financial pressure, equipping nurses with the knowledge and skills to do their jobs often becomes a low priority. This is a false economy because poorly

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trained staff are more likely to make mistakes and deliver poor care. Therefore, senior nurses should work with staff to develop training plans and ensure these can be delivered in the most cost-effective and appropriate way.

Ward sisters and charge nurses also play a vital role in staff supervision, for example, by keeping an eye on what is going on in clinical settings, challenging poor practice, supporting innovation and providing time for reflection so improvements can be made.

Service quality Data on nursing care are presented to boards, but it should also be disseminated regularly to nurses. There is considerable merit in sharing ward or team information between peers, so they can compare performance and make improvements.

Finally, nurses in any organisation should have clear standards for service delivery. In Wales, these are the Fundamentals of Care standards (Welsh Assembly Government 2003), which are audited regularly. This open accountability for care has been welcomed by nurses across services and increases service users' confidence in the quality of nursing care.

Empowerment and repression

Many study participants made similar comments about the link between empowerment and their ability to implement the framework. One senior nurse said: 'If only they would empower us to run our own nursing service, to make decisions, and for non-nurses in the organisation to listen to the nurses… they have a great deal to contribute to making not only the nursing service successful but [also] the organisation as a whole.'

In the course of the study it became evident that an overarching factor that led to failures in nursing services is what has been termed as 'repression' of

a group of staff (Noel and Jermier 1992), and this was particularly evident in the comments made by the senior nurses involved in the study. The theory of 'repression failure' proposed that nurses are repressed by other staff groups who fear that, by giving them power, they themselves will lose control

A fundamental finding in the study was the unspoken role that power plays in the success or failure of nursing services, in particular how the power of other groups affects nurses and the service they provide. This act of repression disempowers nurses and removes their confidence as professionals, and further limits communication, innovation and the ability of the repressed group to act effectively (National Co-ordinating Centre for NHS Service Delivery and Organisation 2006).

Senior nurses who took part in the study frequently stated that no one listened to their views and that they felt ignored, the consequence of which was that failure went unrecognised and the quality and safety of care suffered.

Conclusion

The combination of the 'repression' of nursing staff and the consequent failures to implement the 36 factors for action directly contributes to the failure of specific service areas such as nursing and, inevitably, of organisations.

This study has provided senior nurses with a voice, and it is the responsibility of the nursing profession, particularly its leaders, to listen. Nurses continue to feel subservient in healthcare organisations and believe it is time they are seen and treated as equals in decision making and management processes. This study suggests that, if nurses are not empowered, the risk that service failures will continue is high.

Online archive

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Conflict of interest
None declared

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