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Challenges in Everyday Leadership Capabilities - Conversations with Senior Clinical Nurses

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ABSTRACT

Abstract: Senior Charge Nurses (SCNs) are faced with an increasingly wide range of responsibilities as part of their workload and consequently devote less time to patient care. It is noted that Leadership and organizational management are also important, although adequate training, education, resources, and support to realize these ambitions lag needs. **Design:** A mixed-method focus group informed by a well-established leadership framework was used to explore senior clinical nurses' perceptions of their Leadership. **Methods:** Purposive sampling of SCNs working in Scotland was employed. Data sources included a small focus group and one to one face to face interview. 142 SCNs participated in this interview from 2000 to 2013. **Results:** Twelve main themes were identified: 'Patient-focused leadership and Organization focused leadership" These two themes were further described through domains of Leadership and capabilities that articulate confidence, quality improvement, and team performance.

KEYWORDS: *Quality improvement, Leadership domain, Nurses perception*

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INTRODUCTION

Over the last decade, management in nursing has become increasingly demanding with the role of the Senior Charge Nurse (SCN) having undergone significant change with increased administrative and managerial responsibilities, broader responsibilities for direct patient care, and a more prominent leadership role in the management of staff within the organization. When these factors are considered alongside increased patient acuity, nursing shortages, and organizational pressures, questions arise about the scope and preparation for the SCN role (1), notably as it has been argued that these expanded roles and responsibilities have been taken on without adequate training, education, resources or support (2). It is against this backdrop that policy leaders within the NHS have developed documents such as "Leading Better Care" (3) and "Better Together" (4). The central recommendation from these documents was for "professional development" for SCNs, and has led NHS education for Scotland to produce the developmental framework "Education and Development Framework for Senior Charge Nurses." The highlighted dynamic functions of the NHS framework (2) have well designed support to develop individuals in their position and careers.

This framework provides a single consistent, comprehensive, and explicit environment within which to base the review and development of all staff. "Leading Better Care" (3) and "Releasing Time to Care" (5) comprise part of a more comprehensive cross-professional approach to improving Health Care Quality (1). SCNs have been identified as critical staff in the delivery of this strategy. They act as Clinical Leaders and Guardians of safety and quality in their wards, explicitly working to meet the strategic objectives at an organizational and national level. This contribution is supported by successful teamwork and the achievement of key clinical outcomes, patient satisfaction, and a safe environment. The SCNs role is summarised in five key points (3), namely Improved Leadership Ability, Greater Efficiency, Enhancing Moral, Team Working, and the Development of a caring environment that is safe and secure.

The significant quality indicators that have been the first to be used are (a) food, fluid and nutrition, (b) number of falls and problems with pressure area care, and (c) data collection at ward level to allow the SCN to monitor these levels of care. In addition to these 3 factors that may affect the achievement of optimal targets, other factors such as staffing level, sickness & absence, and patient profile are also taken into account. "Leading Better Care" has articulated a new role framework for the SCN with a supportive education". Releasing Time to Care" is essentially a quality improvement initiative that works in combination with "Leading Better Care" and is complementary and specific to Scotland.

SCN is recognized as having a key leadership role in nursing. Following several reviews of the role, two related functions were given attention. First, attention was directed towards enhancing the SCN role in their clinical leadership function, and second, to provide nurses more generally with a quality tool to enable them to ensure continuous improvement in key areas of practice (6). The hope was that this developing role would provide the direct link with the broader governance of clinical care and a patient safety agenda enabling individual SCNs to understand the impact that their role has in supporting the delivery of national policy and strategic organizational objectives. A previous review of the SCN role carried out by it was shown that people found the job title confusing and that levels of responsibility within the role were ill-defined, lacking clear performance criteria and expectations (Stirling University, Cathy Stoddart). This emanated from patients, the public, and other nurses as well as doctors.

There were misconceptions about the role in general and the skills that were necessary to carry out the role effectively. The review emphasized that maximum benefits would be gained when SCNs exercised their clinical role with all patients rather than providing direct patient care via handling a caseload of patients. The review's concerns over this issue were confirmed by the SCN activity analysis, which showed that much of their time was spent providing direct clinical care that was caseload driven. The need to carry out general administrative duties, with a minority also providing hospital or doctorate cover, has led to the situation in which little time was spent on developing the team and quality improvement. The research to follow has been undertaken to examine SCN views on their role as a follow-up to undertaking further education based on lean methodology and transformational management styles as a mixed-method approach.

Research Methodology

The study used a mixed-method approach to address the area of inquiry, as advocated by Creswell (7). Small focus groups or one-to-one interviews, depending on the availability of staff was adopted in this focus group technique. Although the primary purpose of a survey is to produce statistics that are quantitative or numerical descriptions for some aspects of the study population, the questionnaire used in this study also had an open response section for additional contributions not covered by the closed questions.

The conducted interview used a topic guide covering similar areas to the questionnaire introduced in the light of a low response rate for completing the questionnaire. Focus Groups (9) and one-to-one interviews were conducted (10). Participants were assured of the interviewer's independence from the initiative and that any comments made would be confidential and anonymous. The participants were informed about the main topics within the interviews, and focus groups gathered their views and insights concerning the impact that the training had on their practice. Besides, Challenges to implementing new practices were explored on how this also impacted on other staff and care in general. The concept of visibility to patients and relatives was explored, and also what participants thought could be done differently. Other issues around the job role of relevance could be raised (Topic Guide - Appendix 2). The questions took into account the domains outlined in the role framework (3), although the framework was mainly used for structuring the analysis of the themes within the narrative provided by the participants.

Focus group interviews **(**10) have been shown to be a highly efficient way to collect qualitative data with the range of data is increased by simultaneously collecting several participants' points of view. Interviews include a natural quality control process as the data is collected, since checks and balances on views, mainly where extremes exist, tend to be rationalized. Group dynamics help to focus on the most crucial topic, although a topic guide was used to structure the content of the interviews. Participants can make comments in their own words while being stimulated by thoughts and comments of others and topic guides. Advice on group size varies with some authors (10) recommending 8-12, while other researchers have used groups of 4-6. Participants are reassured that their comments will be anonymous and that all data will be securely stored following the Data Protection Act, and hence confidentiality will be ensured. Interviews will be tape-recorded and transcribed for analysis.A total of 142 named applicants across 16 hospital sites were contacted as possible participants in the study. Of these, 47 (33.1%) responded positively, six responded (4.2%) but declined to participate while the remaining 89 (62.7%) failed to respond. Of the 47 optimistic respondents, 26 attended an interview, 2 of whom were judged to be ineligibly leaving 24 participants in the study.

Key themes

The following issues highlighted the substantial issues:

- The need for protected learning/educational/training
- IT and non-ward issues increasingly detract from the time available for the delivery of direct patient care
- The need to reduce the volume of repetitive paperwork.
- Changed directives at an organizational level before the effect of the previous organizational directives have reached fruition
- Difficulty in managing workload due to staff shortages and non-ward duties.
- Good communication and educational skills are the key ingredients that ensure the effective planning and coordination of patient care.
- Counterproductive nature of a top-down style of management
- Longer-term initiatives for maintaining staff morale and the spirit of inclusiveness.
- The need to contribute to the workload of the ward team during peaks in workload
- The onslaught of unfocussed information and filtering it efficiently for local relevance
- The need to be alert to future changes in organizational direction
- The need to provide quality patient care at all times
- Maintenance of ward skills and fostering the development of staff skills.
- The benefits of gaining information by networking within the organization

Twelve themes were nitrified from the thematic analysis of the one-to-one guided interviews.

These are presented in figure 1.

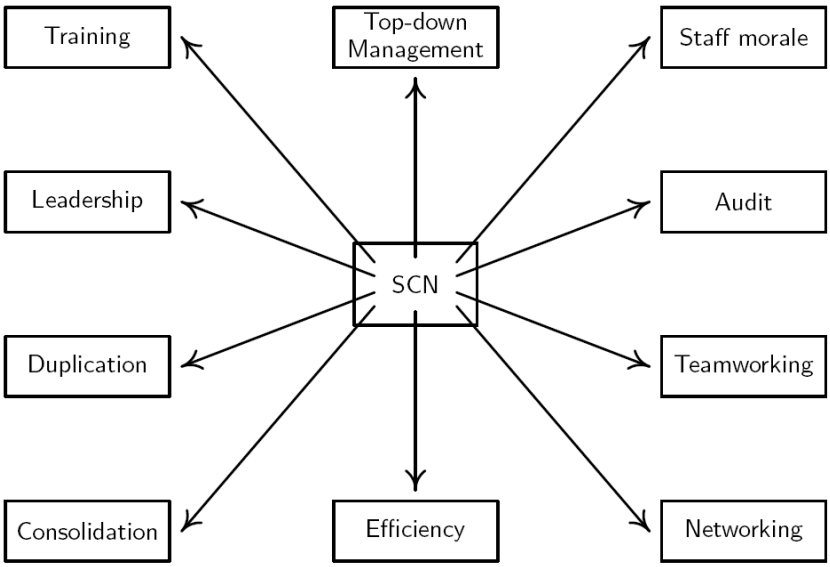

Figure 1 The multi-factorial role of a Senior Charge Nurse from analysis of one-to-one interviews.

Some examples of the comments made by the participants in the one-to-one interviews concerning the key themes of the SCN roles are illustrated in Figure 1.

Leadership - The participants considered the SCN role to be pivotal and the 'glue' within the organization/ward area. They would, however, value further training in managing budgets, health & safety, and human resources, particularly for newly qualified nurse managers. Diversity, responsibility, and succession planning was raised as an essential issue. Contingency planning is essential to ensure that wards run effectively when the SCN is absent, e.g., having a deputy, and would require training to be provided for staff at band 6 level.

Duplication An overload of information and objectives, often duplicated by different development groups, but all of which need time to be read over. However, often they do not relate to your local environment or are organizational objectives remote from the "coal face."

Team-working – The role was recognized as part of a team effort and multi-factorial dealing with estates and audits, pharmacy, entering data, and performing an extensive range of administration tasks before necessarily being involved in direct patient care. Most tasks were supernumerary to the workload of the day –to –day delivery of direct patient care, but on frequent occasions when there were staff absences, e.g., sickness or study leave or on courses or an extra heavy workload, then the SCN became part of the direct care provision team.

Efficiency – The interviewees thought that 12hr shifts were unhelpful in terms of overseeing the management of the ward area. They preferred the 7.5hr shifts as these gave them a better insight into what was happening at the ward level. Whether they were running specialized units such as Renal or Neonatal, in terms of the overall managing of the workload, the SCNs felt that they were overloaded with secretarial work and domestic chores and that consideration should be given to potential efficiencies that may be achieved by introducing a post of ward assistant. It was thought that a one-size-fits-all educational program might not be an efficient way to deliver an educational initiative.

Training - The SCN course was considered better and more appropriate for newly qualified staff, but it could have been more inspiring. Interviewees thought that the course would have been better designed had it been informed from the participants and SCNs rather than imposed in a top-down manner.

Audit – Interviewees thought that some of the data collected at audit were without a broader context. At the health board level, it might mean very little in terms of descriptive details. They felt that audit feedback did not function as it could in terms of having the facility to change practice. Some were concerned that the process of being driven by audit and target indicators meant that it reduced the possibility for independent thought and time with patients. Time spent on the audit was considered to be a trade-off with the amount of time that could be spent on direct patient care.

Top-down management – Interviewees thought that at an organizational level, there was no explicit consideration of how recommendations could be implemented in practice. Often initiatives are put in place so quickly that their outcomes and processes have not been thoroughly thought through. The issue that priorities change frequently and that clinical quality indicators drove these as an excellent way to ensure that clinical quality was monitored. However, the prevailing view of interviewees was that there was little feedback in audit regarding practice to address the shortfalls in terms of the indicator target levels. Some interviewees thought that the educational provision given to support Leadership in the SCN role promoted the concept that SCNs should be managed from on high rather than that they should function as independent ward managers. Often the imbalance between education directives, and what happened in practice and what was learned from practice, tended to treat practitioners as "a rookie."In the perspectives of Identifying political and strategic drivers, most staffthe mechanisms are both local and regional, with consultations taking place with Lead Nurses, Regional/Government

Services, and nursing colleagues external to the local organization.

Staff morale– The interviewees thought that a staff satisfaction initiative would be helpful, and many reported that they valued and saw the benefits of reorganizing and streamlining the ward practices using the lean methodology. External speakers occasionally attended monthly ward meetings, and for them to use a discussion mode of teaching with a training element to develop a variety of topics.

Discussion

Participants considered the course useful, particularly the networking opportunities with other SCNs giving insight into how the role changed in different areas of practice. They considered that there was some overlap with the RCN leadership course and the "Scottish Patient Data Programme," although it was useful to have a reinforcement of the critical issues. The training was considered to be more relevant to newly appointed SCNs as the more experienced charge nurses felt that they were aware of the issues and, in many cases, currently undertaking a lot of the role domains from the role framework. "Releasing Time to Care," a government-led initiative, was considered by the group to have good intentions, although at an organizational level, it had not been considered sufficiently clear how the recommendations could be implemented in practice. The SCN considered their role to be pivotal and the 'glue' within the organization/ward area. Most were supernumerary to the workload, but on the frequent occasions of staff absences e.g., sickness, study leave, on courses or an extra heavy workload, they would assist the team in providing direct care.

They considered their role to be at the helm of the ward with an overview of what was happening across all staff and patients in the ward. Some considered the role to be like that of a 'policeman' to ensure that people were adhering to good practice. This was particularly evident with hand hygiene and their relationship with medical staff. On other occasions, when 'gaps' arose with work that required to be done the SCN would 'pick this up'. Often this could be considered low-level work that could be done by domestics e.g., linen receipt and storage. The role was considered very multi-factorial, dealing with estates and audit, pharmacy, entering data, and performing a broad range of administrative tasks to be done before necessarily involving themselves in direct patient care. They considered their role to be more visible in the ward following participation in the training program, although the notion of having an exact person in charge at all times would be enhanced by having a deputy. This would require training to be provided for staff at the band six-level to put in place contingency plans that would ensure that wards were run appropriately when SCNs were not there. 12hr shifts were thought to be unhelpful in terms of overseeing the management of the ward area. SCNs preferred 7.5hr shifts as these gave them a greater insight into what was happening at the ward level.

Their view was that initiatives are often put in place relatively quickly and that the outcomes and processes have not been thoroughly thought through. They thought that the RCN leadership course overlapped with the Scottish Patient Safety Agency course. There was a wide range of experience among the participants. The more experienced SCNs felt they had little new techniques to learn from the course, although they appreciated the consolidation and reinforcement of messages and outcomes. Many participants suggested that the training should be provided at the band six-level, and that having a succession planning process and deputizing facility in existence would help the role of the SCN. The issue that priorities changed frequently, and that clinical quality indicators drove these, was seen as an excellent way to ensure that clinical quality was monitored. However, they felt that there was little advice in the audit cycle concerning practice to address any shortfalls in achieving indicator target levels.

Some initiatives like the balanced scorecard for infection control and the checklist were seen to be beneficial. SCNs would value further training in managing budgets, health & safety, and human resources, particularly for newly qualified nurse managers. One overarching theme from the different participants was that the networking opportunity was incredibly beneficial for understanding and hearing how other SCNs from different areas manage similar issues. They felt that this was a very positive learning experience.

In terms of other initiatives that are aligned to the senior charge nurse review, the Scottish patient safety program was seen to be very important and has led them on to have a daily safety briefing after the report. In terms of their day to day working practices, they complement the staff providing direct patient care. However, if any gap contingencies need covering, they are the people that are drawn in. They feel that the critical message from the course was that they should think outside the box and also to stress what the specific issues were in their areas of practice, because if people did not know there was a problem, then it could not be sorted. They thought that a staff satisfaction initiative would be helpful and many reported that they valued and saw the benefit in reorganizing and streamlining ward practices using the lean methodology (11,12). It should be recognized that in order to implement the policy documents, "Leading Better Care" and "Releasing Time to Care Initiative to Support Leadership in the Senior Charge Nurse Role" (3) will require education providers to be put in place. Two main concepts were embodied in the design of the education program: first was an understanding and implementation of Lean Methodology (11,12), and second, was an understanding of transformational and distributed Leadership. The Lean Methodology was first used in the motor car industry. The components that have been drawn from this approach and have been used in health care are:

- An understanding of processes in order to identify and analyze problems,
- The ability to organize more effective/ efficient processes,
- Improved error detection and the relay of information to problem solvers in order to prevent errors from causing harm,
- Methods to manage change and solve problems with a scientific approach.

The last item in this list involves a team approach to problem-solving rapidly to ensure that patient safety is dealt with in a timely and managed way, and that there is in place a system for rapid problem investigation (11). Other concepts within the Lean process are improving specific sub-processes within the more extensive processes that are ongoing, particularly intending to eliminate wasted effort or non-valuable activities

within the process (12). Examples of the methodology in practice in the operating theatre introduced different specialism to deal with waste in the system, including introducing a financial specialist, information system specialist, a scheduling specialist, and a nurse for pre-admission preparation of patients.

Wong & Cummings (2007) (13) suggest that transformational nursing leadership is vital to an organization for improving patient outcomes and the clinical environment so that clinical leaders can deliver quality care and ensure all staff is engaged in the process. (14). Therefore the individual contribution that members of the team make should be transparent, that the leader should be identified and that the contribution of their role in delivering a successful team should be made clear. Traditional leadership models often result in many staff going unrecognized and, therefore, being underutilized and undervalued. Buchanan et al. (2007) state that transmission of influence through dispersed Leadership is probably the most significant development in healthcare modernization (15). It is a bottom-up grass-roots approach that meets the expectations of the SCN framework and offers a model of Leadership that can help meet policy challenges. The approach is nearly concerned with developing and enhancing the skills and knowledge of all those in the organization towards creating a culture that is functional and effective (16). Transformational Leadership has an essential role in changing health care culture and systems and influencing staff engagement, level of commitment, and enthusiasm for their jobs and the organization (17,18).

Conclusion

Senior Charge Nurses (SCNs) are faced with an increasingly wide range of responsibilities as part of their workload and consequently devote less time to patient care. It has been noted that Leadership and organizational management are also important. However, adequate training, education, resources, or support to realize these ambitions are lagging needs. To address these issues, NHS Education for Scotland has produced a developmental framework for SCNs designed to support and direct the role of individuals in their post to deliver care that fulfills the full potential of the role. The findings of this report are based on a questionnaire distributed to SCNs, followed by one-to-one interviews. The results of the questionnaire highlighted the multi-factorial nature of the role. Ten themes, namely top-down management, training, Leadership, duplication, vision, efficiency, provision of quality patient care, team-working, staff morale, and the need to maintain and develop skills, were identified as everyday challenges to be met by senior charge nurses. The interviewing process confirmed the importance of the roles of top-down management, training, Leadership, duplication, efficiency, team-working, and staff morale while introducing issues of networking, audit, and consultation. In addition to the comments on the difficulties experienced in the management of workload in the ward due to staff shortages, the reviewing process also identified several organizational issues that potentially undermine the primary role of a senior charge nurse.

First is the generally agreed view of information overload coming from various sources, e.g., mail and email, often containing largely duplicated information, most of which is irrelevant to your area but all of which must nevertheless be sifted for significance. Second is the commonly held view that a more inclusive approach by the organization when proposing changes would help perform the role of senior charge nurse. Often the organization practices a top-down style of management in which change is introduced at too quick a pace, and often before previous changes have had time to become fully operational. This style of management presents difficulties for senior charge nurses. They often feel pulled in two separate directions by, on the one hand, their responsibility to implement organizational objectives and, on the other hand, by their need to motivate work colleagues about the benefits of proposed changes, mainly when those colleagues felt that they had no input into these changes.

Limitation

The primary limitations in this review relate to the relatively small numbers of respondents and the fact that the respondents themselves are drawn from a wide range of nursing specializations. This diversity was evident from the comments received from the workshops. For example, one respondent did not do CQI while another comments that workforce planning is not appropriate for ITU. Despite the smallness of the sample, several common themes have emerged, most noticeable being the feeling that organizational objectives often seem remote from day-to-day life.

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