BECOMING A WARD SISTER:
ACCIDENT OR DESIGN?

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DECLARATION

I certify that this work has not been accepted in substance for any degree, and is not concurrently being submitted for any degree other than that of the degree of doctor of philosophy being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised the work of others.

Signed

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Date

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It goes without saying that I could not have achieved this thesis alone and that I have been lucky enough to have an army of people willing me on enthusiastically. I would like to pay tribute to 'Team McKenna'.

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ABSTRACT

It has long been acknowledged that the ward sister is a pivotal role in healthcare; they have great influence on the quality of patient care, the staff experience and the efficient use of resources. Despite many National Health Service policy documents supporting the need for preparation and support for ward sisters, the preparation and support available remains variable. This study set out to investigate the following questions:

- What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- What preparation and support helps nurses manage the transition to the ward sister role?

A mixed method research approach was used to answer the questions above. Focus groups with ward sisters were used to review the breadth and challenges of the role. Questionnaires were sent to all the Directors of Nursing in acute NHS Trusts in England and to a sample of ward sisters who managed acute adult wards in acute NHS Trusts in England.

The responses from the Directors of Nursing described the various ways in which nurses were prepared to become ward sisters and the different kinds of support offered once in post, there was an inconsistent approach to their development across the country. The responses from the ward sisters gave a unique insight into their development needs and they suggested how, in future, preparation and support should be delivered to be most effective.

This study is significant as it was the first multi-centre UK study that investigated the developmental needs of nurses in transition to the ward sister role from both the employer and employee perspective. The key findings were:

- An inconsistent national standard of experience and qualifications to become a ward sister

- A lack of consistency in preparation programmes to become ward sisters and the support they receive once in these posts

- Confirmation that the ward sisters in my own study concurred with the findings of the RCN (2009) study, in relation to agreeing that the ward sister is a leader, manager of the care environment and an educator, although the participants did not agree that the role included research

- Attending external courses and studying for formal qualifications before becoming a ward sister are interventions that were found to have a positive effect on the time period a nurse takes to reach the stabilisation phase of the Nicholson and West (1988) transition model in the ward sister role. Likewise studying for formal qualifications, attending conferences and shadowing a more experienced peer as a new ward sister was found to have a similar positive effect on the length of transition.

- The ward sisters' development needs and their preferred ways of learning were established

- That ward sister development is a joint responsibility shared between the employer and the nurse

To conclude the following statements summarise the original contribution this study made to nursing knowledge by

- identifying the learning needs of nurses who aspire to be ward sisters

- establishing the development needs of ward sisters

- ascertaining the interventions before and after becoming a ward sister that reduce the time period taken to reach the stabilisation phase in the transition to ward sister role

- proposing a core curriculum for ward sister development and

- designing a framework for ward sister preparation and ongoing development.

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INTRODUCTION

1.1   Introduction

This study investigated the preparation nurses undergo to become ward sisters and the support they receive once they are in these posts. The research questions were

· What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
· What preparation and support helps nurses manage the transition to the ward sister role?

It should be noted that this post will be referred to as 'ward sister' throughout the study but it is acknowledged that both men and women may work in these roles and they may use different titles including charge nurse and ward manager. This chapter introduces the role of the ward sister, gives some political context and explains how the role has been influenced by political decisions. As a preamble I will describe how this study emerged from my own experience as a ward sister and later as a nurse manager and explain the rationale for this study.

I was a ward sister 25 years ago and since that time in the various managerial posts I have held in different organisations I have continued to work closely with this group of nurses. As a Director of Nursing I found that the ward sisters, above all other levels of nurse, had the most influence on the quality of patient care, change management, use of resources and staff satisfaction. I understand that ward sisters are fundamental to a well led, effective health care system and that they deserve to be properly supported. This is one of the reasons that I chose this subject for this research study. My professional perspective of the ward sister role inevitably had an influence on me as a researcher, mainly because it gave me the drive and enthusiasm to delve more deeply into the different aspects of the role. It was also very important to me that the study should offer the nursing community new knowledge about this group of nurses and that it should develop knowledge that would support the professional growth and authority that ward sisters hold within the nursing profession.

This study offers new knowledge about the role of the ward sister to the nursing community and the wider health service. The original contribution that my own study has made to nursing knowledge lies in:

- identifying the learning needs of nurses who aspire to be ward sisters

- establishing the development needs of ward sisters

- ascertaining the interventions before and after becoming a ward sister that reduce the time period taken to reach the stabilisation phase in the transition to ward sister role

- proposing a core curriculum for ward sister development and

- designing a framework for ward sister preparation and ongoing development

1.2   Ward Sister definition

The definition of the ward sister used for this research is a registered nurse who has '*24 hour responsibility for a clinical area*' (Doherty, 2003:33). The ward sister has been acknowledged for decades as a key part not only of the multi-disciplinary clinical team but also of a health care organisation (Bradshaw, 2012). Due to the fact that a ward sister has 24 hour responsibility for the care given to patients in his/her area, the ward sister has great influence on the quality of that care and on the quality of the staff experience. This is the case even though ward sisters do not manage many of the other staff groups who work on their ward such as medical and housekeeping staff (Fenton and Phillips, 2013). The ward sister's American counterpart the 'nurse manager' has been referred to in this study and a definition of this role is a '*nurse having 24-hour accountability for at least one patient care unit*' (Shirey et al, 2010:83) whilst Cipriano (2011:61) builds on this to explain that a nurse manager is '*responsible for nursing practice and quality of care...all personnel and budget matters and creating an environment that supports professional practice and employee engagement*'.

The literature comparing the UK ward sister and USA nurse manager roles was reviewed by Cameron-Buccheri and Ogier in 1994, the search included the previous 20 years but the paper did not state how many articles were found and reviewed. They found the roles to be quite similar and very much supported the aspiration of those in both roles to be supervisory, meaning that nurses in this role should not be counted in the number of nurses on a shift but should be able to work in a supervisory capacity to *teach, direct and monitor care*; they also recommended that nurses in these positions should receive preparation for the role.

The ward sister is part of a nursing structure which places them between the nurses who have a clinical role, mainly staff nurses and nursing support staff, such as health care assistants and nurses in management positions, including modern matrons and divisional nurses. Divisional nurses are senior nurses who manage a number of clinical areas in a speciality division or directorate, they are often a member of a management triumvirate with a senior doctor and manager, they are responsible for all aspects of how the division is managed including the finance, workforce and standards of care. Nursing structures vary among different hospitals; however the majority of ward sisters will, in common with all nurses, be professionally accountable to the Director of Nursing and are likely to be managed by a matron or a divisional nurse. This means that the ward sister is one or two levels below the executive nurse (the nurse on the board of a healthcare organisation; the most senior nurse in an NHS organisation). Ward

sisters on acute wards usually manage between 20-30 staff, control a budget of approximately £1million, and they are responsible for the care of 25-35 patients.

As the National Health Service (NHS) changes due to both technological advances and changes in society such as higher public expectations it could be argued that the role of the ward sister has changed too. The core purpose of the ward sister is to have 24 hour responsibility for everything that happens in his/her clinical ward area and this has not changed over time, however, the demands placed on the ward sister have altered dramatically. The ward sister was expected to be an effective manager 30 years ago in the same way as is expected in the 21st century. The key changes are that ward sisters are now held to account much more than they have ever been, via clinical audit, staff surveys, patient surveys and financial reviews and this aspect of the role is the key element that has changed. Whilst it is clear that ward sisters hold 24 hour responsibility for their clinical area some ward sisters do not have the level of authority they feel is commensurate with the role, and in the absence of any national agreement, authority to act is agreed at a local level within individual organisations.

1.3   The Nurse Consultant and Modern Matron

In the recent past two nursing roles, namely the *nurse consultant* and the *modern matron* roles have been developed to work alongside the ward sister but for two different reasons. The nurse consultant role was first set out by the Chief Nursing Officer for England (Department of Health, 1999). The purpose of this role was to strengthen professional leadership and offer nurses the opportunity of a senior clinical role rather than all senior roles being in management (Department of Health, 1999). In a major research paper concerning the nurse consultant role Woodward et al (2005) explained that there were four parts to the role:

- Expert practice
- Professional leadership
- Education
- Research

Woodward et al's (2005) study set out to explore the role of the nurse consultant from the job holders' perspectives. The researchers interviewed a convenience sample of 10 nurse consultants. Four themes emerged from the data analysis which were i) the characteristics of the post holders; ii) whether they had integrated the four domains of the post; iii) support systems and iv) NHS influences. The paper, however described the characteristics and role achievement only, which is a limitation of the paper. Woodward et al (2005) explained that the nurse consultants who were experienced practitioners and had a Master's degree were more likely to

integrate the four domains of the role, whilst those who are less experienced usually fulfilled the clinical element of the role and the other aspects to a lesser degree. There were a number of recommendations in the paper that reflect the way in which the nurse consultant posts should have evolved and a suggestion that further evaluation studies take place. There was no mention of the ward sister in the paper other than in a case study where both roles worked together to develop practice. The nurse consultant role is a more senior role to the ward sister and should complement it (as can be seen in the case study) rather than work in opposition.

The second role is that of the modern matron, the modern matron role was announced as a policy in the NHS Plan (Department of Health, 2000). In a follow up document (Department of Health, 2001) that described how modern matron roles should be developed, there was a strong message that ward sister roles should also be strengthened and that supporting them by the modern matron would be one way to do this. The Department of health (2001) explained that there would be three main parts to the modern matron role, these were to:

- Provide professional leadership to ensure high clinical standards
- Ensure support services deliver high standards
- Ensure a highly visible presence for staff and patients

The aspects of the modern matron role described above could be seen as similar to those of the ward sister, which would lead in some instances to role ambiguity for those in both roles. Savage and Scott (2004) noted that there was a possibility due to how the modern matron role was described in the Department of Health circular (2001) that the role may cause conflict with the ward sister and/or the more senior nursing roles. The seminal research paper about the modern matron role was written by Savage and Scott (2004). The participants in their study were 176 matrons (69 percent response rate) from ten hospitals across England who responded to a survey, following this over 100 interviews took place, the sample included 21 modern matrons and other key contacts with the role; 123 patients and carers also responded to a survey. Savage and Scott (2004) used the term 'hybrid managers' to explain that the modern matrons had a professional managerial role but were also closely involved in operational aspects of the organisation including patient flow issues.

Savage and Scott (2004) concluded that the modern matron had a key role to play in change management and quality improvement including *infection control practice*, *cleanliness* and *nutrition*. The researchers also found that as a modern matron would oversee a number of wards and therefore work with a group of ward sisters, rather than being viewed as a obstacle, generally ward sisters found modern matrons to be supportive; managerial support is an important element of ward sister retention (Laschinger et al, 2007). However, these authors also

highlighted the need to be clear about the purpose of the modern matron role and to manage the tension between the professional and operational aspects of the role.

In a later small scale evaluation of the matron role (four matrons and four senior practitioners were interviewed) in one NHS Trust, Smith (2008) supported the findings of Savage and Scott (2004). Smith (2008) found that the matron role was having a positive impact on standards of care, once again with a particular focus on infection control practice. Smith (2008) noted that a limitation of the study is the small sample size and recommended further evaluation of the role.

A more recent study in one university hospital in the English Midlands, Currie et al (2009) investigated what modern matrons actually did and related this to the national policy that introduced the role (Department of Health, 2001). Currie et al (2009) used qualitative methodology and interviewed 22 nurses including 10 modern matrons about the modern matron role and how they exercised their authority, with particular focus on their responsibility for improved infection control practice rather than the other aspects of the modern matron role. The interviews were transcribed and thematically analysed, the codes were discussed by the research team which supported the inter researcher reliability of the analysis.

The researchers concluded that modern matrons ability to fulfil the role as proposed in national policy was limited for the following reasons i) the modern matron was positioned outside of the nursing hierarchy and therefore lacked managerial power, ii) modern matrons lacked influence over other staff groups including doctors and cleaning staff from the private cleaning company iii) whilst modern matrons had a target to reduce healthcare associated infections (HCAI) the nurses and other staff they worked alongside had many other clinical and operational targets and HCAI may not have been everyone's priority. It is disappointing that Currie et al (2009) did not discuss how the modern matron role works with the ward sister in any detail, as working with ward sisters collaboratively may enable modern matrons to have a more positive impact on the quality of care. An important limitation of this study is that it was conducted in one organisation only. The findings may not therefore be applicable more generally as they may be influenced by the way that the modern matron role was introduced and developed in this one setting. The lack of managerial authority mentioned by Currie et al (2009) could be an example of this as some NHS Trusts do have modern matrons in managerial roles and others will have developed the modern matrons' influencing skills without having managerial authority.

Both nurse consultants and modern matrons work closely with ward sisters however there is no literature about the impact of these two roles on the ward sister role. When working well together, these three senior nursing roles can have a very positive influence on the quality of patient care. However where there is a lack of role clarity, particularly between the modern

matron and ward sister role there is a danger of duplication and a blurring of professional accountability.

The ward sister is a very important part of the healthcare team. To perform their role effectively they need support and development. It could be that with the advent of new roles such as the Consultant Nurse and the Modern Matron the ward sister role lost some of the prestige and power that it previously employed, but as will be seen in the next part of this chapter, the ward sister has been acknowledged recently as essential to the good care of patients.

1.4   The Policy Context

The role of the ward sister cannot be studied without reviewing it in the context of UK health care policy. The National Health Service, the roles within it and the level of power and influence different staff groups have, are all shaped by history and national policy. What follows here is a chronological explanation of the key national healthcare policies that have shaped nursing roles, with particular reference to the ward sister.

The Labour Government created the NHS in 1948. Early in the development of the new organisation a structure was developed that divided the service into three sections;

i)   hospital care

ii) GP and dental care, (these practitioners had self-employed status)

iii) local health authorities, that managed community and public health services.

It was not until the 1960s that the first major policy reviews were implemented; these included the Hospital Plan in 1962, which developed the concept of district general hospitals (King's Fund, 2007), and the Cogwheel Report (Joint Working Party on the Organisation of Medical Work in Hospital, 1967) which encouraged medical engagement in management. The Salmon Report (1966) included a number of recommendations about the role of the ward sister. It is worth noting two of Salmon's recommendations in particular:

> Recommendation 38-'*Nurses should be systematically prepared for senior posts in the three levels of management, by practical 'on the job' and by courses of instruction*' (p115) and

> Recommendation 41- '*on selection for promotion to charge nurse (Grade 6), staff nurses (Grade 5) should attend a preparatory course lasting four weeks*' (p115).

These recommendations demonstrated that it was recognised almost 50 years ago that nurses needed preparation for the ward sister role (Norman and Cowley, 1999) and this is still not part of national strategy.

The Committee on Nursing (more commonly known as the Briggs review) published its report in 1972 to a Conservative Government. The purpose of the review was to reconsider nursing roles in acute and community care, and the education and training required for different levels of responsibility. The report recognised the ward sister as the most important member of the ward team and advised that ward sisters would play an essential role in the education and training of nurses. As a result Briggs (1972) also recommended that ward sisters *should have increased status and reward compared to their peers in the community* to reflect their higher level of responsibility.

Although financing the NHS was always a concern, resourcing the NHS became a major political issue in the 1980s and has persisted to the present day. Under the Conservative Government policy in the 1980s the NHS became more business focused. In 1983 the 'NHS Management Inquiry' (more commonly known as the Griffiths Report) was published. This report, commissioned by the Secretary of State for Social Services examined the management of the NHS.

The main recommendation of the report was to move away from the consensus management approach introduced in 1974 at the same time as the reorganisation of the NHS into four regional authorities. Griffiths (1983) argued that it could be difficult to know who was in charge in a consensus management model and that a general management approach would improve the NHS. The move away from consensus management was seen by some as increasing accountability within the service, but others, including professional bodies such as the RCN, felt that it disempowered the nursing profession (Gorsky, 2013).

'Working for Patients' (Department of Health, 1989) led to another reorganisation of the NHS and the advent of the purchaser provider split, as well as the formation of NHS Trusts. However, apart from encouraging ward sisters to be more aware of financial management, the report did not directly affect the role. In 1991 the Audit Commission published 'The Virtue of Patients', a report that considered whether nurse staffing resources could be used more effectively. As nursing resources at ward level were (and continue to be) managed by ward sisters the Audit Commission thought it important to highlight that nurses who were new to the ward sister role required support to develop their managerial skills and manage resources more effectively (Audit Commission, 1991). The Audit Commission (1991) report also highlighted an anxiety amongst ward sisters about the change to nursing management roles (Bradshaw, 2012). Although the Audit Commission (1991) report was not government policy, it was influential in terms of ward resourcing. The recommendations concerning the preparation and development of ward sisters were not, however, translated into national action.

In 1997 the new Labour party government set out its vision of healthcare in its White Paper 'The new NHS: modern, dependable' (Department of Health, 1997). The Chief Nursing Officer for England followed this by publishing 'Making a Difference', (Department of Health, 1999) which proposed a national strategy for nursing. The document recognised that leadership at ward level should be part of the remit of ward sisters, and that succession planning and support is required for nurses who aspire to ward sister positions. Despite this being recommended a national programme to support ward sisters was not implemented.

It should also be noted here that at the same time, a plan for devolved governance of the UK was being debated and the Scotland Act (1988), the Wales Act (1988) and the Northern Ireland Act (1988) formed the Scottish Parliament, the Welsh Assembly and the Northern Ireland Assembly respectively (House of Commons, 2009). These Acts meant that health policy could be different in the four constituent parts of the UK, and indeed since devolution there have been different approaches to developing the ward sister role. This is demonstrated through policy documents such as 'Free to lead, Free to Care' published in 2008 which mandated the implementation of a development programme for all ward sisters in Wales from 2009; (Griffiths, 2009). Alongside the 'Leading Care' (NIPEC, 2010) initiative in Northern Ireland, which subsequently led to a development programme for ward sisters (NIPEC, 2013) and the 'Leading accountable and professional care' report in Scotland (2011). All of these reports serve to highlight a different approach than that taken in England.

In 2004 the Labour government further developed the NHS Trust structure and designed a new system which included NHS Foundation Trusts. NHS Foundation Trusts were promised freedom from the Department of Health, but would be regulated by a body called Monitor, this continues to be the present Conservative government's policy.

The Department of Health published 'Modernising Nursing Careers' in 2006. The document set out the direction for Registered Nurses' careers. Although there is no section for ward sisters as a group of nurses, the document discussed the need for there to be effective and strong nurse leadership in the future and also recognised that nurses at all levels will make an essential contribution to the new national healthcare strategy.

Following the publication of the RCN (2009) study, an interview with the Chief Nursing Officer for England was published in the Nursing Times. Waters (2009a) commented on the fact that the Chief Nursing Officer had identified that the ward sister role would be a particular focus within the Prime Minister's Commission on the Future of Nursing and Midwifery, to be published in 2010. The Chief Nursing Officer also recognised, however, that it was the responsibility of local organisations to support ward sisters rather than a central (Department of Health) responsibility,

emphasising the different and less centralist approach taken by England when compared with the rest of the UK.

The Prime Minister's Commission on the Future of Nursing and Midwifery was ordered by the Prime Minister at the time, (Gordon Brown), and was published in 2010. The commission had been tasked to review nursing and midwifery in the 21st century. As early as 1972 the Briggs Report had endeavoured to enhance the status of the ward sister, but the Commission's report identified that the authority and power in ward sister roles had declined in the intervening years and the report included a recommendation that the ward sister role should be strengthened. The Commission's report also recognised that nurses in sister roles should receive preparation and support in their role. Later in 2010 the Labour government lost the general election and no action was taken in response to the recommendations set out in the Commission's report.

The successor to Gordon Brown, Prime Minister David Cameron formed the Nursing and Quality Care Forum in 2012. One of Forum's initial recommendations was for ward sisters to have supervisory status and for nurses to receive preparation for the role (Gillen, 2012). Dean (2012) highlighted that a number of the Forum's recommendations were similar to those in the Commission on the Future of Nursing and Midwifery (2010), emphasising the fact that little action had been taken place in response to the previous report. It is disappointingly notable that the recommendations set out in the Forum's 2012 report have not yet been implemented.

In 2012 the Chief Nursing Officer for England published the national nursing strategy 'Compassion in Practice'. The strategy consisted of six values (commonly known as the 6Cs) which included compassion and six action areas. There followed implementation of a nationwide plan and actions have been focused on achieving the Compassion in Practice strategy's aspirations. Action area four was to build and strengthen leadership, ward managers were mentioned in this section of the strategy and the NHS Leadership Academy developed a programme for ward sisters, however once again although potentially beneficial for participants this development programme was not mandatory for all ward sisters, currently the Leadership Academy offer a range of multi professional development programmes but none solely for ward sisters. The national nursing strategy has recently been refreshed and published (NHS England, 2016), although the ward sister role is not mentioned specifically there is an acknowledgement of the importance of developing leadership capability at all levels of the nursing hierarchy.

In 2013 the NHS underwent another reform led by the Conservative and Liberal Democrat coalition government. This reform promised to base healthcare decisions in a clinically led system whereby groups of GPs formed Clinical Commissioning Groups that would be responsible for commissioning the healthcare for their population. Apart from the different

provider and commissioning bodies' relationships this reform has had little impact on the role of the ward sister, or on nursing in a more general sense.

More recently there has been a number of reports about care failings in the NHS, including the Francis Inquiry into the Mid Staffordshire NHS Foundation Trust (2013). Pinnock (2012) noted that one of the failings of senior management in Mid Staffordshire was that they had not engaged with and listened to the ward sisters. This report included 290 recommendations, one of which referred specifically to the ward sister role. Recommendation 195 proposed that '*ward sisters should have supervisory status so they are able to work with their staff, have time with patients and manage performance effectively*' (p1696). Another recommendation (197) proposed that '*nurses at all levels receive leadership development*' (p1696).

1.4.1   Summary

This review of UK health service policy demonstrated that the role of the ward sister has been, and continues to be essential to the NHS. However, the review also demonstrated that despite numerous policy recommendations in the UK or England since 1966 which have highlighted the need for nurses to be well prepared for, and supported in, the role of ward sister, very little has actually changed. There continues to be no mandatory national programme of preparation or support for the nurses who become ward sisters in England. Although national courses are available from the NHS Leadership Academy and the RCN, there is little information on the impact of these courses and about what local provision is available for ward sister professional development.

Despite the fact that numerous reports have argued for nurses to have access to formal development and assistance when in ward sister roles, it is puzzling that a national directive has not been implemented in England. A focus on the ward sister role has taken place recently in Scotland, Wales and Northern Ireland, demonstrating that such a national approach is possible. However, it must be remembered that England is a much bigger country than its neighbours in the UK, and the complexity and cost of designing and implementing a national ward sister development programme may be the main reason why there is no national strategy to do so. The reports highlighted above add weight to the seriousness of the situation but it should also be noted that there is a dearth of evidence about the ward sister role in Britain. Perhaps implementing such a programme without the relevant research base to evidence value for money would not be supported in the current financially challenging time. The lack of a body of research about how nurses should be prepared for the ward sister role and what continuous development and support is required is the main rationale for this study.

The political background was very important as it set the context for my own study. It is clear that despite awareness that nurses should have adequate preparation and support to be a ward sister there has been no such national programmes developed in the English NHS. My study took place at a time when quality of care was and continues to be under considerable scrutiny and when patents and employing organisations alike need to rely on ward sisters heavily to ensure good quality care is provided. Some, like Castledine (2005) argued that recent national policy has resulted in the loss of the fundamental remit of the ward sister role. This would suggest that rather than adapting to the changes in the health service and being the central figure on the ward, incumbents of this essential role have lost focus and power, with the result that many feel disengaged and disenfranchised. Although the reports published in 2013 on the care delivered at the Mid Staffordshire NHS Foundation Trust highlighted the influence ward sisters have on the quality of care and the associated importance of meeting their development needs, it also demonstrated little has changed in the last decade in terms of the status of the ward sister.

1.5   Conclusion

This chapter has explained the complex role of the ward sister in England and set it in the context of the history and policy framework of the NHS. It is clear that although the role should be one of the most influential and important in nursing, national policy continued to highlight the need for it to be strengthened. It could be that with the advent of new roles such as the Consultant Nurse and the Modern Matron the ward sister role lost some of the prestige and power that it previously employed, but as will be seen in the next part of this chapter, the ward sister has been acknowledged recently as essential to the good care of patients.

The ward sister role is key to the NHS as evidenced by its being cited in major NHS reforms over the last four decades. The need for preparation and continued development for nurses in the ward sister roles is reiterated in the above reforms. My own study was founded on the basis that it was an important step to start to fill the knowledge gap about nurses in these leadership roles and what preparation and support is actually required in the early 21st century. The next chapter will review the global literature in relation to the role of the ward sister, it will also offer a review of a number of transition models which were important in this study as it focused on the time when nurses move into a ward sister role.

LITERATURE REVIEW

2.1   Introduction

This chapter describes the literature search strategy and its results. The literature about the ward sister is then critiqued and the evidence about the different aspects of the role is drawn together to conclude what is known about the ward sister role globally and where there are gaps in knowledge. Finally a conceptual framework is presented to summarise the evidence and explain how this study's research questions materialised from the evidence.

2.2   Search strategy

The main purpose of the literature review was to examine any research findings about the role, competencies and challenges of the ward sister in England and how nurses in these roles were developed. The review also sought to identify empirical studies conducted in other countries and published in English on equivalent roles. The objective of the literature review was to outline what is known about the subject and identify gaps in knowledge about the ward sister role in order to refine   the research question. This is discussed at the end of this chapter (pages 53-56).

The search strategy was influenced by the objective and based on a search using the electronic CINAHL database. The keywords were 'ward sister', 'ward manager' and 'charge nurse', as they are the three most commonly used terms in England for the nursing role that holds 24 hour responsibility for quality of care in a clinical area. The 'charge nurse' keyword search was the only one that had other nursing roles as MeSH terms which included 'head nurse', 'nurse manager', 'practical nurses' and 'nurse administrators'. All of these MeSH terms were reviewed but the only one that gave new papers was nurse manager (the title given to the ward sister role in the USA); therefore a full search on nurse manager was added to the three keyword searches.

Other nursing role titles such as 'clinical nurse specialist' or 'matron' were not used as keywords because the objective of the search was to outline what is known about the ward sister role and therefore search terms were limited to this role. The search commenced in January 2010 and sought to identify studies published between January 1990 and December 2009. Repeat searches were carried out at six monthly intervals between January 2010 and February 2014, using the same criteria as explained below.

2.2.1   Inclusion criteria

Papers were included if they were written in English, were published in peer reviewed journals and focused on the role and competencies of the ward sister, the challenges of the ward sister role, preparation for and development of nurses in ward sister roles. Studies were removed if

they did not fit the inclusion criteria. A small number of opinion articles were used to support the research and the description of policy, because it was important to show that despite the dearth of British research about the ward sister, the nursing profession and the media have strong views on the role and the policy that shapes it.

The British literature search ranged between 1990 and 2013; although there were very few empirical studies in this period it was valuable to commence in 1990 as it demonstrated that the dearth of research about the ward sister is not a recent phenomenon. Due to the plethora of literature published about the American counterpart of the British ward sister, it was decided to limit the literature search for the term 'nurse manager' to studies published after 2003. This would offer at least ten years' publications once the study was completed. It is interesting to note that the 'nurse manager' term provided more than twice as many references (2510) than the three terms of 'ward sister', 'ward manager' and 'charge nurse' put together (1044).

2.2.2   Exclusion criteria

Papers were eliminated from the search if they fell into one or more of the following categories

- The subject was the ward sister role in a specific clinical setting (e.g. Intensive Care) rather than a general focus of the role, or the subject was clinical (e.g. pressure ulcers)
- The subject was a different nursing role i.e. nurse practitioner rather than a ward sister
- The subject was an article about an initiative that was happening in one organisation
- The article was news or opinion about ward sisters, however as described above nine of these opinion articles were used in the literature review
- The article was about a named, individual nurse
- Book and conference reviews
- Letters
- Not written in English
- Duplicates of the same paper found under different search terms

2.2.3   Search results

The search initially identified of 3554 papers and articles in total, Figure 2.1 shows the number of papers that were included and excluded following the assessment. In total 50 opinion articles and research papers were found in the literature search; 30 research papers and nine opinion articles were included, there were 11 duplicate papers found in the search. In addition to the articles found by the search, four research papers were included that were not found during the electronic search but were known to the researcher (these were all RCN authored papers), there were also seven research papers and two opinion articles that were found by searching the

references of papers identified by the CINAHL search. Therefore the total number of papers that were finally included in the literature review was 41 research and 11 opinion articles.

Figure 2.1 Search strategy results


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Ward sister        Ward manager       Charge nurse        Nurse manager
(n=236)            (n=184)            (n=624)             (n=2510)

                    Total for title review  (n=3554)

Exclusion criteria :

Editorials, letters, news items, opinion articles
Not English language, book and conference reviews,
About individuals or organisations (n-1545)

                    Articles to screen (n=2009)          Total number of opinion
                                                          articles included  (n=9)

Papers not about the ward
sister role (n=396)

                    Total (n=1613)

Papers about ward sister but in
clinical context (n=613)

                    Total (n=1000)

Papers about subject  other
than ward sister (n=950)                                 Total  number of research
                    Total (n=50)                         papers included  (n=30)
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2.3   Literature Review

As a result of the literature search it was found that although there is a dearth of research about the ward sister role in the UK (Royal College of Nursing, 2009), there is an established body of scholarship about its counterpart role in the USA and globally. The vast majority of papers about the ward sister in the UK were opinion articles a small number of which are referred to in this chapter.

The literature is critiqued below and for ease of reference is divided into the following themes:

· *Role and competences of the ward sister*
· *Becoming a ward sister*

· *Ward sisters' leadership style*

· *Managing ward sisters' perceived stress*

· *Support given to ward sisters*

Design and evaluation of development programmes

2.4   Role and competencies of the ward sister

The following critique of studies reviews what the ward sister role includes and the requisite competencies. Having led the way in research about the role of the ward sister with a series of research study publications in the 1980s, the most recent large scale study in the UK on this subject was also published by the RCN Institute in 2009. The research was not published in a journal but as an RCN document and although it has not been peer reviewed it has influenced national policy. Publishing research in a peer reviewed journal is a traditionally accepted as a proxy indicator that a study is of high quality. It does not however guarantee the quality of the research process and likewise if a study is published without going through a peer review process it does not mean that it is of poor quality (Courtney and McCutcheon, 2009). The report is referred to in the Prime Minister's Commission on the Future of Nursing and Midwifery (Prime Minister's Commission, 2010) when it recommended strengthening the role of the ward sister.

The RCN used current health care policy when looking at the importance of the ward sister in helping to achieve the emerging quality agenda. The purpose of the research was to understand the experience of modern day sisters in delivering the quality agenda, gaining these insights through focus groups (a qualitative methodology). A focus group method seems appropriate as it enables a researcher to gain insight into a group of people's perspective of a situation of which they all have experience (Holloway and Wheeler, 2002). The disadvantages of using focus groups are discussed later in the method chapter, however it should be noted that some participants may dominate the discussion and others not say what they wish, the facilitator may steer the conversation in one direction and the sample may not be representative of the population (Zigmund and Babin, 2007).

In total approximately 90 ward sisters participated in the focus groups from a number of different NHS organisations in England. It cannot be ascertained from the document how this sample was chosen nor was there any demographic detail about the sample. Due to the lack of detail about the method used in this research I contacted the RCN to find out who the authors were so I could contact them. The RCN told me that the report was authored by an external researcher and that there was no one currently working in the RCN who knew who this was.

During the focus groups the following issues were addressed:

- · *'purpose and role of ward sister*
- · *key skills, competences and capabilities*
- · *preparation for the ward sister role'* (p13)

There was very little detail about the procedure used to gather and analyse the data, other than that six focus groups were held initially and that the data from the original focus groups were validated by more focus groups with other ward sisters and a group of Directors of Nursing. Due to the lack of detail it was difficult to judge the scientific adequacy of the research; from the document it would be difficult to know how to replicate the research.

Much of the document related to the findings which were very clear and linked well to the purpose of the research and were reflected in the recommendations of the report.

The following features were found to be key to the purpose and role of the ward sister (p13-14)

- · *'An expert clinical practitioner who leads nursing practice...*
- · *An effective communicator and be the ward 'hub'...*
- · *To be the ward leader...*
- · *An educator...*
- · *A manager'*

There were a number of issues that the ward sisters raised during the focus groups which were barriers to them being effective in their role;

- · *The job title, according to the research 'there was unanimous dislike of the title 'ward manager''(p14). The post-holders would much rather be called sister.*
- · *The sisters found it difficult to manage the standard of care on the ward if they were also expected to be the allocated nurse for a group of patients during a shift.*
- · *Many sisters felt undervalued as a result of the low levels of recognition and pay they received.*
- · *Most of the sisters felt they lacked real authority to act.*

The sisters found it difficult to define the skills, competences and capabilities required to be an effective ward sister, which the researchers viewed as a result of the many expectations of ward sisters and the lack of role clarity. The following themes about the essential components of the role emerged; *a leader of people and care, manager of staff and care environment, educator, nursing and clinical expert* and *a researcher*.

In relation to the third aim of the study (preparation for the ward sister role) it was found that the majority of nurses had received no training to become a ward sister. The key areas where they felt under-prepared for the role seemed to be; *leading a team, human resource processes, management of resources, assessment of clinical risk, using audit, influencing senior managers* and *policy*.

The findings were clearly used to develop the recommendations, all of which suggested action across the country to support and strengthen the role of the ward sister and enable them to contribute to the quality agenda. The recommendations included suggesting that the RCN work with the Chief Nursing Officer for England to develop further the work on key competences, holding joint summits with sisters to discuss the policy context for care quality, and the development of frameworks for care accountability from ward to board. The RCN also recommended that ward sisters should become supervisory, that they should assume the title 'ward sister', and that Directors of Nursing should review ward sisters' remit and ensure they have sufficient authority to be effective (Waters, 2009c). There were several opinion articles written in the nursing press supporting the recommendations in the RCN (2009) research study, including Waters (2009a) and Naish (2009).

Following publication of the RCN (2009) study, the Nursing Standard surveyed 224 ward sisters. Thirty-seven percent of respondents said that having more authority would give them greater job satisfaction (Waters, 2009b).

It should be noted that this is not a 21st century phenomenon and that the Salmon report (Ministry of Health, Scottish Home and Health Department, 1966) noted that whilst ward sisters enjoyed authority in their wards, the same report recommended that the matter should be clarified and that '*All posts in Grade 6 (Charge Nurse) should have a definite sphere of authority*' (p32).

The RCN's (2009) study has had an inevitable influence on my own study because it is the most major and recent piece of UK research about the role of ward sister. I have chosen to refer to this paper throughout the study as it is the most recent UK research paper about the role of the ward sister and as such my own study builds upon its findings. Although the research study may not be robust, at the time of its publication the RCN (2009) paper was influential nationally, gained a great deal of press exposure and promoted discussion within the profession. As no further research which has led the debate about the role of the ward sister has been published since, I have used the RCN's (2009) study as a major reference in my own study. It is disappointing that its recommendations were not fully implemented and that follow up research regarding the ward sister role did not ensue. The main aspects of the ward sister role were clearly articulated within

the paper and the findings were used as the basis of the discussion guide in the focus groups (phases II and IV) in my own study. The findings, particularly about the breadth of the role and the lack of training were used as one of the sources of information in my own study for both the directors of nursing and the ward sisters' questionnaires in phases I and III.

The paper published by Sherman et al (2007) is also a useful background for my own study in that it described the role of the ward sister's American counterpart the nurse manager. Sherman et al (2007) used face to face interviews and a grounded theory methodology to explore the role and challenges encountered by nurse managers. Forty chief nurses from the South Florida region were approached to nominate nurse managers in two categories; i) those who had been in post for over two years and were performing well and ii) those who had been in post for less than two years. Twenty-three of the 40 chief nurses responded (57 percent response rate). The final sample included 98 experienced nurse managers and 22 nurse managers with less than two years' experience. The authors noted a number of limitations of this study, however they did not include the fact that the participants were nominated by chief nurses, this might have meant that they put forward positive nurse managers. Another limitation was that the nurse managers who worked with the chief nurses who did not respond to the initial request did not have the opportunity to contribute, both of which may have skewed the results.

It appears that the interviews were not audiotaped and the researchers' field notes were used to analyse the data, this is a limitation of the research as the researchers' notes may have missed key information that would have been noted if the interviews had been recorded. This was managed at three levels;

  i) verbatim statements were categorised

  ii) level two themes were identified

  iii) development of category constructs.

Six competencies became apparent from the findings: these are shown in Figure 2.2.

Figure 2.2   Nursing Leadership Competencies (Reproduced with permission from Sherman et al, 2007)

A grounded theory methodology was appropriate as the researchers were developing theory from the data. It should be remembered that the researcher is likely to generate an element of subjectivity in the data analysis which is one of the disadvantages of grounded theory alongside not always ascertaining significance or the ability to generalise results to the larger population (De Chesney and Anderson, 2008). In the discussion of their findings, the authors highlighted that there were few development opportunities for nurses in nurse manager positions, but did not explain the reasons for this. However, they did suggest that the competencies that featured in this study should be included in any curricula developed for this cohort of nurses. They also emphasised the importance of chief nurses supporting nurse managers to develop this skill set. The similarities between this paper and the later RCN (2009) study in England that examined the role of the ward sister from a ward sister's perspective are very interesting. The competencies described in both reports were similar.

In an opinion article, Castledine (2004) suggested that the many skills of a ward sister include:- *planning, directing and evaluating care, conducting ward meetings, organising rosters, staff supervision, encouraging teamwork and acting as an expert clinician*. These skills reflect the findings of the research studies in this chapter.

Kleinman (2003) argued that a degree level education was necessary for nurse managers to develop the full range of clinical and business management competencies. In her research study she investigated the requisite competencies for the nurse manager role. Kleinman's (2003) research was based on the results of a questionnaire administered to nurse managers and nurse executives who had attended the American Organisation of Nurses Executives' (AONE) conference, and the members of the AONE in Jersey. The questionnaires were also sent to

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nursing management in a hospital in the North East USA. The paper did not state the total sample size but 35 nurse managers and 93 nurse executives responded. The results demonstrated that both the nurse executives and the nurse managers thought that *staffing, rostering,* and *managing human resources* were the three most important skills for nurse managers. However, there was a difference of opinion in relation to whether a degree was necessary to fulfil the nurse manager role effectively. Kleinman (2003) found that 69 percent of nurse executives thought graduate education very or extremely important for nurse manager roles whilst only 51 percent of the nurse managers agreed. As Kleinman (2003) explained this may be because a lower percentage of the nurse managers were educated to degree level and may not therefore understand how higher education would affect their ability to be an effective nurse manager. In her conclusion Kleinman (2003) also identified other methods that would be helpful for nurse managers to gain the required competencies, including academic courses, online education and mentoring.

Titchen and Binnie (1993b) described a two part study that explored the development of team and primary nursing and how it affected the role of the ward sister. Primary nursing is a way to organise nursing on wards brought from the USA to the UK in the late 1980's which increased in popularity during the 1990's. Primary nursing devolves responsibility for a group of patients from the ward sister to a registered nurse who manages a small team of nurses to implement care (Binnie and Titchen, 1999). The paper referred to the methodology briefly, stating that it was described in a different paper not published in a journal, however the main method used was action research. Within that approach, interviews and observations took place over a five month period. This seems to be particularly suited to the research question as action researchers look at a process and implement initiatives to improve it (McNiff et al, 2003). Certainly, an improvement in practice was observed to be a result of this study.

There are a number of limitations that should be noted about action research, including a large workload for the researcher due to their inherent participation, and the study is likely to be small scale because of this. It would not appear that this had an impact on this particular study as the aim was to move to primary nursing in one ward only, however, because it was a small scale study the results were dependent on the culture of one clinical area only and may not be representative of how other ward areas would have reacted to the change. Another limitation is that due to the role of the researcher it might be challenging to maintain their neutrality throughout the study (Denscombe, 2010) and indeed, a particular weakness is that part two of this research was conducted in one of the authors' wards and there was no mention of the potential for bias during this stage of the investigation. There would have been a possibility of bias during this study because although the staff were used to working with the researcher as

their ward sister they knew that she was researching the process of moving to primary nursing and may react more positively or negatively because of this. Another potential for bias is that the researcher was very positive and motivated to implement primary nursing and this may have had an impact on how she managed the change process and the study. Having noted this, there was a second researcher who did not work on the ward who would have provided an objective perspective.

The sample used in the first part of the process was comprised of team leaders and the ward sister on one ward implementing team nursing. Titchen and Binnie (1993b) stated that a phenomenological approach was taken to analyse the data and that because the data were acquired using different methods the researchers were able to cross check it between those sources. As the researchers were working with the team of nurses to understand their perception of a change in practice, a phenomenological approach seems to be appropriate (Cohen et al, 2000).

The researchers found that the experience of implementing team nursing had been quite negative and demonstrated the challenge of transferring responsibility for patient care from the ward sister to a registered nurse, due to traditional hierarchical expectations of those roles. The researchers used this data to form the basis of part two of the study which took place on Binnie's (one of the authors) ward. Binnie (Titchen and Binnie, 1993a) had implemented team nursing on her ward and wanted to evolve this into primary nursing, however she had experienced tension from her staff due to the change from a traditional ward sister role. A workshop was facilitated to review and clarify the changing nursing roles. The authors wrote that three months after the workshop there was evidence that the goals had been achieved; for example team leaders were engaged and taking on their roles and the ward had made the transition to primary nursing.

This study adds to the literature regarding the role of the ward sister, particularly in a non-traditional model of nursing. However a weakness of the paper is that it cannot be replicated because it included so little detail regarding the method.

Lewis (1990) published a research study that sought to explore the perceptions of ward sisters about their responsibilities. The paper focused very much on the findings, discussion and recommendations of the research and therefore it is a weakness of the paper that the methodology is not described in any detail, other than references to use of a grounded theory methodology and the sample size of 10 ward sisters from two hospitals. Grounded theory would appear to have been an appropriate methodology for the research question, in that he investigated the sisters' own perceptions and formed a new theory (Charmaz, 2006).

Lewis (1990) set out his reasons for the limitations of the study as the time constraints involved and the fact that the evidence was from interviews only and therefore relied on what the sisters said they did. If observation had taken place (as in Pembrey's 1980 study) this data could have been used to verify the ward sisters' accounts and therefore given the research increased validity. Additionally the minimal description of the methodology gave insufficient detail to allow replication. However, a strength of the study is the significant amount of information given regarding the findings and the discussion which is clearly linked to relevant literature associated with the themes including *rituals, managerialism* and *control*.

From the interview data, Lewis (1990) found that the sisters had two main strategies to define nursing, these were i) *setting frameworks* and ii) *standards*. He found that frameworks were usually written, and were the rules of the ward, whereas standards were more informal but defined what the sister expected from her staff. He also found that the sisters had two strategies to manage nursing; i) *monitoring*, ensuring that the staff were competent, and ii) *facilitating,* ensuring the smooth running of all aspects of the ward. Finally Lewis (1990) made recommendations for practice in relation to the ward sister role.

· *Sisters should be involved at early stage of change*

· *Sisters should be exposed to higher education regarding theory related to management and practice*

· *Sisters' clinical role not to be sublimated to a managerial function.*

Lewis' (1990) study is relevant to my own in that it gave a definition of the ward sister role and painted a picture of a nurse who is essential to patient care by virtue of the way in which they set and monitor nursing standards.

Lewis (1990) also recommended that where a primary nursing method is used to deliver care the ward sister should fulfil a clinical supervisory role. Although the RCN (2009) study did not focus on primary nursing, Lewis' recommendation that ward sisters should occupy a supervisory role is reflected 19 years later.

The seminal research paper on the role of the sister in the UK, and the most referenced study in all of the documents reviewed, was part of a series of research publications by the Royal College of Nursing (RCN) in the early 1980s entitled '*The Ward Sister-Key to Nursing'* (Pembrey, 1980). Although this work was carried out more than three decades ago, many of the key findings were reflected in more recent research, as will be described later, and because the research series is so influential in subsequent nursing research it deserved to be included in a review of the literature about the ward sister role. It is worth noting that this series of research papers followed two important policy documents that had important implications for the role of the ward sister, the

Salmon Report (1966) and the Briggs Report (1972). The Salmon Report (1966) made many recommendations about the administrative roles and grades within the nursing hierarchy and developed core job descriptions for ward sisters and above. The Briggs Report (1972) focused on the education system in nursing and referred on many occasions to policy proposed in the Salmon Report (1966). The report recognised the key role that the ward sister plays in education and organisation of care.

The research studies were published by the RCN and not in peer reviewed journals, although there was an editorial board for the series of research publications; it may be because of this that Pembrey (1980) was able to describe the full research study and findings in detail. In '*The Ward Sister*' Pembrey (1980) said that she had wanted to explore what ward sisters do every day to ensure individualised nursing care, the purpose of the study was to identify some of the influences on sisters' work. Pembrey (1980) investigated the experience of a set of nurses and consequently used qualitative methods to do so. This was an appropriate approach because the study involved observing and recording behaviour (Young Brockopp and Hastings-Tolsma, 2003).

The sample of 50 sisters came from three hospitals in England and two in Scotland. The criteria by which the sisters were chosen were i) that they worked on a ward that was a medical or surgical ward and ii) had between 20 and 30 beds. A total of 52 wards met the criteria and the ward sisters were invited to participate in the study, one sister did not want to be observed and it was found that another managed a ward and a department so both were excluded; which resulted in a final sample of 50 ward sisters. Pembrey (1980) gave demographic details of the sisters and a general description of the five organisations.

The main methods of data capture used by Pembrey (1980) were interviews and observation of the sisters. This qualitative design was appropriate to the research question, because she was studying how sisters managed nursing care. Interviews will give the researcher access to the participants' perception of their experience and their subsequent feelings (Denscombe, 2007). As Pembrey (1980) needed data about how ward sisters experienced their day to day work, a questionnaire may not have given her the depth of detail required. The observation of sisters at work would have allowed her to increase the validity of her findings as she was actually able to see how they worked (LoBionda-Wood and Haber, 2002). As with all research methods there are disadvantages to observing research participants, including that they may act differently because they know they are being watched and researcher bias may be involved as no one can be assured that they see the same events and interpret these in the same way as others would (Cargan, 2007). Having observed each sister for one day Pembrey (1980) classified the actions in themes

to analyse the data she collected. Pembrey (1980) produced criteria to judge how a sister completed the daily management of the ward, and used those criteria to analyse the performance of each sister in the study.

It was found that in the first part of the study, in the majority of wards, the sister did not actively manage the nursing care of each patient. These results were then tested in the second part of the investigation to validate them. In this latter part of the study the sample was seven sisters from three of the five hospitals. The same observation method was used for a number of days to see the consistency of managerial presence of the sisters. Pembrey (1980) found that the sisters were very consistent in their approach. Having been observed, the sisters were interviewed to identify the factors that contributed to their performance. The key finding within these interviews was that ward sisters found watching 'role model' sisters was more effective in learning how to be a sister than participating in front line management programmes. The study identified a number of attributes possessed by ward sisters which enabled them to deliver individualised patient care. These included *post registration qualifications* and *professional behaviour*. It was also stated that even though the organisation recognised sisters as managers they did not have the appropriate level of authority to match the level of responsibility they had for managing the ward resources. Pembrey (1980) goes on to state that the strongest conclusion from the study is that the sisters' role should be '*strengthened*'.

A particularly strong point of this study was that it was written in a great deal of detail in a logical sequence, including the data collection sheets; this study could be replicated with ease. One limitation is that the study used a sample from five different hospitals, and although this gave a good sample number, the organisational culture of the five organisations would have affected the way in which the sisters managed care; this is acknowledged by the author. There is a recommendation that the study should be replicated using quality of patient care indicators to compare outcomes from different types of ward sister. The study has been seen as a landmark in nursing research but is not current in that it was written over 30 years ago in a different NHS culture, which was less focused on finance and activity targets. However, it does set the scene for my own research and in many ways remains relevant because it gave a clear picture of the role of the ward sister in the 1980s to which my own study can compare current practice.

It is clear that there is a lack of a published body of evidence about the role of the ward sister in the UK. However the role would appear to have recently increased in importance perhaps as a result of recent reports about nursing and patient safety including the Prime Minister's Commission (2010) on the Future of Nursing and the Francis Inquiry into the Mid Staffordshire NHS Foundation Trust (2013). However the UK and global literature, based on predominantly qualitative research does give a clear perspective on the role of the ward sister in that the role's

purpose is to manage a clinical area, to have 24 hour responsibility for the quality of patient care and patient experience and to lead a group of staff. To do this key skills are attributed to the ward sister including communication, directing or managing care and managing human resources.

2.5   Becoming a ward sister

There is little published literature about the transition to a ward sister role and the following three papers are small scale studies from Australasia and Finland adding to the knowledge about the transition nurses experience to become ward sisters. Townsend et al (2012) investigated the development of nurses for the role of ward manager in a hospital in Australia. Their rationale for undertaking this study was the changing role of the ward manager. They interviewed more than 80 senior nurses, 14 of whom were ward managers and a similar, unidentified number of deputy ward managers, there is no explanation of how these nurses were recruited to the study. However the paper reported on the results of only around 40 of these interviews rather than all of them; the reason for this was not stated. This is a limitation of the study as it did not report the complete data. The interviews were audiotaped, transcribed and analysed using NVivo, which is software that helps researchers to analyse qualitative data (Bazeley and Jackson, 2013). The results of the interviews identified that the majority of ward managers had not previously had ambitions to be ward managers, rather they appear to have attained this level by accident, and as such were ill-equipped with the skills needed to be effective in this role and they felt unprepared for it.

In 2010 McCallin and Frankson published a paper in New Zealand about a descriptive exploratory study into the role of the charge nurse (similar role to the ward sister in the UK). The purpose of the research was not unlike that of my own study in that it intended to gain an insight into the preparation the nurses received for this role, the expectations and challenges of the role, and whether the post-holders had received management training whilst in the charge nurse post. An exploratory, descriptive research design was appropriate as the researchers were firstly identifying the different aspects of the role that the charge nurses found to be challenging and exploring where they found job satisfaction through face to face interviews. The descriptive part of the study followed the analysis when the researchers classified the key themes and were then able to describe the role of the charge nurse (McNabb, 2010).

The study was based in one urban hospital, two meetings were arranged to explain the purpose and methods of the research, 14 charge nurses attended these meetings and were asked to contact the researchers if they wanted to participate. Following the meetings 12 charge nurses volunteered to participate and were interviewed face to face. The data were analysed to identify themes and the key finding was that the nurses found their role to be unclear. It was also found that the charge nurses' position was made more difficult because the post-holders lacked

business management skills, and perceived that others had unrealistic expectations of them. The researchers noted that it was plain to see that the nurses had found the transition to the charge nurse role difficult; they were also critical of the fact that the nurses were poorly prepared to take on this important managerial role. The paper suggested that organisations should develop charge nurses in house and that performance would be enhanced by clinical supervision.

A study in Finland investigated nurses' experience of transitioning into management roles (Bondas, 2006). The members of the sample of 68 ward leaders and nurse executives were all students on leadership courses across the country, it is not clear in the paper whether the participants were on the courses at the same time but it would appear that the courses were not exactly the same. The fact that the participants were not on the same course and might not have been on courses at the same time may skew the results, however the purpose of the research was to investigate how these nurses attained their leadership position rather than evaluate the courses and therefore it is likely that this had minimal effect on the study's results. The participants completed a semi-structured questionnaire comprised of eight open ended questions. The data were analysed using constant comparison as founded in grounded theory. The researchers reported that there were a number of ways by which nurses gained nursing leadership posts, and organised those routes into;

i) *the path of ideals* (*n*=16) - this is a conscious career choice based on wanting to make a difference;

ii) *the career path* (*n*=11) - based on aspirations to success;

iii) *the path of chance* (*n*=37) - where the situation has helped the nurse in to the position, rather than it being a conscious career choice; and

iv) *the temporary path* (*n*=4) - where the leader is in an interim or seconded position.

These findings mirrored the results of Townsend et al (2012) described above, and are an issue for nursing leaders when developing ward sisters for two reasons; i) if the majority of nurses gain these positions by chance they are unlikely to have been well prepared for them and ii) if it was not a conscious decision to seek advancement their commitment to the role may not be as full as that of someone who has striven for the promotion.

In a personal report about the process of transitioning to a nurse leader role, Stevenson-Dykstra (2003) reported that both the individual and the organisation have responsibility to manage the transition to this post. She suggested that organisations should identify the learning needs of new ward sisters and provide appropriate educational opportunities so that these nurses can develop their leadership skills. However, Sprinks noted in 2010 that in a poll of 224 ward sisters for the Nursing Standard, that 40 percent reported that they had not received any management or leadership training.

A key aspect of the role in England is that the ward sister has 24 hour responsibility for everything that happens in their ward. Some may argue that this offers power and great opportunity but when viewed in the context of the 21ˢᵗ century National Health Service (NHS), issues such as the increased managerial focus of the role (McSherry and Browne, 1997) and, nursing staff shortages can make ward sister positions appear undesirable (Doherty, 2003). If junior nurses see their ward sisters struggling with the pressures of managing a ward area it is unlikely to motivate them to aspire to be a ward sister themselves (Scott, 2012). This view is supported by a finding from the Nursing Standard's poll of 224 ward sisters in 2009, which showed that 44 percent of the nurses who responded would be unlikely to recommend that a newly registered nurse aspire to be a ward sister (Sprinks, 2010).

The literature investigating how nurses become ward sisters portrays a situation where the majority of nurses attain this level of post through actions of others rather than having a career strategy to be a ward sister. This route to becoming a ward sister results in nurses not being formally prepared for the position as they were not necessarily on a defined career pathway. It should be noted that the literature is not from the UK and therefore there is a gap in the evidence about such career pathways in this country.

2.6   Ward sisters' leadership style

In 2011 Scherb et al investigated how staff nurses and nurse managers preferred to be involved in decision making and whether there were any differences between these two groups. It was a descriptive correlational study that used postal questionnaires to all 857 registered nurses in an organisation running a 250 bedded hospital and a number of primary care clinics in a Midwestern health system. Following the initial response rate of 22 percent the researchers sent a reminder and removed the demographic questions as they thought this would encourage more people to respond. There was a final response rate of 39 percent and following exclusion of 26 incomplete questionnaires the sample included 290 staff nurses and 22 nurse managers. It should be noted that a desirable response rate should be at least 60 percent (Johnson, 2002); this is explained in more detail in the findings chapter (5). The researchers noted that the low response rate was a limitation to their study and due to this they were unable to match the responses between nurse managers and the staff nurses with whom they worked.

The questionnaire measured how the registered nurses preferred to contribute to decision making and how they actually did so; an independent sample *t*-test was employed to calculate the actual and preferred style and the differences between different staff grades. This statistical test was used because the researchers compared independent samples, i.e., staff nurses and nurse managers (one person cannot be a member of both groups). The *t*-test compared the mean scores

of the two groups and the results show whether there was a real difference or not between the two groups (Urdan, 2005). The findings showed that the staff nurses rated their actual participation in decision making as 2.10 (*SD*, 0.58), (the higher the rating the more involvement) and their preferred involvement was 2.79 (*SD*, 0.52). These results were statistically significant (*p*=.001). Similar results were gained from the nurse managers, in that their actual rating was 2.22 (*SD*, 0.36) and their preferred was 2.56 (*SD* 0.45). Again, these were statistically significant (*p*=.001). Comparison of the nurse managers' responses with the staff nurses' actual ratings was not statistically significant (*p*=.164), however they were on the preferred scale (*p*=.046).

This study's results are not representative due to the low response rate and it is important to remember that this is a local study confined to one healthcare organisation. The authors concluded that the staff nurses desired more involvement in decisions than the nurse managers thought they should have. However, at the same time the staff nurses' preferred rating was less than 3.0, which according to the authors meant that the nurse managers should be investigating why staff nurses do not wish to be more involved than they were. It should also be noted that the nurse managers thought they should have more involvement in decision making so this may be an organisational issue for this institution in particular rather than a characteristic of all that can be generalised across the nurse manager population. Contributing to the future of a team and a clinical area is known to be a positive in terms of job satisfaction and retention and this study gave nurse managers food for thought in terms of the gap that may be present and how they facilitate involvement in their area.

Casida and Pinto-Zipp (2008) studied the effect of nurse managers' leadership style on the organisational culture in a clinical area. The Multifactor Leadership Questionnaire (MLQ) and Denison's Organisational Culture Survey was returned by a convenience sample of 278 staff nurses (69.5 percent response rate) and 37 nurse managers (100 percent response rate) from four acute healthcare organisations in New Jersey. It was found by correlational analysis that there was a statistically significant correlation (*r*=0.60, *p*=0.00) between nurse managers who exhibited transformational leadership styles as described in the Multifactor Leadership and an environment where mission (clear organisational strategy) and adaptability (customer focus and learning organisation) traits dominate. Correlational analysis was appropriate because the researchers investigated the strength of relationship between two variables (the MLQ and the organisational culture survey). The authors are clear that one limitation of this study is that the results demonstrate an association between more transformational leadership styles and organisational culture rather than cause and effect. The statistical analysis is applied to the two sets of data from each participant and the results will show the positive or negative relationship

between the variables on a range between -1 and +1 (Rowntree, 2004). Denison and fellow researchers identified four dimensions of organisational culture that enable effectiveness; they described the mission and adaptability components as outward facing whilst involvement and consistency traits have an internal focus (Zheng et al, 2010).

Because a number of studies in this review used the MLQ and referred to transformational leadership it may be useful to describe the focus of the MLQ. The MLQ is derived from the Full Range Leadership model developed by Bass and Avolio (1994) and consists of three leadership behaviours, each of which is composed of a number of leadership factors as seen in Table 2.1. An assessment using the MLQ will result in a description of a leader's preferred leadership style on a spectrum from being transactional to transformational.

Table 2.1 Full Range Leadership Model (Bass and Avolio, 1994)

Leadership Behaviour	Leadership Factor
Transformational	Idealised influence
	Idealised behaviour
	Inspirational motivation
	Intellectual simulation
	Individualised consideration
Transactional	Contingent reward
	Management by exception active
	Management by exception passive
Non-transactional laissez-faire	Absence of transaction

In a non-experimental, descriptive design study of high performing nurse managers in 'Magnet' hospitals Kramer et al (2007) investigated the characteristics of nurse managers that their staff found to be supportive. Magnet hospitals are organisations in the USA that have been assessed and awarded Magnet status due to the high rates of patient and staff satisfaction and the high quality of care delivered (Jenkins and Stewart, 2010).

The study used a number of methods, including interviews with 244 staff nurses, 105 nurse managers and 97 physicians; the data from these interviews were analysed by constant comparative analysis to develop themes and then categories. The researchers also used their self-developed tool the '30 item Nurse Manager Support Scale' (Kramer et al, 2007:331), the results of which were subject to statistical analysis. The survey was given to 2382 staff nurses in 199 clinical areas in eight 'Magnet' hospitals, percentage return rates ranged between 38 percent and 72 percent, the median was 56 percent.

Respondents were asked to identify which leadership attributes were expected by the staff nurses and whether or not they were demonstrated by the nurse managers. Findings demonstrated that all of the 30 nurse manager behaviours in the Support Scale were identified by the interviewees. They found that *managing resources* and *leadership functions* were the top behaviours expected by staff (mean expectation score 4.51 and 4.40 respectively) and that staff found these to be the most supportive attributes in a nurse manager (a mean expectation score of 3.5 or less was described as not supportive).

Anthony et al (2005) demonstrated how pivotal nurse managers were to creating positive work environments that help support nurses and aid nurse retention. The study involved 32 nurse managers from seven acute care hospitals participating in four focus groups. The sample was purposively chosen by the researchers, this was achieved by meeting nurse managers to explain the study at routine management meetings held in their place of work; those nurse managers who were interested in participating in the focus groups were asked to contact the researchers. The nurses were allocated into the focus groups categorised by their educational level attainment. The authors were able to differentiate the different perspectives of nurse managers from different educational backgrounds this is one of the first studies to take this approach. The focus groups were audiotaped and transcribed, and the data were analysed by software called Nudist QRS5 (more recent versions are now available called NVivo). One of the researchers then identified themes, and following this two of the researchers reviewed the analysis to agree categories.

The results demonstrated that nurse managers understood the importance of the relationship they had with their staff and the impact of this on the ability to recruit and retain staff nurses. It was reported that nurse managers who held a master degree described their role in much more broad terms than those who were diploma level educated. The nurse managers described the components of their role which were categorised by the researchers as *technical; professional; administrative* and *fiscal*.

The nurse managers in the study were experienced, but the researchers highlighted the need for 'novice' managers to be supported in their managerial and leadership development. This reflected the findings of Laschinger et al (2007) described below, in that they found nurse managers were more likely to find job satisfaction if they had a good relationship with their line manager; likewise if they had effective working relationships with their staff, the staff would experience more job satisfaction.

In 2006 McGuire and Kennerly published a research paper that examined the relationship between a nurse manager's leadership style and the staff nurses' allegiance to the organisation.

Eleven of 21 chief nurses from hospitals in the Midwest of the USA agreed to their nurses' participation in the study; 119 nurse managers were approached and the final sample had 63 nurse managers (53 percent response rate) and 500 staff nurses. To be included in this descriptive correlational study the nurse managers had to agree that at least five of their staff would also participate. This study used similar methods to that described in the Casida and Pinto-Zipp (2008) study in that they used correlational analysis of data obtained from participants who scored the MLQ (Avolio and Bass, 2004), and a questionnaire developed by Porter and Smith (Mowday et al, 1979) to measure organisational commitment.

It was demonstrated that the nurse managers rated themselves as more transformational (3.89-4.28) than their staff nurses perceived them to be (2.90-3.58). A positive, statistically significant relationship was found between idealised influence (one of the five characteristics of transformational leadership as described in the MLQ) and organisational commitment from staff nurses (r=0.393, *p*=<0.01). This study emphasised the importance of having charismatic, transformational nurse managers in post; it is likely that these types of leaders will have a positive impact on the staff.

Manion (2005) interviewed 26 nurse managers from across the USA who were known to be successful in their role. The purpose was to determine the methods they used to retain their staff. The data from the interviews were analysed and five key categories emerged from the analysis:

· *Put the staff first*

· *Forge authentic connections*

· *Coach for and expect competence*

· *Focus on results*

· *Partner with the staff*

Manion (2005) also offered eight recommendations for employers to support nurse managers including facilitating a peer network and ensuring the Human Resources department supports nurse managers.

VanOyen Force (2005) carried out a literature review of nurse managers' leadership traits in the USA, she reviewed literature published since 1987, the total number of articles is not cited, however she discusses nine papers. VanOyen Force (2005) found the following attributes all led to greater staff job satisfaction and nurse retention.

·*Transformational leadership style – the nurse managers were effective communicators and made the link between themselves and their staff in relation to organisational goals and values*

·Positive personality traits – nurse managers were more likely to be extroverted and open

·Magnet hospital organizational structures that support nurse empowerment – staff working in Magnet hospitals often perceive they have better teamwork and greater influence than colleagues in non Magnet hospitals

·Tenure and Graduate education – longer experience in a nurse manager post often enables greater expertise and confidence in leading a team

·Atmosphere of Autonomy – Organisations with similar cultures to those with Magnet status will encourage shared governance and have a reward system

These leadership traits correlate with what was found in the research studies following VanOyen Force's review in 2005.

Kleinman (2004) used a prospective, correlational study to investigate how staff nurses perceived the leadership behaviours of nurse managers. Prospective participants from one acute care organisation in North East USA received invitations to participate via their work mailboxes. Completed Multifactor Leadership Questionnaires (Avolio and Bass, 2004) were returned by 79 staff nurses (25 percent) and 10 nurse managers (62 percent). The paper did not state how the data were analysed, but the results were presented in frequency tables so the statistical analysis of the results could have been done by a statistical software programme or manually: the analysis did not appear to be complex.

Although this research study is less robust than others in this section the author reported that the results suggested that staff nurses who spend less time with their nurse managers than others have a less positive perception of their manager's leadership approach. Kleinman (2004) like McGuire and Kennerly (2006) found that the nurse managers thought they used a transformational leadership style more frequently than their staff felt that they did. This is an issue for appraisal, because if nurse managers are not aware of this perception they are less likely to focus on developing a more transformational style, which has the potential to have a detrimental impact on both them and their staff.

In 1982 Ogier published a study entitled '*The Ideal Sister*?' as part of the RCN nursing research series. This was a small scale study, the purpose of which was to 'develop a grounded substantive theory that would account for the leadership style and verbal interactions of ward sisters and nurse learners' (p59). To develop the theory the study employed two questionnaires, the Fleishman's Leadership Opinion Questionnaire (1969) which allowed ward sisters to self-assess their leadership style. The second was the Learners' Perception of Ward Climate Questionnaire (this had been developed previously by the researcher) which enabled nurse learners to rate the leadership style of the ward sisters. The study also involved observation of the ward sisters' interactions with the nurse learners.

Ogier's (1982) study focused on four ward sisters and an unreported number of nurse learners. The researcher acknowledged the limitations of the study and explained that a lack of time resulted in a sample technique for observing the interactions. This meant that not all contacts were observed. Ogier (1982) also highlighted that the different variables such as patient mix and demeanour of other professionals in the wards could not be controlled over time and as nurse learners joined the ward the environment would not have been exactly the same as at other times. It is very unlikely that researchers will be able to observe participants constantly and this has been noted as one of the limitations of this research method as researchers may miss actions that may have an impact on the study. Other disadvantages of observational research are that some groups will be inaccessible because people would not want researchers looking at their behaviour especially if it was not deemed to be socially appropriate; that the observation is described by the observer who may not record the situation in the same way as another researcher and finally it is labour intensive and therefore costly (Sapsford and Jupp, 2006). However there are advantages of observational research which include seeing and therefore having an understanding of the environment in which the participants are studied; a researcher may observe features that participants do not and would therefore would not discuss in an interview and information gained by observation may be used to supplement information from other sources such as interviews (Sapsford and Jupp, 2006), indeed Ogier's (1982) paper is an example of this.

In relation to building a theory Ogier (1982) described five categories of learning opportunities and three important leadership characteristics of a ward sister. The learning opportunities were described as; *theory* (knowing about); *ward climate* (work atmosphere); *learning accessories* (i.e. textbooks), *practical* (doing) and *etc.* (aspects outside of the ward area that has an impact on patient care, i.e. housing). The three leadership qualities were i) *approachability* (nurse learners can ask for help), ii) *nurse learner orientation* (ward sisters are aware of nurse learners' needs) and iii) *directiveness* (how a ward sister manages the ward).

Ogier (1982) concludes that 'Ward sisters who have a leadership style that is approachable, nurse learner orientated and sufficiently directive for the nature of the work, will have a pattern of verbal interaction with nurse learners that is perceived by the nurse learners to be propitious to them' (p64). This research had a number of limitations including its small sample size however, it provided a theory about ward sister leadership. Although the study is about ward sisters' relationship with nurse learners rather than staff nurses the results do reflect a number of the results reported above in more recent studies about leadership style, including the importance of ward sisters working and interacting with staff.

The studies above have illustrated the pivotal role ward sisters play in creating an effective workplace and how important it is to work with and involve staff, however these studies also demonstrated that there are ward sisters who did not display these behaviours as consistently or to as high a standard as some staff nurses would expect.

The literature focusing on ward sisters' leadership styles is interesting as it is principally quantitative in nature and therefore less descriptive than the studies relating to the ward sister role and preparation for such roles. There is robust evidence to suggest that ward sisters who employ a transformational leadership style are more likely to have better working relationships with their staff and their staff are more likely to be loyal to the organisation. However it should also be noted that in the papers above ward sisters were likely to assess themselves to be higher on the transformational leadership scale than their own staff would rate them to be. This is a key message for preparation and development of nursing leadership.

2.7 Managing ward sisters' perceived stress

Kath et al (2012) studied how nurse managers can be helped to manage their perceived stress levels more positively. The study was a cross-sectional quantitative design (using questionnaires), which seems to be appropriate in that the research investigated the extent to which nurse managers experience subjective stress and the actions taken to reduce the stress at one point in time (Crosby et al, 2006). Cross-sectional design is limited in that it can determine relationships between variables (in this instance stress and age) but is weaker at establishing cause and effect (Mann, 2003).

The questionnaire used 12 different validated scales, including the 4-item subjective stress scale of Motowidlo et al (1986) and the Camman et al (1983) job satisfaction tool (also known as the Michigan Organisational Assessment Questionnaire) (Rafferty and Griffin, 2009). The researchers correlated 12 different variables including organisational commitment, physical health problems, mental health problems, autonomy and work stress. Motowidlo et al (1986) described subjective stress as something negative that is likely to have a detrimental effect on work performance and is caused by experience in the workplace. By using this scale, Kath et al (2012) measured perceived stress, rather than physiological stress.

The sample was recruited from a convenience sample of 36 hospitals in the South West of USA, all nurse managers who worked in these hospitals were invited to participate. The 480 nurse managers who responded (75 percent response rate) to the questionnaire reported that they found their jobs stressful, with the average score for perceived stress 3.66 [SD,0.80], reported to be above the midpoint of scale (the midpoint was not detailed in the paper). The results of the study demonstrated that there was a 'significant negative correlation' ($r= -0.10$, $p=<.05$) (p220)

between perceived stress and nurse managers' age: younger nurse managers reported experiencing more stress. Interestingly, recently appointed nurse managers who were older at the time of the study did not report similar levels of stress. Increased perceptions of stress seemed to be associated with age, rather than levels of experience. Kath et al (2012) suggested that the negative aspects of subjective stress can be mitigated by certain interventions, these are summarised as:

· being enabled to be autonomous,

· good working relationships with line managers (as suggested in Laschinger et al, 2007 later in this chapter)

· support from their peer network.

Two other key findings were the significant correlation between perceived job stress and mental health problems (r=0.47) and between perceived job stress and physical health problems (r=0.45). Although the report suggested that the nurse managers perceived the role affected their physical and mental health it may be that a percentage of the nurse managers did not enjoy good health and therefore that made the role more challenging. The researchers recommended that employers implement the strategies above to support nurse managers in their roles and stated that using these interventions would affect the nurse managers' job satisfaction positively and would also have a positive effect on the quality of care.

In 2006 Shirey published a review of the research relating to nurse manager stress, she found it to be limited and not of good quality, highlighting the need for further study into this area.

Following this review, in 2010 Shirey led a group of researchers to study the elements of a nurse manager's work that caused stress and how that stress can be managed. The study used a qualitative design and focused on a subjective narrative (how the participant described stress) rather than physiological symptoms of stress. The study used a demographic questionnaire and face-to-face interviews with a purposive sample of 21 nurse managers from three acute hospitals. The interviews were recorded and then transcribed, the interviews were analysed individually, compiling data from each of the 14 questions which identified the situations that were perceived by the nurse managers to cause them stress. The data from all of the interviews were then coded and three themes and 10 sub themes were identified.

The findings showed that 86 percent of nurse managers perceived *staff* as a source of subjective stress; this category related to *people management* and *working relationships*. The next category was related to the *volume of work, finances* and *staffing the area,* found to be a source of perceived stress by 76 percent of the nurse managers. The final source of perceived stress related to *patient safety* and *patient experience* (67 percent). The researchers found factors that increased

the subjective stress experienced by nurse managers. These included the perceived *high level of responsibility* attached to the nurse manager role (48 percent). It is interesting to see these issues identified as they reflect the challenges highlighted by the Director of Nursing responses in Phase I of my own study. Shirey et al (2010) also found themes that decreased the nurse managers' stress. These were *being able to finish tasks and achieve targets, having support* and *being empowered*.

The researchers provided eight recommendations to reduce the perceived stress experienced by nurse managers, a couple of these are highlighted below.

· '*Chief nursing officers should establish formal succession planning models... and these should target the nurse manager position...*

· *Chief nursing officers should establish programs that support and fund nurse manager career development including formal nurse manager orientation programs...mentoring relationships, and release time for career development is also needed to enhance the current educational preparation and confidence of nurse managers'* (p90).

Although my own study did not focus on how ward sisters perceive stress, this paper is important as it highlights the actions that can be taken to help support ward sisters in their role.

A study by Redfern (1981) is another in the series of publications about the ward sister by the RCN. The study investigated ward sisters' perceptions about their role. The sample of 152 ward sisters was from two hospitals in the West Midlands. The ward sisters (88 percent response rate) were asked to complete a set of attitudinal questionnaires which, primarily measured job satisfaction and perceived stress associated with the work role; this included the Minnesota Satisfaction Questionnaire and Job Related Tension Index. A total of 15 nursing officers also responded to a questionnaire rating the ward sisters' performance in the role.

This study took place in the late 1970s, a time when the new structures proposed in the Salmon (1966) report were well established. The ward sisters were asked their view on the reforms, the key change of which was the introduction of a clinical managerial career ladder for nursing and the 'nursing officer' post. More than half (56 percent) of the respondents did not support the new nursing roles, particularly the nursing officer position, which was a role above ward sisters and responsible for a group of wards, a major criticism was that the nurses in the nursing officer posts did not have the requisite clinical knowledge to fulfil the role expectations. However the ward sisters did recognise that Salmon had developed a better career ladder for those who wanted to move into management.

The participants were overwhelmingly content in their job, with only five percent stating they were not satisfied. However, over 60 percent reported work associated tension. The main reasons

for the reported tension were; *workload* (47 percent); *lack of clarity about scope of role* (46 percent); *lack of information* (46 percent) and *uncertain expectations* (44 percent).

The paper also described what gave the ward sisters job satisfaction, this included; *being able to use their skills; a sense of achievement* and *doing things for others*. Two main variables were identified as having influence over the ward sisters' decision to stay in the role, which were the *level of pay* and the *competence of the nursing officer in training staff*.

There were similarities between the research papers reviewed in that the ward sisters continued to gain more satisfaction from their role when they recognised they have achieved something and they demonstrated that the relationship with their manager is also a key determinant in job fulfilment. Perceived stress is an important factor to consider when developing a supportive working environment, and although there are gaps in the research the findings from the papers above provide an important perspective on what ward sisters find stressful in their role and potential ways to mitigate the effects of this. It is interesting to note that although Redfern's (1981) research is over 30 years old the findings resonate with the more recent studies above.

2.8   Support given to ward sisters

Balasco Cathcart and Greenspan (2012) researched nurse managers' perspectives on how they managed their role using Benner's (1984) (novice to expert) framework. Ninety-one nurse managers from three hospitals wrote a story about their experience of being a nurse manager, they then read these to their peers in small groups and the researchers analysed the accounts for themes. The paper did not describe how the nurse managers were recruited to this study which is a limitation of the publication as others cannot replicate the study. A disadvantage of narrative research is that stories are unlikely to be told in exactly the same way when repeated, the researchers minimised this risk as they asked the participants to write their stories and therefore they were captured and could be repeated accurately.

The results demonstrated real differences between the new and the more experienced nurse managers in that the more experienced managers understood and were more able to manage the complexity of the role. The use of narratives for research would appear to be an appropriate method when examining nurses' work experience, it is a good alternative to the often preferred method of interviewing (Leiblich et al, 1998). However, because narrative research is relatively new there are no fixed rules or frameworks for interpretation of the data from the stories (Tamboukou et al, 2013) as there are in grounded theory. Not surprisingly there was little detail in Balasco Cathcart and Greenspan's (2012) paper about how the narratives were analysed other than thematically.

The researchers recommended that nurse managers should be developed throughout their career and that the use of case studies and reflection would be an appropriate method to develop mastery in management practice and probably more effective than using theoretical managerial programmes only.

Mackoff and Klauer Triolo published two papers in 2008 on *how to engage nurse managers to improve their job satisfaction,* with the desired result of retaining them in their job roles. The research was undertaken by interviewing 30 nurse managers using a convenience sample from six hospital settings across the USA. The participants received the interview questions prior to being interviewed, although a rationale for this was not given in the paper, having the questions before the interview would have given the participants time to think about their responses. This might have given the researchers richer data than they would have if the nurse managers had responded to the questions without preparation.

The interviews were transcribed, the data were then analysed for themes relating to the nurse managers and those relating to the organisations that employed them. The themes were then ranked in terms of occurrence. The sample was not necessarily representative; the nurse managers were nominated by their managers because they were recognised as established and high-performing in their leadership role. The sample therefore, excluded nurses who were new to the nurse manager role and those who were perceived to be struggling with it; nonetheless the research findings did contribute to knowledge of what support is required for nurse managers.

The researchers put a strong argument in place for engaging nurses in nurse manager positions to support them in their roles and ensure stability of the workforce. They suggested this should be done via socialisation and sustainment. The researchers highlighted that the nurse managers suggested that socialisation of new nurse managers can most effectively be carried out by mentorship and preceptorship. Socialisation mirrors the Nicholson and West (1988) transition model in that if nurses are socialised before they become nurse managers they are probably more likely to have a positive experience of transition. Mackoff and Triolo (2008b) made the link between socialisation of nurse managers and their levels of engagement. They identified that socialisation can be successful using such methods as; asking nurses to lead on projects before becoming nurse managers to increase their networks and confidence.

Mackoff and Triolo (2008a) also made it clear that nurse executives should continue to engage nurse managers to sustain them and keep them motivated when they are more established in their

roles. This is important as it is the current nurse managers who will inspire future leaders, and therefore the more engaged they are the more successful they may be in influencing the career choices of less experienced nurses. These two studies are very useful to my own study because they raised the part socialisation has to play in the transition to the role of the ward sister and emphasised that giving nurses projects can act as a good preparatory step on their career ladder.

Laschinger et al (2007) reported the results of their non-experimental investigation into the relationship between the support given to nurse managers by their line manager and the impact this has on nurse managers' job satisfaction. They sent a self-administered questionnaire to a random sample of 223 managers from acute care hospitals; from this 101 nurse managers and 40 middle managers responded. The questionnaire measured the quality of relationships using the leader-member exchange theory (LMX), and, the hypothesis was that the higher the LMX rating the greater the job satisfaction of the nurse managers. The findings suggested that the better the relationship reported by a nurse manager with their manager, the more job satisfaction the nurse manager would experience (β= .37).

Laschinger et al (2007) commented further that ensuring nurse managers are happy in their jobs not only had a beneficial impact on individuals but would also help the future of nursing; if junior nurses experience working with nurse managers who enjoy their job, they are more likely to aspire to nurse leadership roles themselves in the future. This has been highlighted as a key issue for the future of nursing earlier in the literature review. Laschinger et al's (2007) research is important for my own study as it tested the impact of support given to ward sisters. As a cross sectional study it had the advantage that participants were asked to respond only once (Mann, 2003) however, a disadvantage of studies of this kind are that the findings are not evaluated over time so that researchers are trying to understand the future using data from one period of time only (Babbie, 2008).

Laschinger et al (2006) conducted a descriptive, correlational survey study that investigated how nurse managers perceived the support they received using Eisenberger et al's (1986) Perceived Organizational Support survey. The researchers sent the survey to a random sample of 346 nurse managers who worked in hospitals in Ontario, 202 of whom responded (58 percent response rate). The data were statistically analysed using SPSS software, and Pearson correlational analysis helped to investigate the relationship between different variables, including personal characteristics, attitudes, performance, health outcomes and organisational characteristics. The factors that were found to be linked with perceived organisational support were *rewards* (r=0.64), *being treated with respect* (r=0.64), *job security* (r=0.48) and *autonomy* (r=0.32). Descriptive statistics were also used and identified that the nurse managers in this study reported

that they had average levels of perceived organisational support (M=4.44, *SD*, 1.09). A seven point Likert scale was used, therefore the highest possible score was seven.

Thorpe and Loo (2003) used a Delphi study with 41 participants (66 percent response rate), most of whom were nurse managers and nurse administrators; the sample was randomly chosen from a randomly selected list of 20 percent of all Canadian healthcare institutions with over 100 beds. The study commenced by interviewing 26 nurse managers to find out what support they would like to receive, the data were analysed using Nudist software and then used to conduct the Delphi study.

The use of a Delphi study is interesting because it is a method that enables a researcher to gather information from a large group of experts (in this case, nurse managers) with ease (Hubner-Bloder and Ammenworth, 2009). Delphi studies allow quantification of qualitative data by asking the participants to what extent they agree with different issues relating to the subject being investigated (Jones and Hunter, 1995). There are, however, a number of disadvantages to using a consensus research method, the main one being that a group of experts may struggle to reach agreement about the answer and therefore it is suggested by Jones and Hunter (1995) that a Delphi study is not used alone. Thorpe and Loo (2003) appear to have overcome this drawback as they merged the data from the Delphi part of the study with the data from the interviews.

The data from the interviews and the Delphi study were analysed by two individuals separately using a grounded theory methodology, and then together to provide inter-rater reliability. A tool is said to be more reliable when it produces similar results at different times (Harris, 2002) however, results may differ when researchers interpret data in a different way. Judging consistency can be done statistically using an inter-rater reliability correlation coefficient, however in a qualitative study such as this it is likely that the researchers reviewed their findings and judged how comparable they were (Aday and Cornelius, 2006). The results demonstrated that nurse managers would like *access to resources, a supportive work environment* and *training and development*. It is emphasised in the paper that training and development for nurse managers is as important as clinical training for ward nurses.

There were also suggestions as to how educators can support these nurses, by involving them in curriculum development, and, linking education to the post-holder's priorities. It was also recommended that there should be courses to support nurse managers in their on-going role.

Before the studies above were published Castledine (2001) suggested, in an opinion article that there should be more clarity about the ward sister role, He highlighted that role clarity, meaning that the incumbent is aware of boundaries, expectations and what they are responsible for, is an

important issue in relation to the ward sister and job satisfaction. This is reiterated in the more recent studies.

The research studies above used a wide range of methods including narratives and Delphi to investigate what support has a positive impact on ward sisters. The findings gave a wide array of supportive mechanisms to improve ward sisters' job satisfaction and there is little correlation between the studies other than highlighting that a positive relationship with their managers will help ward sisters feel supported. This reflects the findings in the leadership research in that staff nurses feel the same about their relationship with ward sisters.

2.9   Design and evaluation of development programmes

There are a number of papers that described how development programmes were designed and give details of how local development programmes were evaluated by ward sisters, these studies are critiqued in this section. Enterkin et al (2013) published an evaluation of a programme that was co-designed by an NHS Trust and a university to help prepare nurses to become ward sisters. The programme was delivered over eight months, the participants attended workshops one day each month. The evaluation consisted of questionnaires sent to the 60 nurses who completed the course in three cohorts. There was a 60 percent return rate, which was stated as a limitation of the study by the authors. The nurses reported that they had received little preparation for the role of ward sister before the programme and went on to say they were much more aware of the broader context in which they were working and had an increased self-awareness. Enterkin et al (2013) concluded that most of the participants acknowledged that they had benefitted due to the programme.

 A development programme in an NHS Trust in the North of England is reported by Kenny and Eagle (2012). The development programme was a result of collaboration between the trust and a university and was founded on national leadership competencies, local values and 360 degree appraisals of ward sisters. Forty ward sisters were included in the first two cohorts and the programme was delivered through interactive sessions and a workplace based project. An independent evaluation was conducted and the participants (the paper does not state the response rate) gave unanimously positive feedback about how the peer networks and action learning had helped them through the challenges of their role, enabled them to share good practice, and in particular to have a better knowledge of change management and productivity improvement.

Fennimore and Wolf (2011) evaluated a nurse manager development programme that was developed and implemented in a hospital in Philadelphia. The programme content was based on a set of nurse manager competencies identified during a literature review (see Table 2.2). The programme was delivered in five days over a two month period and was evaluated using

questionnaires and analysis of the nurse managers' self-assessments using the Nurse Manager Inventory Tool (American Organization of Nurse Executives, 2006). Twenty-five nurse managers participated in the pilot programme and more than 100 nurse managers subsequently undertook the development programme. Twenty-two of the 25 participants responded to the pre course questionnaire and 21 responded to the post course evaluation, there is no explanation in the paper about the non-responders. The responses to the questionnaire were very positive and cited how the nurse managers used the knowledge gained in their work. The self-assessment scores also improved in all aspects of the nurse manager skills inventory, the scores increased overall by 0.68 (the highest possible score was five).

Table 2.2 Nurse Manager Competencies (Fennimore and Wolf, 2011)

Personal mastery	Leading employees
Financial management	Strategic planning
Human resource management	Inspiring commitment
Caring	Managing change
Systems thinking	Resourcefulness
Staffing and scheduling	Being a quick learner
Risk management	Doing whatever it takes
Interpersonal skills	Building effective teams
Setting the vision	Translating vision and strategy
Conflict management	Maintaining a focus on patient and customer

In 2009 Wendler et al evaluated an internship programme during which staff nurses could test out the responsibilities of the nurse manager role. The purpose of the internship was to give nurses a safe experience of being a nurse manager and the chance to learn about the role without having the full range of responsibilities. The programme was developed using the leadership competency model developed by Sherman et al (2007) described above. The pilot consisted of four nurses from the same 500 bedded tertiary care hospital in Illinois who became interns for six months. The internship consisted of shadowing nurse managers and directors who managed nurse managers. The interns were given two hours per month for reflective practice and time with their colleague interns to share experiences.

The researchers used a number of methods to evaluate the development programme including a qualitative questionnaire which each intern was asked to complete after the monthly teaching sessions. At the end of the internship the participants completed a final evaluation of the course objectives and then participated in a focus group with their peers. Some may say this internship was a controversial action to take as it may make staff nurses even less likely to be attracted to a future role of nurse manager. However in their evaluation Wendler et al (2009) found that the four staff nurses on the pilot programme were impressed with the support that nurse managers

received, the professional development opportunities nurse managers were offered and the fact that they felt the nurse managers wanted them to succeed. The conclusions from this evaluation are very limited due to the very small sample, however on the grounds of this evaluation the hospital offered the internship to a second cohort of staff nurses.

Programmes such as this are important as they offer staff nurses the chance to experience the role of the nurse manager in a safe environment, allowing them to base their future career choices on evidence rather than their perspective of the nurse manager role. A potential drawback of internship programmes is that they may give nurses an unrealistic view of the nurse manager role as they are likely to include a lot of support and provide protection from the real stresses experienced by nurse managers. However, from this paper it certainly appears to be an effective way not only to help with succession planning for future ward leaders, but also to prepare staff nurses for the role ahead of them.

Fairbairn Platt and Foster (2008) described how a charge nurse development programme was developed in an NHS Trust based on learning needs identified by the nurses themselves. The concepts covered included *time management, understanding budgets* and *people management* and were accompanied by a 'charge nurse handbook'. The course was originally delivered over four days but after evaluation by 20 charge nurses it increased in length to nine days over a 16 week period. The programme was subsequently evaluated by 95 charge nurses from five cohorts using questionnaires and 95 percent of whom evaluated the course positively with the majority of participants having found it to be empowering and had improved their confidence.

Conley et al (2007) described the implementation of an induction programme for nurse managers in one hospital in Boston. The organisation reviewed its nurse manager induction programme in response to an unusually high turnover rate amongst nurse managers. A group of 10 nurse managers was asked for their views about the elements of an ideal induction programme, the authors did not describe the selection process for these participants other than five had started in the last five years, three in the last two years and two in the past year. The participants suggested that it should be very nurse manager specific, it should include a competency base and a formalised preceptorship model. The eight competencies included in the framework are shown in Table 2.3.

Table 2.3 Nurse Manager Competencies (reproduced from Conley et al, 2007)

Nurse Manager Competencies
Clinical judgement
Caring practices
Facilitator of learning
Advocacy/moral agency
Response to diversity
Collaboration
Clinical inquiry
Systems thinking

Induction is an essential part of recruiting any staff, and an important time for new ward sisters as the level of support they receive will influence the extent to which, and the speed at which, they become confident in their new role. The key elements of the induction programme developed by Conley et al (2007) were *nurse manager skills, preceptoring by the nurse manager's manager* and *general management issues*. The new induction programme was piloted by two nurse managers in 2005 and three in 2006. The evaluation process was not detailed in the paper, and was noted to be limited due to the small number of nurse managers (n=5) involved in the programme. Despite the poor research technique described in the paper it was concluded that the individuals who experienced the programme did give feedback and particularly liked the preceptorship element.

Maries-Tillot and Lees (2006) described an evaluation of a new development programme for ward sisters in a hospital in the UK Midlands. The programme was created using a self analysis of learning needs by the ward sisters and included *staff performance management, business planning* and *evidence based practice*. The course was delivered over 10 days using a mixture of theoretical and practical exercises and a coaching framework was put in place. Ten ward sisters were identified to participate in the programme but only eight completed it and provided evaluation of the programme.

The evaluation included a self-assessment against the national Knowledge and Skills Framework (KSF) (Department of Health, 2004), an assessment using a local Nursing Annual Audit Review (NAAR) of how productive the ward sisters felt their areas were, judgements about whether or not the ward sisters felt they had achieved their objectives, and presentations about their personal

change projects. The course was evaluated well by the sisters and the researchers used the following criteria to judge its success:

- '*Self-review of progress against the KSF*
- *Self-review of progress against the NAAR*
- *Achievement of set goals*
- *Presentation of change management projects*' (Maries-Tillott and Lees, 2006:23)

The evaluation of the programme led to further development of the ward sister programme and continued coaching. The matrons supported a positive evaluation by recognising that the sisters had achieved the majority of their personal and directorate objectives (Maries-Tillott and Lees, 2006).

An evidenced based framework for a nurse manager development programme was introduced by Sullivan et al (2003). A total of 94 nurses including chief nurses, nurse administrators and nurse managers from an unidentified healthcare system participated in focus groups and the chief nurses were also interviewed individually. Collectively those involved described the most satisfying and challenging elements of the nurse manager role and then identified the subjects they would have found most useful in a development programme. A grounded theory methodology was used to analyse the information from the focus groups, and the focus groups continued until theoretical saturation was achieved, at which point the data from the focus groups were analysed and coded into categories.

The nurse managers derived job satisfaction from the level of professional autonomy they had and by achieving their objectives. They cited managing staff as their main challenge, followed by having more delegated responsibility and being in the middle management tier between the staff and more senior administrators. Referring to their developmental needs, the nurse managers included, *management skills, communication skills, role transition, financial skills and performance management* in their ideal development plan. There was also overwhelming support for a formal induction period and programme. The subjects listed in Table 2.4 were included in the nurse managers' feedback as the key developmental needs of both new and experienced managers, it is not stated in the report whether these are in rank order. The authors highlighted that the main differences in the type of development required between the less and more experienced nurse manager. The new nurse managers required support in obtaining skills in fundamental management skills such as communication and finance, whilst their more experienced colleagues required development in more advanced skills including negotiation, strategy and policy development.

Table 2.4   Nurse Manager Development Needs (Sullivan et al, 2003)

Development needs of experienced nurse managers	Development needs of new nurse managers
Conflict resolution	Communication skills
Managing multiple sources of professional nurse resources	Organizational skills/prioritization
Recruitment and retention marketing strategies	Financial management, budgetary, and payroll skills
Human resources updates	Conflict resolution
Updates on regulatory agency compliance issues	Performance management (staff counselling and evaluation)
Life-work balance management	Staffing/scheduling skills
Time management in current pace of healthcare industry	Institutional policies and procedures
Inter-systems collaboration, negotiation, and delegation	Regulatory agency compliance issues
Business practices in current healthcare market	Human resources issues
Computer skills	Introduction to key personnel and support department staff
Financial management/budgetary expertise	Structured orientation program
Maintenance of clinical skills in complex, rapidly changing patient care environment	Formal mentoring program
Mentoring, developing, and motivating staff	Computer skills
Policy development	Role expectations and description
Strategic planning	Skills for leading staff meetings
Team building	Life-work balance management
Leadership of professional practice	Time management
Research role in practice	Goal setting and evaluation
Organizational alignment/alliance	Role transitioning
Expert communication strategies	Intradepartmental and interdepartmental delegation

The grounded theory approach used in this study seems appropriate as it led to the development of theory. However there are disadvantages to using this method, including:

- subjectivity - the results are dependent on the investigator's perspective to analyse the results (De Chesney and Anderson, 2008),

- it is time intensive (Addington-Hall et al, 2007)

- it is best to involve only researchers who are skilled in developing theory (Kolb, 2008).

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The way in which ward sisters learn was the subject of Foster's (2000) paper. This study investigated different modes of development using questionnaires based on an adapted model of situational leadership and managerial style followed by focus groups, the sample was 22 nurse managers (who managed ward sisters) from one NHS Trust in London. Fifteen nurse managers responded to the questionnaire (68 percent response rate) reporting how they preferred to be developed and what methods they thought best for the ward sisters they managed. The findings demonstrated that whilst nurse managers preferred self-directed development they thought a more top down approach was more suitable for ward sister development.

The paper alluded to a second part of this study that would examine what methods ward sisters themselves preferred, however this does not appear to have been published. This paper is important to my own study as it demonstrated there may be a difference in opinion between ward sisters and those responsible for their development and support, and my own study investigated the ward sisters' preferred methods of development.

The RCN created a specific course for ward sisters in 1995 (Cunningham and Kitson, 2000b) which is still being offered 20 years on. Cunningham and Kitson (2000a) described the methodology used in a longitudinal study to investigate the effectiveness of the RCN's clinical leadership programme. The results of the study were explained by Cunningham and Kitson (2000b) in a second paper. A sample of 24 ward sisters and four senior nurses from four different NHS Trusts were selected to participate in the study, which used a number of pre-test, post-test questionnaires including the MLQ to evaluate the difference in leadership ability following the intervention.

The intervention was based on the ward sisters participating in the RCN clinical leadership programme which included workshops, having personal development plans and action learning over an 18 month period. The questionnaires were completed by the ward sisters, senior nurses and their staff. The ward sisters' self-assessment using the MLQ pre and post intervention was analysed using a paired *t*-test and demonstrated that they thought they had improved in all leadership variables, this was reflected in their staffs' assessment of them too, albeit to a lesser extent. It is interesting to note that the ward sisters thought that they were more transformational than their staff did; a finding that was not noted by the researchers. These results were similar to

McGuire and Kennerly's (2006) findings in that the nurse managers in their study rated themselves to be more transformational in their leadership style than their staff perceived them to be. The study concluded that the RCN clinical leadership programme did improve the ward sisters' leadership competence, it also stated that before participating in the programme the ward sisters had not been prepared for the role and did not enjoy good working relationships with their managers.

Each of these development courses in England link to my own study in that they gave evidence of what can help nurses in these leadership positions to be more effective. However, it should be noted that all (except the study on the RCN leadership course) the courses described above were developed in individual organisations rather than founded on national knowledge as in my own study and were time limited rather than continuous, which will be discussed later in the thesis. The evaluations demonstrated unanimous support from the participants who responded, however, this could be due to bias as the majority of evaluations were in house and respondents may not want to be negative. Another reason for such a positive response may be that the ward sisters have not had such development before and therefore any development would be judged to be good.

2.10   Transition

2.10.1 Introduction

This study investigated how nurses are prepared and supported during major job transition, from staff nurse or junior sister (Band 6) to the ward sister role (Band 7). It is therefore important to the study that the process of job transition is understood. Many issues affect how an individual manages a job transition including the control they have over the change and personal qualities such as resilience and motivation. There are many transition theories which offer similar but distinct perspectives on how individuals experience transitions, a small number of which will be referred to below.

In their study on personal identity during a career transition, Ibarra and Barbulescu (2010) noted that jobs are very important to most people as they play a fundamental part in an individual's self-image. Ibarra and Barbulescu (2010) suggest that people are more likely to flourish in a successful transition if they develop a personal story about their past achievements and aspirations for the new job. Equally, an unbelievable or incomplete narrative is likely to make a transition less successful. This is an important feature of transition and should be regarded as essential within the encounter and adjustment phases of the Nicholson and West (1988) transition cycle explained below. It should be remembered that the job transition being examined

in my own study is a move into a management role from an essentially clinical role and this gives it an extra dimension of complexity; ward sisters have to assume a leadership role and their success will be determined by their team, rather than their individual contribution as it has been in the past (Paese and Mitchell, 2007).

Paese and Mitchell (2007) conducted a study of transition into leadership roles. The study involved a survey of 600 leaders at different levels of management in global organisations, meaning that the sample worked in companies based around the world, a quarter of which had revenues of more than $10 billion and more than half employed over 10,000 staff. Of the sample 38 percent were in 'people leader' roles similar to ward sister level positions. The report focused on the results of the study rather than the method and gave no details of how the participants were recruited or of the response rate. This is a weakness of the study as others will not be able to replicate it by reading the paper; however the purpose of this research appears to have been to offer practical help to companies rather than make a contribution to the academic literature, it is included here as it offers a perspective of job transition using a large sample and offered insights which may be reflected in my own study.

Paese and Mitchell (2007) highlighted nine issues from their results, two of which are particularly relevant to my own study:

> i)leadership transitions are amongst the most difficult life events people will encounter, and
>
> ii)	it would appear that transitions become more stressful as seniority increases.

Thirty-eight percent of people leader level (similar level to ward sisters) respondents in the Paese and Mitchell's (2007) study felt that organisations were doing little to support leaders through transitions. A disparity in the reported experiences of men and women was also noted; men were more likely to view promotion as having a positive effect on their life (men 65 percent, women 49 percent). Thirty-three percent of women reported the transition had had a negative effect on their life as opposed to only 15 percent of men. Paese and Mitchell (2007) recommended that the key thing organisations can do to help leaders in transition is be clear about expectations.

Although Reitman and Williams (2006) do not offer a transition theory they do propose some useful insights into managing job transitions. They explained that the difference between a change and a transition is that the transition will bring closure to the change that has happened. Their paper outlined six key issues that help individuals manage their transition successfully.

These were:

    i) preparedness to handle risk
    ii) maintaining an open mind
    iii) self-assurance
    iv) recognising the situation they are about to experience
    v) having a group of people on whom they can rely and in whom they can confide
    vi) the ability to deal with the stressful transition period.

Fischer (2009) used the Kahn et al (1966) role episode model to explain that how a person manages a new role is dependent upon their personality but is also influenced by the behaviour of their manager, organisational issues and relationships with all stakeholders. These are important factors as they focus on the individual's skills, mind-set, resilience and relevant external dynamics. It has been taken into account during my own study that although preparation and support is required for people experiencing a job transition, the success of the move will always be affected by the personal attributes of the individual being promoted and the environment in which they work.

Gabarro (1987) created a five stage transition model. He described the five phases as

    i) *Taking hold* - starting the role and becoming orientated to it and the organisation
    ii) *Immersion* - becoming totally absorbed in the new role; there is little further change
    iii) *Reshaping* - a time of more change, during which the post-holder acts on the knowledge gained in the earlier phases and becomes more established in the role
    iv) *Consolidation* - living through the decisions made in the reshaping stage; and finally
    v) *Refinement* - the post-holder improves his/her performance.

There are a number of similarities between this model and the Nicholson and West's (1988) model set out below, however one major difference is that there is no preparation stage in Gabarro's (1987) framework. This is an interesting omission as other models emphasise the importance of a period of preparation. Another distinction is that Gabarro (1987) proposes a linear whilst Nicholson and West's (1988) model is more cyclical. A cyclical model gives the opportunity for continuous development, returning to the same issues but viewing them from a different perspective and learning whilst a linear approach would suggest that once the change has occurred that is the final stage.

2.10.2 Nicholson and West (1988) transition theory

Nicholson and West's (1988) transition theory is presented as a cycle with four stages and was chosen to underpin this study because it included a preparation phase which is a particular focus

of this study which is designed to investigate the preparation that nurses receive to become a ward sister. The other significant factor influencing the decision to select Nicholson and West's (1988) transition theory is that it models the process as a cyclical rather than a linear event, in that once a person has experienced a transition it is likely that they then go through the next transition.

The Nicholson and West (1988) transition cycle commences with *preparation*, before moving to subsequent stages called *encounter, adjustment* and *stabilisation*. Nicholson and West (1988) end the cycle by going back to preparation, suggesting that transition does not end but merely continues into another transition cycle. There is no timeframe attached to the transition cycle as individuals will take a different amount of time to reach the stabilisation phase, however Matthews (2002), in a study investigating becoming a librarian asserts that a job transition could last between 12-16 months.

Figure 2.3   The four stages of the Nicholson and West (1988) transition cycle

Preparation

Stabilisation

Encounter

Adjustment
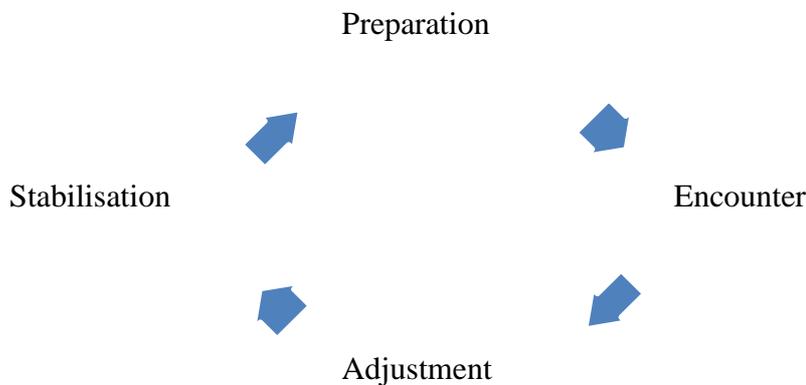
2.10.3 Stage 1 – Preparation

The *preparation* stage is about how people get ready for the career change they are about to face, it describes their state of *readiness* for their new job role. It also encompasses their *expectations* of the role, their *mental preparation* and their *feelings of anticipation and anxiety*. The preparation stage enables people to reflect on and plan for the skills and knowledge they will require for the new role (Matthews, 2002). In her *career transition model* Turner (2007) identified that the preparation phase can be very emotional and may involve the individual grieving for the job, colleagues and organisation that s/he is leaving, despite being happy about

the future role. The preparation stage is when a person reviews the skills and knowledge required for the next career role and makes a self assessment to identify what preparation is required to be ready to apply for a role. During the preparation stage a person would also find out about what the role entails in terms of such aspects as purpose, everyday tasks and levels of authority. In the context of my own study the preparation stage would include both the nurse and organisation accessing practical and training opportunities to develop the knowledge and skills required for the role of ward sister; it would also include the notice period between being successful at interview and starting the ward sister role.

2.10.4 Stage 2 – Encounter

The *encounter* stage describes the first days and months in a new role. The encounter phase may also be described as the time of culture shock (Nicholson and West, 1988). It is about establishing oneself in a new culture, meeting new people (including new managers above and staff below), learning new organisational norms, starting to understand the history of the organisation and setting one's own expectations about the role and how it will be performed. The encounter phase is when the individual starts to understand his/her new role in reality (Matthews, 2002). A newly appointed person will know to a certain extent what the job entails but if the transition is a promotion then it is likely that the new ways of working may be required. For example, when a staff nurse moves into a ward sister role, they will have fewer direct clinical responsibilities and more clinical supervision and an increase in administrative tasks. This may be difficult to manage in the encounter stage. There is a point of view that suggests that an organisation has a responsibility to support staff through transitions, but to do so the organisation needs to understand that the support required will be different at each level, meaning a generic programme will not suffice (Paese and Mitchell, 2007). In my own study the encounter phase would be when the nurse commences his/her ward sister role and reality of the transition hits him/her.

2.10.5 Stage 3 – Adjustment

The *adjustment* phase starts once a person has settled in to his/her new role. Adjustment means the phase of socialisation, when an individual 'fits in' or becomes part of the team and organisation. There is an argument that the adjustment phase is continual as organisations are an ever-changing environment (Matthews, 2002); however once a person feels quite confident in his/her new role then it is likely that s/he has completed the adjustment phase. To complete the adjustment stage successfully the person will accept themselves in the new role and therefore have an altered work identity and understand that others will perceive them differently particularly in a promotion situation. The adjustment phase in my own study would be when the

ward sister feels that s/he has established him/herself as the leader of the team, and understands the role and expectations.

2.10.6 Stage 4 – Stabilisation

Once a person has established him/herself within a new role a period of *stabilisation* follows. In this transition theory stabilisation refers to the time when a person can develop within the role and live through the decisions made previously to demonstrate an element of success or failure. As mentioned above, this transition theory is a cycle, and after stabilisation the post-holder goes into another preparation stage. This is likely to involve performance appraisal and objective setting, which enables the individual and his/her manager to reflect on performance, prepare for improved performance and identify development required to support this. Once again, in relation to my own study the stabilisation phase would be when the nurse is established in his/her ward sister role, s/he is living through decisions s/he has made in the past and setting objectives for the future.

Depending on the individual, the context and the organisation, the Nicholson and West (1988) transition cycle can be experienced as either a positive or a negative experience. Nicholson and West (1988) explain that the stages of the cycle are mutually dependent, and that how an individual managed one stage will affect how s/he deals with the next stage. This resonated with my own study in that the way in which nurses are prepared and therefore experience stage one of the cycle may affect the second, or encounter stage of the transition within the ward sister role.

Nicholson and West (1988:6) in their book '*Managerial Job Change*' suggested that a job transition can be '*radical, onerous, unexpected and rewarding*'. All of these adjectives paint a picture of an experience that can be positive as well as challenging. Nicholson and West (1988) also point out that job change can be instigated by the individual or by the organisation, either of which will alter the level of control the individual has, and they therefore also examined in their study how organisations help people through job transitions.

2.11   Summary and Conceptual Framework

Having reviewed the literature about the role of the ward sister and its global counterparts the conceptual framework set out in Figure 2.4 was developed. The conceptual framework visually represents the evidence that was found about the role of the ward sister in the literature review and summarises the aspects of the role where there was no evidence.

The six themes that emerged from the literature are described in more detail below.

The role and competences of the ward sister: The evidence describing the role and competences of the ward sister emerges from a small number of qualitative studies both from the UK and the USA. These studies are supported by a number of opinion articles in the UK press about how vital the ward sister role is to patient care. The studies are, on the whole small scale and are not multi-centre so their generalisibility is likely to be low. However the studies do build a consensus of opinion that the key features of the ward sister role internationally has 24 hour responsibility for a clinical area and encompasses setting nursing practice standards, leadership, education and managing resources. There is no agreement in the empirical literature as to the experience and qualifications required to be an effective ward sister. Clarity about the scope of the ward sister role is important as the preparation and support for nurses in these posts should be based on the role specification and the competences required to be effective; a lack of clarity may lead to role ambiguity with other nursing colleagues such as modern matrons.

Ward sisters' leadership style: Evidence from the literature suggested an association between a ward sister employing a transformational leadership style had a more positive effect on their staff and on the working environment. There was also evidence to suggest that staff appreciated spending more time with the ward sister. Most of the studies from which this theme was derived were conducted in the USA, used quantitative methods and had large samples. These results suggested that discussions of different kinds of leadership styles and in particular transformational leadership, should be part of ward sister preparation and support because leadership style will have an impact on the effectiveness of the relationships with their staff.

Managing ward sisters' perceived stress: The evidence about what aspects of their role ward sisters perceive to be stressful is weak however the two more recent studies' results correlated in terms of how employers can support nurses in these roles to manage the stress. The themes from these studies is that social, supervisory and managerial support help nurses to manage the stress whilst in ward sister roles, which is a critical element of their ongoing development and support.

Becoming a ward sister: The evidence from three qualitative studies from Australasia and Europe. The majority seem to have attained the position of ward sister due to certain circumstances. Although the evidence is weak, the three studies agree that because the majority of nurses have not planned to become ward sisters they are ill prepared for the role.

Support given to ward sisters: The studies that investigated what type of support develops ward sisters offer a number of different options including; reflection; engaging ward sisters in decision making; mentorship; good relationships with their managers; training and being treated with respect. Although the nurse managers found these interventions to be helpful the studies did not

put forward a clear hierarchy of support and therefore the evidence does not offer Directors of Nursing a clear vision of what support methods they should use or which enabled a faster transition period to the role.

The conceptual framework summarises the key themes and evidence from the literature review. The main concepts which have an evidence base shown within the conceptual framework are

- *The role of the ward sister/nurse manager, the key studies that have contributed to this are RCN (2009), Kleinman (2003)and Titchen and Binnie (1993)*

- *The competencies of the ward sister/nurse manager, the evidence is drawn in the main from RCN (2009), Sherman et al (2007), and Lewis (1990)*

- *The effect ward sisters' leadership has on the culture of the ward the following studies offered the strongest evidence, Scherb et al (2010), Casida and Pinto Zipp (2008), Kramer et al (2007) and McGuire and Kennerly (2006)*

And to a lesser extent

- *Managing ward sisters' perceived stress, the two studies that offer evidence on this are Kath (2012)and Shirley et al (2010)*

- *Becoming a ward sister, the man evidence is from Townsend et al (2012), McCallin and Frankson (2010) and Bondas et al (2006)*

- *The support given to ward sisters, Laschinger et al (2006 and (2007), and Mackoff and Triolo's (2008) studies offer the key evidence about what support helps ward sisters.*

The conceptual framework also highlights where the literature review demonstrated that there were gaps in the evidence, these are:

- *No evidence about what development ward sisters require*
- *No evidence about development prior to becoming ward sister*
- *Little evidence about design of development programmes*
- *No evidence about what education and qualifications required for the role*

The four phases of the Nicholson and West's (1988) transition model are also illustrated in the conceptual framework.

Having identified the gaps in the evidence from the literature (shown in Figure 2.4) the purpose of my own study therefore was to investigate the following; what preparation prior to becoming a ward sister would be helpful to get nurses ready for ward sister posts (the preparation stage of Nicholson and West's (1988) transition model) and what development would be found to be required once the ward sister is in post (encounter, adjustment and stabilisation phases of the Nicholson and West's (1988) transition model). The research questions in my study were developed from the gaps found in the evidence in the literature review:

- What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- What preparation and support helps nurses manage the transition to the ward sister role?

My study therefore addresses three of the four main gaps in the evidence about the role of the ward sister and given it is such an influential role the preparation stage for these nurses and meeting their ongoing development needs would appear to be a study that has the potential to have broad impact across the nursing profession and wider health service.

Figure 2.4   Conceptual Framework
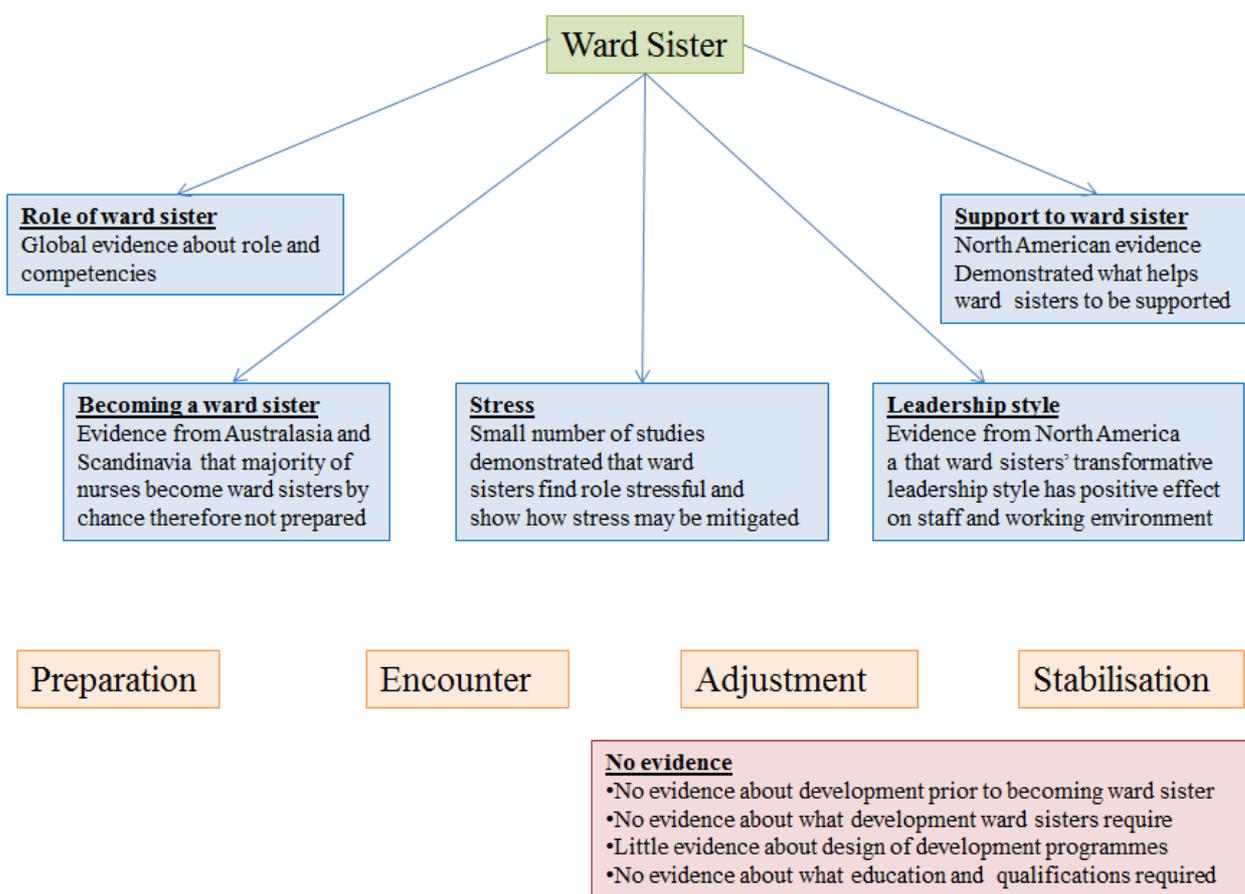
METHODOLOGY

3.1 Introduction

This chapter identifies the main philosophical beliefs that underpin research methods and offers the justification for the philosophical approach taken to my own study. The rationale for using a mixed method research approach is explained and the research design of the study will be described using Onwuegbuzie and Leech's (2006) framework. The ability of a researcher to be objective is discussed as is the subject of the researcher being considered an insider or outsider by themselves and the research participants.

The research questions in my study were

- What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- What preparation and support helps nurses manage the transition to the ward sister role?

These questions were determined as a result of the fact that there was so little information on these subjects in published UK literature and a growing recognition in the NHS of the importance of the ward sister role in safeguarding the quality of care.

3.2 Positivism

Most research is carried out from a positivist or an interpretivist viewpoint (McNabb, 2010). Both are valid but are underpinned by different beliefs about reality (ontology) and of how knowledge of the world (epistemology) is gained.

Bruce et al (2008) described positivism as a philosophy that developed in the eighteenth century in a period known as the 'Enlightenment'. During this era there was a move away from religious explanations of the world, towards reason and logic. Positivists believe there is an 'objective reality' (Denscombe, 2002:15) that can be identified through scientific method, whereas an interpretivist assumes 'that reality is socially constructed' (Merriam, 2009:8) and there is no one definitive reality that everyone shares.

Comte (1798-1857), amongst other philosophers is generally seen as a leader in the school of positivism and it is Comte who moved on from research focusing on the natural world to the social world (Potter, 1996). This progress is described by Comte as having taken place in three steps, moving from theology to metaphysics and then to positivism (Cowan, 2009). The positivists thought that because a deductive approach to research had previously been so effective it could also be used in social research; Comte (1851:12) stated that as it had become the main research method for physics and biology, positivism should *complete its range of influence by including the study of social phenomena*. It is from this school of thought that the

reasons why humans acted, reacted and interacted in different ways began to be researched under a positivist philosophy.

One of the core principles of positivism is that the researcher is independent of the subjects they are investigating; positivists aspire to complete objectivity. Objectivity is a core principle in quantitative research and is a goal to which all quantitative researchers should aspire to a greater or lesser extent. Quantitative researchers understand that complete objectivity is difficult to achieve however they suggest that if certain principles in the research design are adhered to then a greater level of objectivity will be attained (Sarantakos, 2013). The goal of quantitative research is to identify the objective reality; this leads to a tendency to prefer quantitative approaches to analysis in an effort to reduce the subjectivity and bias found in qualitative work (Crossan, 2003). Therefore the use of research methods which are not based on the investigator's interpretation are favoured in quantitative research to limit the ability of a researcher's beliefs to affect the results of a study.

Bowling (2005) explained that the positivist philosopher Popper (1902-1994) argued for the verification of the truth through empirical data and the ability to negate a hypothesis. It can be argued that the positivist approach is limited as it will not enable an "in-depth" study of human behaviour because it does not take account of the complex narrative which includes subjective information about humans' feelings (Denscombe, 2007) and their reactions to situations, but instead breaks actions and reactions into calculations (Denscombe, 2002).

There are several important approaches in quantitative research including randomised controlled trials of complex interventions, surveys, which may be cross-sectional correlational or longitudinal, or observational studies where variables are included to control statistically for confounding variables so that the relationships of interest can be estimated. Randomised controlled trials involve participants being randomly assigned to one of two groups, one of the groups of which will receive an intervention, which will not be delivered to the control group. Statistical analysis enables comparisons between the experimental group and the control group, to test whether the intervention has been effective (Denscombe, 2010). Drug trials are a good example of an experimental design. Objectivity is a key characteristic of such research methods, implying that the data exists separately from the researcher (Denscombe, 2007) and that the researcher bears no influence on the meaning of the study's results. In social science, the use of experimental designs is becoming more common and random controlled trials are often used to assess the effect of complex sociological interventions, such as education or feedback. In the literature review for my own study there were no examples of experimental research designs, which may be because it would be extremely difficult for ward sisters to work under experimental conditions. However, it would be possible to investigate the impact of a ward sister

leadership programme by involving a group of ward sisters who attend the programme (experimental group) and a group who do not (control group).

The second main quantitative approach is the use of surveys which was one of the most common approaches to the research reviewed for my own study. There were some good examples of the use of surveys to conduct quantitative research, such as that of Laschinger et al (2007) who used a non-experimental design to review the relationship between the support given to nurse managers by their line manager and the impact this has on nurse managers' job satisfaction. Although surveys have many benefits including being able to have a large sample and manage a lot of data with ease, disadvantages of this method include i) possibility of superficial responses due to the way in which questions are asked or where respondents are not given the option for explanatory text (Kelley et al, 2003), ii) obtaining a statistically suitable response rate is, at least partially, out of the researcher's control (Cargan, 2007) and iii) non response bias is likely to occur when there is a low response rate (Bowling, 2005).

The post positivist movement originated in the late 19th century, post positivism rejects the fundamental view of the positivist philosophers by proposing that the absolute truth cannot be discovered (Creswell, 2003). Post positivists consider that evidence is always fallible and flawed and despite basing research in positivist principles including objectivity and using valid and reliable tools findings will be open to question and this is unavoidable.

3.3   Interpretivism

There was, however growing criticism that a quantitative approach would not find the subtleties inherent in the social world as it is so different to the natural world (Bryman, 2008), and therefore interpretivism using qualitative research methods was developed as an alternative philosophical perspective to positivism.   Denscombe (2002:18) explained why a different approach was required '*social reality is something that is constructed and interpreted...rather than something that exists objectively "out there"*'.   Qualitative research uses an inductive approach which means the theory develops from observing the research participants. This process contrasts to the deductive method highlighted above which starts with a hypothesis derived from theory and tests it using empirical data. Griffiths (1996) simplified this to explain that interpretivist research methodology answers the 'why' questions whereas the purpose of the positivist approach is to discover causality (Hammond and Wellington, 2013). Interpretivism also does not demand that the researcher remains objective, and appreciates that the previous knowledge of the researcher will play into the information gleaned from the research participants (Cowan, 2009).

A key principle of qualitative research is the idea of 'verstehen'. This term is closely associated with the German sociologists, Weber, Simmel and Dilthey. Verstehen is the German word for understanding and when referred to in research it relates to the way in which the qualitative researcher gains knowledge and understands the meaning of what has been learnt about an individual's experience (Flick, 2002). This is seen as being essential to the analysis of social research data (Cowan, 2009), in that the researcher can delve in depth into the meaning of an experience in subjective terms, rather than analyse it in statistical terms only. However, this is criticised by the positivists as bringing a bias into the study; positivists believe researchers should '*remain detached from their subjects in order to remain "value free"*' (McNabb, 2010:16). Positivists claim that because of this, qualitative research lacks rigour, and is difficult to repeat as the researcher has an individual interpretation on the meaning of what has been found (Pope and Mays, 2006). Ability to repeat research and obtain the same findings is a feature upon which its quality will be judged (Cowan, 2009). Replicability of qualitative research studies is the source of much discussion. It is generally viewed that replicability is a feature of quantitative research whereas it is not as important in qualitative research Lewis et al (2014) cite a number of reasons for this including that:

- *qualitative researchers promote the idea that there is 'not one truth out there' and therefore results cannot be replicated;*

- *the experiences being investigated in qualitative research are likely to be very complex and therefore difficult to replicate and*

- *qualitative research is an active process and therefore studies are difficult to repeat.*

The research methodology of a study is not only dictated by the philosophical standpoint of the researcher but also by the research questions. Having looked at the philosophical foundations of qualitative and quantitative research it is important to stress that it cannot be said that either approach is the single best method (Bruce et al, 2008); both have limitations and as Denzin and Lincoln (2005:1) assert, both are '*scientific*'. It is essential for any researcher to be clear about the research question (Pring, 2004) and his or her own values before agreeing which method to use. The result of employing the most appropriate method is that the research is more likely to be '"*true*", "*repeatable*" and "*generalisable*"' (Williams and May, 1996:15). When the researcher is clear about the purpose of the study and therefore the research questions, the appropriate methodology to use will emerge.

Four of the main approaches used in interpretive research are *phenomenology, ethnography, narrative analysis* and *grounded theory* (Merriam, 2009). A phenomenological approach is used when a study aims to explain the lived experience as identified by the research subjects (Cohen

et al, 2000). This approach underpins many of the qualitative research methods (Munhall, 1994) and was used by Titchen and Binnie (1993b) when they implemented primary nursing and studied the ward sister's role within this new way of organising the nursing team. The level of objectivity of the researcher is an integral aspect of all research designs. Corbin and Strauss (2008) regard objectivity in qualitative research as a 'myth' (p32). They go on to discuss the concept of sensitivity as being the opposite of objectivity and argue that qualitative researchers should be cognisant of their identity, values and beliefs and how these impact on the research process. Corbin and Strauss (2008) do not criticise sensitivity but encourage researchers to confront the influence they have on their research and understand the bearing it may have on the analysis and interpretation of data.

There were no examples in the literature review for my own study of a pure ethnographic research design, which is where the researcher becomes one of the research participants and is therefore more able to narrate the experience from the participants' perspectives than other research methods allow (Fetterman, 2010). However one of the authors (Binnie) of the Titchen and Binnie (1993b) study was herself the ward sister of the ward team being researched and as a result the researchers spent a significant amount of time with the research participants and in the culture of the environment being studied. One of the major benefits of ethnography is that the researcher is able to actually observe the subjects from within the group, this may offer richer data than relying on the subjects' perspectives only (Denscombe, 2010). However because of the close relationship between the researcher and the participants there is potential for the study to accumulate descriptive stories rather than provide an analytic perspective, it may also be difficult to gain ethical approval for an ethnographic study due to privacy issues; this was a concern in Pembrey's study (1980) when one of the participants declined to be observed (Denscombe, 2010).

Narrative research is relatively new and as such lacks an agreed definition (Tamboukou et al, 2013), however it analyses participants' stories to understand how they experienced a certain event, this can be done by the subject being interviewed or by writing an account of an event. Squire (2013) promoted narrative research because story telling is a natural way for humans to make sense of experiences, however she also clarified that a limitation of narrative research is that a person is unlikely to tell a story in exactly the same way more than once because perspective changes and therefore the story changes with time. Balasco Cathcart and Greenspan (2012) used a narrative research design to investigate how nurse managers managed their role; the participants were asked to write and share their stories with peers, and the resultant data from the narratives were analysed thematically.

Grounded theory methodology provides researchers with a framework for qualitative data analysis the information from which is used to create theories (Charmaz, 2006) rather than test them. A method of comparative data analysis is employed from the first data collection until the point of saturation occurs (when no new data has appeared). Because the point of saturation is an unknown it is often difficult to predict the required sample size, but Stern (2007) suggests 20-30 would usually be adequate, Stern (2007) also pointed out that if a sample is too large some of the data may not be analysed. An example of using grounded theory is when Sullivan et al (2003) analysed data from 94 nurses who took part in focus groups about the role of the nurse manager and their developmental needs. Another concern of grounded theory methodology is that it may not always produce a theory (De Chesney and Anderson, 2008).

Having taken into consideration the differences in approach and philosophical standpoint of the two main methodologies, analysed my personal beliefs of epistemology and reality (ontology) and reviewed the research question, it is clear that the phenomena investigated in this research, ie, *the preparation and support provided to nurses to become ward sisters* can be measured quantitatively. My personal philosophy is more aligned to understanding what happened, the characteristics of a population and the relationship between variables rather than understanding how people experienced a certain phenomenon. I find it difficult to agree that research findings are not contestable and therefore rather than taking a positive approach this research is conducted from a post positivist position.

An important aspect of my own research process was to recognise the extent to which I could remain objective given my personal interest in the role of the ward sister and the fact that when I started the research I was in contact with a group of ward sisters in my daily work, although this changed mid-way through the study due to my personal job move. As stated above objectivity may be somewhat of an illusion (Corbin and Strauss, 2008) however it was important to me that my professional experience and knowledge was used positively throughout the process and its influence was limited. The use of predominantly quantitative methodology helped to constrain the potential bias as the majority of the data was produced by using a survey and were therefore numerical with little opportunity for me to manipulate them (Denscombe, 2007). It is understood that the interpretation of the focus group data and the thematic analysis of parts of the surveys in phases I, III and IV will be affected by my personal values and beliefs.

The degree to which the researcher is able to remain objective leads on to whether I was considered to be an 'insider' or 'outsider' researcher in this study. Merriam et al (2001) explained that it is rare to be able to simplify the position as being one or the other and I would identify as being both an insider and an outsider in different parts of this study. To analyse this further in the most general terms every participant in my own study was a registered nurse and

because I share that status I would be an insider in terms of the norms of the profession. In phase I, the participants were Directors of Nursing and at that time (although not currently) I was also employed in that role and therefore would be recognised as an insider by that group. The remainder of the study focused on interaction with ward sisters, and although I had once been a ward sister it was over 20 years ago and therefore would be considered an outsider to this cohort. Blythe et al (2013:10) describe four key challenges for insider researchers, these being:

- *Assumed understanding* - this is when a participant does not describe the phenomenon in detail because they think that the 'insider' researcher understands what they are saying and there is no need to be specific. In such situations it is important that the researcher probes the participant to ensure the information is elicited. There was potential for this to happen in the focus groups in my own study, however as a skilled interviewer I did probe further to ensure I understood the participants' perspective.

- *Ensuring analytic objectivity* - because an 'insider' researcher will have their own experience and therefore perception of what the participant has shared it is vital that when analysing the data that the researcher does not bias the analysis from their own knowledge. One method to minimise researcher bias is to have a second person analyse the data. This was a limitation that has been acknowledged in the limitations chapter (8), however to reduce the effect, the data from the questionnaires was reviewed and coded on six occasions.

- *Dealing with emotions as an insider* – a participant is likely to share similar experiences to an 'insider' researcher and depending on the study topic it may raise a number of emotions in the researcher. It is important that when this happens that it does not affect the participant or the information they wish to impart in the process. A researcher should at the outset acknowledge that this may happen and ensure there is the facility to debrief after collecting or analysing data. The discussion in the focus groups was not particularly disturbing and did not have a detrimental effect on me.

- *Managing participants* – as in any research study the aims should be clearly explained to all participants, this will help manage participants' expectations particularly if they expect the research to have an impact in the area being investigated, for example by a change in policy. All participants received a Participant Information Sheet which helped to manage their expectations; no participant contacted me for further information about the study.

Understanding the fluidity of my position through this study I endeavoured to be aware of the above issues and mitigate them by recognising both the advantages and disadvantages of being an insider and outsider researcher.

An associated issue that I was cognisant of was that although I may not be perceived to be an insider researcher to the ward sisters, some of them would recognise that I held a senior role in the NHS and therefore identify that I would exercise a certain amount of power in the relationship between researcher and participant. Merriam et al (2001) assert that there are power based relationships in all research and it is for the both the participants and researcher to negotiate how this works.

The position I hold within the NHS did help me to navigate the system and to have relatively easy access to the Directors of Nursing and therefore to the ward sisters. However I was mindful that I wanted to reduce the effect of my perceived power; in relation to this, the first focus group (phase II) was held in a neutral environment and the second (phase IV) was held in the participants' workplace. In addition to this the supporting documentation for the questionnaires (phases I, II and IV), for example the PID were very clear that I was a student researcher at the University of Greenwich. Participants knew that this was a study as part of a PhD study and not a study related to my work or my position within the NHS. Participants in the surveys were given the option of not participating and although the number of responses was high it was clear through the amount of non-responders that the participants felt able to exercise this right. One way of potentially reducing the power relationship I had with the participants would have been for a research fellow to gather the data, this may have changed the response rates and the honesty of the answers, as the participants would have had no interaction with me. This technique was not employed, because one of the purposes of studying at doctoral level is to learn about the research process. It was important for me to lead on all aspects of the research and to learn from when I managed it well and when it could have been improved or the research was limited due to an event that happened (see limitations chapter (8)). Having explained my own situation it was important to me to find out in the most objective way possible what training and development nurses require to make the transition from staff nurse to ward sister.

3.4   Mixed Methods Approach

Having stated that this research is founded on a post positivist philosophy it should be noted that both qualitative and quantitative methodologies may be used in the same study (Glaser and Strauss, 1999), and therefore a knowledge and understanding of the philosophy behind them both should be developed. Inductive and deductive approaches can also be used successfully in the same study and this benefits the investigation by '*maximising the strengths of both methodologies*' (Newman and Benz, 1998). My own study had four phases, two of which incorporated focus groups (phases II and IV) and questionnaires were used in three (phases I, III and IV), therefore both qualitative and quantitative methods were used. When quantitative and qualitative approaches are used together the resulting approach is referred to as a mixed methods research approach; this style of research was developed during the 1990s (Denscombe, 2007). It is also thought to be a less rigid approach to social research than using a strict positivism or interpretive methodology.

There is however criticism of how mixed methods are used, and rather than bringing out the best of both positivism and interpretivism, Giddings (2006) asserts that mixed methods research is

rarely a completely integrated piece of work with equal use of quantitative and qualitative methods. Giddings (2006) goes on to explain that the majority of mixed research studies are post positivist in nature and many have the qualitative aspect 'fitted in'. I would contend that the qualitative method in my own study (the focus groups in phases II and IV) were not 'fitted in' but actually played a significant role in assessing how ward sisters viewed their role in 2012 and 2014 and helped to develop the ward sister questionnaire in phase III as intended. Driscoll et al (2007) also suggested that mixed methods may lose the depth of qualitative data when it is quantified. In my own study the qualitative data in phases II and IV were analysed to present a picture of what the ward sister role was in 2012 and 2014 and therefore was not quantified.

Although the underpinning philosophy of this research is post positivism the methodology is essentially a mixed methods research approach. In an effort to define mixed methods research, Johnson et al (2007) asked 36 mixed method researchers to define this methodology. Once the responses were analysed Johnson et al (2007:129) developed their definition and stated that '*Mixed methods research is an intellectual and practical synthesis based on qualitative and quantitative research; it is the third methodological or research paradigm (along with qualitative and quantitative research)*'. It is interesting to note here that Johnson et al (2007) legitimised mixed methods research by naming it the third methodological paradigm.

3.4.1 The research design

Onwuegbuzie and Leech (2006) offered a framework from which to develop research questions in a mixed methods research approach this can be seen in Figure 3.1. The thought processes for the development of the research questions in my own study are now discussed with reference to Onwuegbuzie and Leech's (2006) work and my own philosophical view. Onwuegbuzie and Leech (2006) stated that the first step of the research process was to decide on the goal of the study; the objective of my own study was to investigate how nurses are prepared for and supported to be ward sisters, and what would help them to prepare to be an effective ward sister.

Once the goal has been finalised the research questions are derived from it, as this was a non-experimental, cross sectional, descriptive study the questions arising from the goal were;

- What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- What preparation and support helps nurses manage the transition to the ward sister role?

It can be seen in Table 3.1 that non-experimental research designs are in the hierarchy of evidence but are not considered to be as scientific randomised controlled trials. This view was supported by Kelley et al (2003) who explained that the advantages of descriptive studies were

that the findings were based on actual information, and that due to the larger sample size the results are probably generalisable. The main disadvantage was that the results may be secondary to the researcher as they try to gain a large sample size and that the data may be superficial.

Having agreed the goal and questions the next stage in a mixed methods research study is to determine how the methods will be mixed. After consideration of the goal of this research, it was decided that a quantitative methodology would be appropriate to obtain the data required. This decision was also supported by my own philosophical viewpoint that I believe the answers can be identified by asking ward sisters about their actual experience via a questionnaire, enabling the study to focus on facts rather than interviews, the results of which may have been more subjective and focused on the respondents' feelings (Potter, 1996). The questions were investigated through a mainly non-experimental research design, via two questionnaires, one to Directors of Nursing of NHS acute hospitals in England and the second to ward sisters in NHS acute adult in-patient wards in England. Questionnaires were used as the method of data collection in phases I, III and IV because the study was based on investigating the current situation of preparation and support for nurses becoming ward sisters, it is to a greater extent collecting facts and as such Denscombe (2007) would support the use of surveys. This approach is helpful when a study investigates the current situation (Young and Hastings-Tolsma, 2003), and suited my own study as it explored what is currently helping nurses prepare for and manage the transition to a ward sister role. Therefore the methodology of this study was not founded on a phenomenological or qualitative approach as it investigated the factual preparation of nurses to be ward sisters and not as Potter (1996:30) described phenomenology about '*how humans attach meaning to experiences in their own minds'.*

Figure 3.1 Mixed Methods Approach Research Design (Reproduced with permission from Onwuegbuzie and Leech, (2006))
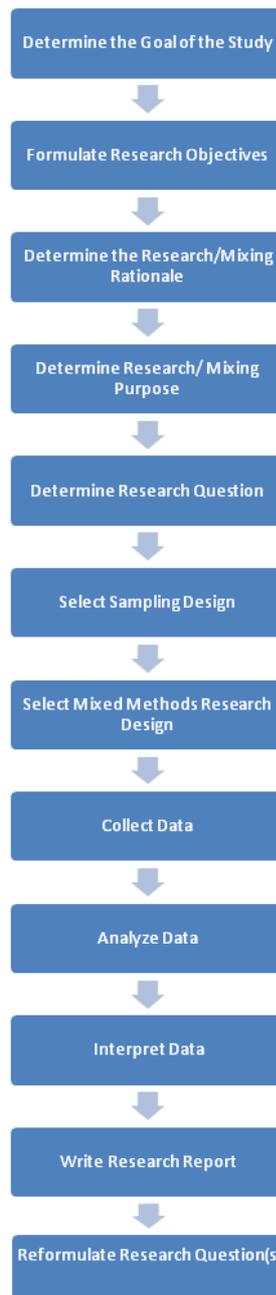
It was decided that the addition of qualitative focus groups in phases II and IV gave a further dimension to the study and broadened its depth. The focus group also added to the third phase of the study by providing information to help develop the ward sister questionnaire. The objective of the ward sister focus groups was to explore the findings of the RCN (2009) report in the current context, and in particular to explore whether the findings still held true. The RCN (2009) study is the most recent national large scale study which investigated the role of the ward sister and I wanted to use these findings to develop the ward sister questionnaire in phase III of the study. However, it was thought necessary to review and validate the results of the RCN (2009) study which were three years old at the time of the first focus group to ensure they continued to

reflect the current view of the ward sister role for this research; the focus group was utilised to do this.

The data from the focus group could have been collected via a questionnaire but the subjects would have had less freedom to describe the role, their day to day activities and challenges (Denscombe, 2007). A questionnaire method would also have lacked the richness of the group conversation and the ideas and comments that were initiated because of the sisters' interaction with each other during the session (Zigmund and Babin, 2007). Focus groups are an effective method for investigating such topics as they bring together people who have had similar experiences and focus on their views of a certain topic, (Holloway and Wheeler, 2002) (in this instance their experience of being a ward sister), and as such it was judged to be the most appropriate method to elicit this information. There are a number of disadvantages of using focus groups that a researcher should be aware of including that not all the participants may feel able to contribute and conversely some may dominate the conversation, it should also be noted that the moderator may steer the conversation away from what the participants wish to discuss (Zigmund and Babin, 2007), these can be counteracted by skilful facilitation.

Implementing a mixed methods research approach in this way has brought strength to my own study, and this was the rationale for using mixed methods research rather than a pure quantitative approach. The next step according to Onwuegbuzie and Leech's (2006) framework is selecting the sampling design. This was different for each phase of the study and is discussed in the method chapter.

The seventh stage is to select the mixed methods research design. This has been described in more detail earlier, but in summary, phases I and III were quantitative, phase II was qualitative and phase IV was both quantitative and qualitative. The remaining steps in the process, as can be seen in the Figure 3.1 are;

- · collecting the data
- · analyzing the data
- · validating/legitimating the data
- · interpreting the data
- · writing the mixed methods research report.

All of these elements are covered later in this thesis.

Greene et al (1989) stated that there are five reasons why a researcher would use a mixed methods research methodology.

In summary these are

i) *triangulation*
ii) *complementary*
iii) *developmental*
iv) *initiation* and
iv) *expansion*

Greene et al (1989) explained that triangulation of research findings is the most commonly given reason for use of a mixed methods research approach in research studies. Mixed methods allow different approaches to the investigation of the same phenomena, and by using more than one means of collecting and analysing data, (for example, a quantitative questionnaire and interviews) researchers can triangulate the results to enhance their meaning. Although, as stated above, the opportunities for triangulation are the most commonly cited reason for using mixed methods research, when Greene et al (1989) reviewed 57 mixed methods research studies they found that in reality the majority of researchers did not use the methods for triangulation of results. Triangulation may therefore be a mis-used term when justifying the use of this methodology.

Use of a mixed methods research approach in a complementary way means that both quantitative and qualitative methods are used to measure similar and different aspects of a study, in this way they may overlap but not look at the same phenomena as in the triangulation example above.

The third reason for using a mixed methods research approach is that it allows development of the research study over time. When using the approach for this reason it is likely that the methods are implemented sequentially rather than at the same time. An example of this would be using a questionnaire to gain information that would then help to develop an interview guide.

In respect of the 'initiation' reason Greene et al (1989:260) explained that '*discovery of paradox and fresh perspectives may well emerge rather than constitute a planned intent*'. By the use of this methodology, the research can develop into something that the researchers may not have envisaged when planning the study. The application of mixed methods approach for expansion is when the researcher has the intent to gain as broad a scope as possible by including many different perspectives.

Greene et al's (1989) framework was very helpful in defining the utilisation of a mixed methods research approach. Having analysed the ways in which mixed methods research may be applied,

my own study used a mixed methods research approach in a developmental way. This is because there were four phases: the first, a quantitative questionnaire to all Directors of Nursing in NHS acute hospitals in England to elicit information about what preparation is given to nurses to become ward sisters and what support is offered to them once they assume the role. The second phase was a qualitative focus group of ward sisters, the purpose of which was to review the RCN's study 'Breaking Down Barriers' (2009) to identify whether it was still a reliable representation. This was necessary because the RCN (2009) study was used to develop the quantitative questionnaire that was sent to a sample of ward sisters in NHS acute in-patient wards in England in phase III. Finally, the fourth phase which was a repeat of the questionnaire in phase III to the ward sister population of an NHS Trust to validate the results in phase III and a second focus group to identify any changes two years from the focus group held in phase II. It is submitted that the use of the focus group to help develop the questionnaire is what Greene et al (1989) call a developmental use of mixed methods.

My own study also used mixed methods in a complementary way: the data from the focus groups were triangulated with the data from the two questionnaires in phases I and III, as described in the discussion chapter. However it should be noted that these mixed methods were used one after the other and not concurrently. Mixed methods were not employed in either an initiation or an expansion way as the intent of the research and the plan had been clear and agreed from the outset and although the results may offer a perspective that was not expected this did not have an impact on the way in which the methodology was managed. It is important to be clear about how mixed methods are to be used in a study. Bryman (2007) pointed out that on many occasions researchers set out using a mixed methods research approach but do not collate the quantitative and qualitative results and therefore do not make the most of the methodology.

In their study of mixed methods researchers Johnson et al (2007) found that there was a 'continuum' in mixed methods research with 'quantitative dominant' on one end of the scale and 'qualitative dominant' on the other. Earlier in this chapter it was stated that my own study is derived from a post positivist position. With the four phases, comprised of three questionnaires and two focus groups, I would suggest that on Johnson et al's (2007:124) continuum my own study would be '*symbolized as QUAN+qual research*' making it quantitative dominant. The idea of a continuum is supported by Giddings (2006).

To summarise, this research investigated the reality of the preparation and support nurses get to become a ward sister in the English NHS acute provider sector in 2013. The research was based

on the factual world of these nurses and did not focus on how they felt when experiencing the transition to this role and therefore is underpinned by a post positivist philosophy.

Rees et al (2010) described the hierarchy of evidence formulated by Sackett in 1986. As indicated in the table below systematic reviews and meta analyses are identified as the strongest scientific research designs, whilst descriptive studies are the weakest.

Table 3.1 Hierarchy of Evidence (Rees et al, 2010)

1. Systematic reviews and meta-analyses
2. Well-designed randomised trials
3. Well-designed trials without randomization
4. Well-designed non experimental studies
5. Opinions of well-respected authorities based on clinical evidence, descriptive studies or reports of expert committees

My own study fits stage four 'well designed non-experimental studies'. The hierarchy of evidence relates only to quantitative research and ignores evidence arising from qualitative research, as a result qualitative evidence is thought by some researchers to be less valid than any of the five quantitative designs in Table 3.1(Griffiths, 1996).

However, a further hierarchy of evidence, for qualitative research design, was described by Daly et al (2007). This second hierarchy is described in the table below.

Table 3.2   Hierarchy of qualitative evidence (Daly et al, 2007)

Generalisable studies using conceptual frameworks to derive an appropriately diversified sample with analysis accounting for all data
Conceptual studies that analyse all data according to conceptual themes but limited by lack of diversity in the sample
Descriptive studies without detailed analysis
Single case studies

It is made clear in Daly et al's (2007) study that a limitation of the hierarchy of evidence is that it is too broad in its assumptions in that a poorly designed and executed systematic review may not be better research than a well designed and implemented non-experimental study. The research

design should match the aims of the study; it should be the most effective way to obtain the most appropriate data to answer the research question. Therefore, for instance, a quantitative research design will not be appropriate to find out how people felt when they experienced a certain phenomenon.

3.5   Conclusion

In summary my own study was rooted in a post positivist philosophy and used a mixed methods research approach with a dominant quantitative influence. The way in which the different methods were used to collect the data to answer the research questions is in Table 3.3.

Table 3.3   Research Questions and Phases of the Study

Research question	Phase and methods
What methods of preparation for new ward sisters are used in NHS acute hospitals in England?	Phase I – Questionnaire to Directors of Nursing (Quantitative)
What preparation and support helps nurses manage the transition to the ward sister role?	Phase II – Focus Group gave information to help construct questionnaire in phase III (Qualitative) and presented a view of the ward sister role.
	Phase III – Questionnaire to ward sisters (Quantitative)
	Phase IV – The focus group gave further information about the current role of the ward sister (qualitative). The questionnaire gave information to validate the data from phase III (quantitative).

The data were collected from three questionnaires and two focus groups, the second questionnaire was informed by the outputs of the first focus group. This design was thought to be appropriate to the questions under consideration as it had the potential to gain a large amount of data from national samples, which helped to demonstrate what preparation and support nurses were offered in their transition from staff nurse to ward sister.

METHOD: Becoming a ward sister, accident or design?

4.1   Introduction

This chapter describes the methods used in my own study and how the study was conducted. The research was underpinned by a post positivist philosophy but was conducted using a mix of methodologies with a QUANTITATIVE:qualitative dominance (Johnson et al, 2007). The purpose of this study was to identify what preparation and support helps nurses in the transition to the ward sister role. The research questions were:

·   What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
·   What preparation and support helps nurses manage the transition to the ward sister role?

There were four phases in this study;

·   Phase I was a questionnaire survey to all of the Directors of Nursing in acute NHS organisations in England investigating the preparation and support they offered nurses becoming ward sisters.

·   Phase II used a focus group method with a sample of ward sisters to review the findings of the RCN's (2009) report 'Breaking down Barriers'.

·   Phase III was a questionnaire to a sample of ward sisters in acute NHS organisations to examine what preparation and support they had received and whether it had been found helpful.

·   Phase IV repeated the focus group in phase II and the questionnaire in phase III, this time with a population comprised of a group of ward sisters from one NHS Trust. The purpose was to add information and validate the information gained in phases II and III.

Table 4.1 below illustrates how the different phases fit together and helped to answer the research questions.

Table 4.1 Research Questions and Phases of the Study

Research question	Phase and methods
What methods of preparation for new ward sisters are used in NHS acute hospitals in England?	Phase I – Questionnaire to Directors of Nursing (Quantitative) Phase I gave the baseline view from an employer perspective about what preparation and support were given to nurses in ward sister posts. Phase I linked to phase III as the data from both phases contributed to identifying the differences and similarities in views between directors of nursing and ward sisters.
What preparation and support helps nurses manage the transition to the ward sister role?	Phase II – Focus Group gave information to help construct questionnaire in phase III (Qualitative) and presented a view of the ward sister role. Phase II linked with phase III as it influenced the questionnaire design and the data from both phases were used to describe the ward sisters perspective on the preparation and support required to become a ward sister.
	Phase III – Questionnaire to ward sisters (Quantitative) Phase III was the main part of the study, the data from which were used in combination with data from the other three phases, to describe the overall findings about the preparation and support that facilitates nurses' ability to manage the transition to the ward sister role.
	Phase IV – Focus Group and Questionnaire to ward sisters in one organisation (Quantitative and Qualitative) The focus group gave further information about the current role of the ward sister (qualitative). The questionnaire gave information to validate the data from phase IV (quantitative).

It is important to use the methodological tool that will ensure the researcher gains the right type of information (Pring, 2004). Using the wrong method may result in '*loss of generalizability, increased cost and invalidity*' (Morse and Field, 1995:15). This chapter will focus on how the research was implemented and includes the pilot studies for phases I and III, questionnaire development, sampling design and ethical issues for all four phases, preparation and facilitation of the focus group and data collection procedures.

The timeline of how the research was undertaken is illustrated in Figure 4.1.

Figure 4.1 Research timeline

	Phase I Questionnaire to Directors of Nursing	Phase II Ward sister focus group	Phase III Questionnaire to ward sisters	Phase IV Focus group and questionnaire
January 2012	Questionnaire designed	Focus group designed		
May 2012	Questionnaire pilot	Facilitated focus group		
July 2012	Questionnaires sent to 139 Directors of Nursing	Analysed focus group data		
January 2013			Questionnaire designed	
May 2013			Questionnaire pilot	
July 2013			Questionnaires sent to 228 ward sisters	
January 2014	Analysed questionnaire data	Analysed questionnaire data		Questionnaires sent to 45 ward sisters
August 2014				Facilitated focus group
September 2014				Analysed focus group data
October 2014				Analysed questionnaire data
November 2014				

4.2 Pilot studies: Phase I, questionnaire to directors of nursing and phase III, questionnaire to ward sisters

This section describes the pilot studies for phases I and III; as phase II was a focus group it did not have a pilot study. The purpose of phase I of my own study was to investigate what methods were used to help prepare nurses for the role of ward sister and what support was offered to ward sisters in England during the study period. Directors of Nursing were identified as the recipients of the questionnaire as they are the individuals in provider organisations who would generally be responsible for nurses' professional development. For the purpose of this research, Directors of Nursing are the nurses who are executive members of NHS acute provider boards (such posts

also exist in commissioning organisations) and are normally responsible for the quality of nursing care in these organisations (Burdett Trust, 2006).

The third phase of this research study focused on the ward sisters' experience of being prepared for and supported in the role of the ward sister. Both questionnaires were tested in pilot studies; a pilot study gives the opportunity to check that the questionnaire is fit for purpose, ie. that it is understandable and will give the information required to answer the research question (Cargan, 2007).

4.2.1 Questionnaire design

Both phases I and III used questionnaires to collect data. This method was used for these parts of the study because they are an effective way to collect data from large groups of people (Wood and Ross-Kerr, 2011). Questionnaires are also suitable because the data required to answer the research questions were factual rather than perceptions or feelings about the situation so the use of qualitative methods such as interviews or focus groups was thought to be unnecessary (Thomas, 2003). It is recognised, however, that there can be limitations to data gathered by questionnaire surveys which include bias, due to few participants responding to the survey, or not completing answers to every question, and response bias error, arising from respondents not telling the truth or being unable to recall accurately the details of a past set of circumstances about which a question is asked (Zigmund and Babin, 2007). Cargan (2007) agreed that the researcher cannot tell whether respondents are being truthful, he also pointed out that another potential weakness of surveys was that respondents may give conventional answers so as not to be viewed as different compared to social norms. The advantages of using questionnaires were thought to outweigh the limitations for collecting data in phases I and III.

Both of the questionnaires used in phase I and III were developed using the framework described by Denscombe (2007). Denscombe (2007) explained that once the questions are written in draft it is important to evaluate the questionnaire to ensure that the respondents will be able to understand the questions, be able to answer them for themselves (it is asking them about something they know), does not duplicate questions and that there are sufficient options if it is a multiple choice answer. All of these stipulations were taken into consideration when formulating both questionnaires. Piloting the questionnaires gave the opportunity to test the above criteria and as a result of the feedback from the pilot participants both questionnaires were changed and made more relevant to the audience, which is described below.

Researchers aim for a high response rate and one way that this may be achieved is by making the questionnaire varied so that it keeps the respondents' attention. The questionnaire in phase I was

intentionally simple as the respondents were extremely busy Directors of Nursing and the purpose was to gain a national picture of preparation and support offered to ward sisters; therefore the answers required were either short text or multiple choice. This question design suited the factual information required from the respondents and was easy to complete. A table clarifying how the questions in the questionnaire related to the conceptual framework (Figure 2.4) and Nicholson and West's (1988) transition model (Figure 2.3) is in appendix 1.

The questionnaire for phase I (appendix 2), was based on information derived from the published American literature, the RCN (2009) study and my own experience as a former Director of Nursing. The draft questionnaire was discussed with my supervisors, submitted for ethics approval to the University's Ethics Committee (ref 11/12.3.5.22) (appendix 3), then piloted with two Directors of Nursing (subsequently removed from the final sample) and the content was altered in response to the pilot study, as described below. The questionnaire asked four questions about the organisation; these questions would enable correlation between the type of preparation and support offered to nurses and the size, type and location of the organisation. There were four questions which related to the ward sisters in the organisation; and multiple choice questions about the type of preparation and support the organisations offered nurses moving into the ward sister role. Finally there was a free text question about what the Directors of Nursing thought were the three greatest challenges for nurses becoming ward sisters, this gave qualitative data, which would give an employer's perception of the ward sister role.

4.2.2   Phase I pilot study, questionnaire to directors of nursing

Once the questionnaire for phase I had been developed three Director of Nursing colleagues in acute provider organisations in Kent, UK were asked to participate in the pilot study and they all agreed. A date was set to meet to complete the questionnaire, unfortunately one of the Directors of Nursing could not attend on the day at short notice but a decision was made to continue the pilot study with the two remaining Directors of Nursing.

The two Directors of Nursing completed the questionnaire (appendix 4) individually and then the questions were discussed. There were a number of suggestions from the two colleagues:

- *Clarify the definition of ward sister*
- *Add five new questions*
- *Make some minor word changes*

4.2.2.1 Changes to phase I questionnaire in response to the pilot

In the survey used for the pilot the ward sister role was defined as '*ward sisters who have 24 hour responsibility for acute adult wards only*'. The two Directors of Nursing proposed that this would be open to interpretation so the definition was changed to the following:

> '*For this study ward sisters are defined as those who have 24 hour responsibility for a ward, they are usually band 7 and are primarily in charge of a ward. They may be called ward manager or charge nurse and includes both males and females. All ward sisters of acute medical, surgical and gynaecology wards only should be included. This study excludes paediatrics, critical care units (ICU, HDU), theatres, maternity and community care.*'

This defined the role more clearly, it gave alternate titles for the role and it also gave the recipients of the survey the inclusion and exclusion criteria of the subjects of the survey.

During the conversation about the questionnaire the two Directors of Nursing suggested that five more topics which could be interesting to add to the survey, these were i) the methods used to recruit ward sisters; ii) whether ward sisters had supervisory status; iii) succession planning; iv) whether or not the employer organisations had a ward sister competency framework and v) how much money the organisation invested in ward sisters' development in their first year. It was agreed that these would add value to the survey and as a result it was decided to add three more questions to the questionnaire: a multiple choice question on the methods used to recruit ward sisters in the organisation (question 7), a multiple choice question about how much money was invested in ward sisters in their first year (question 12) and whether or not ward sisters had supervisory status (question 13). The other two issues that the directors had proposed in the original questions were included as additions to the multiple choice answers, resulting in succession planning being an option in the answer to the question about the preparation offered to nurses (question 10), and the existence in the employing organisation of a ward sister competency framework being added as an option for the question about support provided in the first year (question 11). The discussion following the pilot was also helpful in making minor changes to the wording of a number of questions. The pilot study results and final questionnaire were discussed with my supervisors and sent it to the University's ethics committee who agreed the changes.

4.3   Phase I: Questionnaire to directors of nursing

4.3.1   Ethics

Ensuring high ethical standards in the way in which a research study is carried out is essential to protect the participants and deliver a high quality research product. There are many potential ethical issues that may arise during social science research, however there is useful national

(Department of Health, 2005) and local (University of Greenwich, 2012) guidance to help researchers in their endeavour. Garner et al (2009) suggested that the main issues requiring ethical consideration were *confidentiality, informed consent, how people decide to participate, data storage, protecting vulnerable people* and *potential bias*.

As described above it was essential to test the questionnaires in phase I and III with people from the same population that would be used for the research sample; however, it was also important that the pilot sample was ruled out of the research. Following the pilot study the three Directors of Nursing were excluded from the main study sample to eliminate the risk of bias (Profetto-McGrath et al, 2010). Once the alterations were made to the phase I questionnaire in response to the comments made by the pilot sample it was submitted to the University's ethics committee with an explanation for the alterations. The ethics committee agreed the changes (ref 11/12.3.5.22).

The samples in phase I and III were Directors of Nursing and ward sisters respectively and as such it was thought they would be able to understand the information given to them about the study and their participation if they decided to respond. It was therefore decided that written consent was not necessary for these phases and that they had given implied consent if they responded to the questionnaire.

4.3.2 Implementing phase I, questionnaire to directors of nursing

Following the pilot study and gaining ethics approval (ref 11/12.3.5.22), the questionnaire was sent to the 139 Directors of Nursing in English NHS acute organisations via email using Survey Monkey (Survey Monkey Inc). A number of electronic methods to distribute the questionnaire had previously been investigated and Survey Monkey (Survey Monkey Inc) was chosen as the tool to use, mainly due to previous experience and, its simplicity, price and the ability to transfer results to SPSS (IBM, 2011). The questions were written into the Survey Monkey software.

4.3.3 The sample

The sample for this survey was all the Directors of Nursing of acute NHS Trusts and Foundation Trusts in England. This was a non-random sample as 100 percent of the population (excluding the three Directors of Nursing invited to participate in the pilot study) were included and as such were representative of the wider population of Directors of Nursing in such trusts (Onwuegbuzie and Collins, 2007); because all Directors of Nursing in England were invited to participate a sample size calculation was not necessary.

The email addresses of the 139 Directors of Nursing had to be obtained, and this was achieved using a number of different methods. I already possessed a number of the email addresses due to my professional work and, I was able to find other addresses by reviewing the websites of the remaining organisations. The outstanding addresses were obtained by phoning the secretaries of the Directors of Nursing via their trust's switchboard. This was a labour intensive period of the study and it took four weeks in total to compile a complete list.

The email addresses were then transferred to Survey Monkey (Survey Monkey Inc) and the invitation to participate (appendix 5) with a link to the questionnaire was sent to the 139 Directors of Nursing on 3 July 2012. Reminders were sent twice via Survey Monkey (Survey Monkey Inc) to the Directors of Nursing on 28 July 2012 and 12 August 2012. Most responses were received between 3 July and 15 August 2012, however late responses were delivered on 17 October 2012 and 5 January 2013. A further response was received on 10 September 2013 which was prompted by the request for sisters to participate in their survey in phase III of this research study. The results were downloaded from Survey Monkey to SPSS format on 18 January 2014.

4.3.4   Analysis of the data

The majority of the data (questions 1-13) were analysed using descriptive statistics using SPSS version 20 (SPSS, IBM). The chi square test was also used to analyse the data: this statistical test is an effective way to scrutinise data from questionnaires, because it enables the researcher to analyse the relationship between different variables rather than relying on reporting frequency of responses only (Greasley, 2008). This test can help explore the relationships between the opportunities for development and size of organisation, or type of organisation e.g. NHS Foundation Trust versus NHS Trusts, or those in different geographical locations. The researcher used thematic analysis (Miles and Huberman, 1994) for the qualitative data in the answer to question 14, which asked the Directors of Nursing what they thought the three greatest challenges were for these nurses; the coding structure will be described later in this chapter.

One question asked the Directors of Nursing to list the top three challenges for ward sisters in their first year. In total there were 93 comments; the results were analysed using thematic analysis, the themes having been drawn primarily from the conceptual framework which summarised the literature review, ie,

i)   perceived stress,

ii) relationships,

iii) the ward sister role,

iv) ward sister competencies.

However as new themes emerged that did not reflect the conceptual framework two additional themes were included, these were

i) development

ii) transition.

A thematic framework (Ritchie and Spencer, 2002) was developed to code the data within the responses; this is in appendix 6. Following analysis, the data were assigned to one of the four themes as described above; if the data did not align to one of the four they were set aside. The data were analysed once more and two further themes were developed, these were *development* and *transition*, resulting in six primary codes. Further comparison of the data ensued and sub categories were created under each of the six codes, these were titled to give more definition about the participants' opinions, as explained by Ezzy (2002). The analysis was somewhat subjective as it was difficult to attach meaning to the opinions because in the majority of cases the participants had written one word only, such as '*staffing*' or '*time*'; therefore similar words were grouped together and this analysis was repeated five times over one month to be sure the categorisation was reliable.

4.4   Phase II: Ward sister focus group

The objective of this qualitative phase of the study was to gain an insight into the then current perceptions of ward sisters about their role. Understanding what the ward sisters perceived their role to be in 2012, rather than relying on less current information would aid the development of the survey in phase III. As the most recent and relevant UK study about the role of the ward sister the findings of the RCN (2009) study 'Breaking down Barriers' were used as a framework for the focus group discussion. A practical decision was made to use one focus group only in 2012. Attendees at a conference for ward sisters were invited by me to participate in a focus group before the one at RCN Congress but there was a lack of interest, in phase II therefore, due to time and resources one focus group only was used to gain an understanding about how ward sisters define their role. The disadvantage of using one focus group only is that the data are limited. It is possible that had I been able to organise a series of focus groups they would have generated a much richer quantitative dataset (Bryman, 2008). However, the role of the focus groups in my study was primarily exploratory and was secondary to the questionnaire to ward sisters in phase III. It was a conscious decision not to use more than two focus groups as this was not the main method of the study and was being used to identify how ward sisters describe their role, this was achieved in the focus group.

A focus group is a way to obtain views from a group of people who will all have experience of the issue being discussed, and allows a researcher to gain perspectives on how people experience or think about an issue (Liamputtong, 2011). The main advantages of a focus group method is that people may be more likely to speak about issues when in a group of people than when being interviewed alone, and it is likely that the flow of conversation will prompt them to remember elements that they may forget in a one to one interview (Zigmund and Babin, 2007). As with all research methods there are some drawbacks of using focus groups, the main ones being that conversely people may not want to be open about their views on delicate issues in front of strangers, and that samples used in focus groups are unlikely to be representative of the wider population. Focus groups can also be expensive to facilitate (Zigmund and Babin, 2007).

4.4.1 Preparation

To ensure the focus group was an effective and efficient use of time I prepared in detail for the event, as recommended by Holloway and Wheeler (2002). The first element of this was reading about the role I would fulfil in the focus group, i.e., the moderator. Krueger (1998) details the different roles of focus group moderators. Using Krueger's (1998) definitions a 'seeker of wisdom' role was adopted which he explained as obtaining '*understanding, insight and wisdom'* (Krueger, 1998:46) from the focus group participants. The moderator has great influence on how well the participants contribute, how the information is gathered from them and therefore should be a calm, welcoming and fair individual (Powell and Single, 1996). The moderator should speak less than the participants, although they should be able to interrupt the conversation if it is thought to be straying from the subject. The moderator should ensure that every participant has a chance to speak (Kitzinger, 1995) and should be aware if certain participants are either over powering others or conversely not speaking: good chairing skills can ensure that there is an equal approach to the debate (Radcliffe, 2007). The moderator also has the opportunity of either clarifying issues by asking participants to explain more about the point they have raised or delving into more detail about an issue if it is particularly pertinent to the subject. An essential part of the moderator role is to manage the time, ensuring that all the issues have been discussed before the end of the session (Zigmund and Babin, 2007).

Understanding the time and location constraints that there would be for the focus group, a question schedule was prepared. This schedule was written following analysis of the key findings and recommendations from the RCN (2009) study. The schedule was also helpful in minimising my own perspective on the focus group discussion; because it was based on the RCN (2009) study I limited my own influence over the questions and the ensuing conversation. There were four questions which are listed below;

1. *In its study 'Breaking down the barriers' the RCN highlights the huge breadth of the ward sister role. I would like to explore what you think are the key skills, competencies and capabilities of ward sisters.*

2. *During the study the RCN found that there were certain pressures that the ward sisters experienced, what are the main pressures you face?*

3. *Most ward sisters in the RCN study said they had little education and training to prepare them for the role. Please put your hand up if you had no training or education that prepared you for the ward sister role. For those of you who had education and training, please tell the group what it was and how it helped you. The moderator will ask whether this training was funded by the employer or by themselves.*

4. *I would like to know when you look back to becoming a sister what do you think would have helped you manage the transition more effectively?*

Once the questions were finalised the focus group discussion guide was developed (appendix 7). The discussion guide ensured the focus group covered all aspects of the issue under study that the researcher wanted to investigate (Edmunds, 1999). This guide was the framework for the 50 minute long focus group and aided management of the group and the time effectively. Edmunds' (1999) model was the framework for the discussion guide as it was thought to give enough detail to plan the focus group.

The plan started with the moderator welcoming everyone to the group and explaining the purpose of the focus group which was stated as:

'*The focus group is part of a PhD study investigating what preparation and support is given to nurses when they move to the role of the ward sister to help them move successfully. For the purpose of the research and the focus group the ward sister will be defined as ward sisters who have 24 hour responsibility for acute adult wards only and can be male or female. The primary purpose of the focus group is to review the findings of the RCN's 2009 study 'Breaking down barriers', with particular reference to the remit of the ward sister and the challenges faced by ward sisters. The participants will also be asked about the preparation and support they received when they first started their jobs as ward sisters. The information gained from the focus group which is phase II of the study will be used to develop the questionnaire to ward sisters in phase III and the main part of the study.*'

The next step would be to develop the ground rules. These were necessary to focus everyone's attention on the topic of the focus group and to guide behaviours (Hodell, 2011). To save time at the beginning of the focus group, a list of proposed ground rules were printed for agreement on

the day. It was planned to explain this to the participants and offer them as a suggestion which could be changed.

The proposed list was:

'*Confidentiality*
The discussion will be recorded
There are no right or wrong opinions
One person to speak at a time
Speak loudly enough so everyone can hear
Try to stay focused
Respect the views of others
Participants free to stop at any time'

It was then planned that everyone would be given the opportunity to introduce themselves by name and work location; this is important not only as a way for participants to identify each other but it also allows everyone to speak at the beginning of the session (Radcliffe, 2007).

The plan then set out the four questions listed on the discussion guide and finally the closing comments which would bring the discussion to an end, explain what the next steps would be and thank everyone for their time.

The other essential part of planning for the focus group was developing the information for the participants. It is vital that potential participants understand the purpose of the focus group, the objective of the study they would be contributing to and also their rights and responsibilities if they chose to participate (RCN, 2011a). The participant information sheet (PIS) (appendix 8) was developed to explain the whole study and that the focus group was the second phase of this. A consent to participate form was also developed (appendix 9) which gave the participants further information about the study, the reasons why they had been asked to participate and their rights during the study (RCN, 2011a).

4.4.2   Ethics

It was important to engage a group of ward sisters who did not know or work with me for the focus group, to reduce the bias in the sample (Profetto-McGrath et al, 2010). There are national meetings and conferences which ward sisters would attend, one of which is RCN Congress 2012. I spoke to two Royal College of Nursing (RCN) regional directors and asked if they thought it would be possible to do the focus group at the RCN Congress in May 2012. Both directors were very positive about this and also said they would help to advertise it and invite ward sisters. The

action taken by the two directors ensured that I had no input to forming the sample and therefore decreased the potential for bias in the sample as I did not know any of the participants.

The sample that participated in the focus group was comprised of ward sisters and it was determined that they, like their colleagues in phase III, would be able to understand the objective of the study and what I was asking them to do. However, because they were in a group and not interacting with me in a one to one relationship they were asked to complete a consent form, which they all did. The consent forms were collected, and have been kept in a locked cabinet, as agreed on the consent form, to meet data protection requirements (RCN, 2011a) and according to the University of Greenwich's data retention policy. It should be noted that University ethics approval for the focus group was given at the same time as approval for phase I (ref 11/12.3.5.22).

4.4.3 The sample

The sample chosen for the focus group was a convenience sample, this is because the RCN directors contacted participants who were easily accessible to them (Marshall, 1996). This sample is recognised as not being representative, however their views are applicable to the issue being discussed as they had experience of being ward sisters. I gave the RCN regional directors an invitation (appendix 10), the PIS and the consent form, and they emailed these to the ward sisters they knew would be attending RCN congress. Within a few days I had received confirmation that eight ward sisters would like to participate in the focus group. An effective focus group usually has 6-12 participants (Stewart et al, 2007).

4.4.4 Implementing phase II, ward sister focus group

I arrived at Harrogate for the RCN Congress on the day before the focus group. The focus group was planned for the lunchtime on the first day of congress, due to time constraints it was important that the venue was close to the congress hall. I knew from experience that there would be no quiet areas at lunchtime in Congress so asked the management at the hotel opposite the conference centre if there was a room where the meeting could be held. All the meeting rooms were booked (due to fringe events for Congress) but I did obtain agreement that a corner table would be reserved in the bar. This was not an ideal venue in many respects but did have the advantage that it was close to Congress with easy access, that there was a confirmed venue and there would be refreshments for the participants. On the evening before the focus group texts and emails were sent to the participants confirming details of where and when to meet for the focus group.

The eight participants gathered as planned in the corner area of the bar, as they arrived they settled and ordered lunch. The focus group was facilitated as planned (see above). The participants introduced themselves, and agreed the ground rules (printed copies of which were available on the table for all participants to read) without changing any of them. I audio recorded the conversation and made detailed notes, it is vital to an effective focus group that a record is made of the proceedings (Morgan and Krueger, 1998).

Each of the four questions was asked in sequence, and the conversation flowed well throughout the 50 minutes; the four questions were all answered to my satisfaction. The only prompt question that was asked followed the first main question and was used because the participants had not mentioned research in their discussion. They were asked whether they thought the ward sister role included being a researcher. The ward sisters were confident, and although a couple of the participants spoke more than others they did not overpower the conversation allowing everyone to contribute throughout the 50 minutes. It was important to me that I did not influence the discourse and for that reason I followed the discussion guide closely. A positive aspect of my professional background, however is that I was able to speak their 'nursing language' but I also recognised the need to ask for clarity rather than interpret their meaning myself; Merriam et al (2001) raise this as both an advantage and a disadvantage of being an insider researcher.

As the focus group came to an end I thanked the ward sisters for their contributions. I explained that the notes would be sent to them so they would have the opportunity of reviewing the discussion and points raised. The participants were also reminded that the results of the focus group would be published and the article would be emailed to them for information.

In the evening after the focus group I reviewed the notes I had made; due to the background noise in the bar environment during the meeting the recording of the conversation was not audible; I was therefore dependent on the detailed notes I had taken. It is important to review the notes as soon as possible following a focus group (Lazar et al, 2010). A bulleted report of all the notes taken from the focus group was written (appendix 11) and then compared them with the RCN (2009) findings (Table 5.8). This report was sent to the participants of the focus group, however only one replied to say that she agreed with the content and that it was an accurate record of the discussion. Although it was disappointing that not all of the participants responded, it was important that that they had the opportunity to do so.

4.5   Phase III: Questionnaire to ward sisters

4.5.1   Questionnaire Design

The purpose of phase III was to examine what preparation and support ward sisters had received and what had helped them in the transition to the role of ward sister. The survey in phase III was based on a survey used for middle manager research by Ashridge Business School (Armstrong and Russell, 2012), after I received agreement that it could be used from Dr Amy Armstrong the researcher at Ashridge (appendix 12). It was important to use a questionnaire that resulted in data that would answer the research question 'What preparation and support helps nurses manage the transition to the ward sister role?' A number of questionnaires that had been used in the research studies in the literature search were investigated to understand whether they would be appropriate for the task. These questionnaires included the MLQ and the Michigan Organisational Assessment Questionnaire, both were considered unsuitable as the former analyses the person's leadership style and the latter investigates job satisfaction. Leadership style and job satisfaction are likely to have an impact on how a ward sister transitions into a new role, however these variables would not help answer the research question, and they were therefore not used in this study.

I attended a presentation about the Ashridge study and read the paper; the questionnaire was appended to the study which allowed full access to the questions, I subsequently contacted the researcher and was able to ask questions about the questionnaire before its use in my own study. The questionnaire investigated development needs and learning styles of middle managers which reflected the objectives of my own study. Following discussion with my supervisors and statistics teacher it was decided that with adaptations this questionnaire would be likely to offer data that would enable the research questions to be answered. The Ashridge questionnaire was adapted from the Ashridge Management Index questionnaire, which has been used for over 15 years. The questionnaire was designed to rank measure the development needs of managers and has re-test reliability having been completed by several thousand managers to date.

Using a pre-tested survey increases the validity of the data (Morse and Field, 1995). The content of the questionnaire used the majority of the questions in the Ashridge survey and was adapted in response to the results of the Director of Nursing survey, the feedback from the pilot and the information gained from the sisters in the focus group. A detailed explanation about how the questionnaire was adapted for use in my own study is at appendix 13; to summarise, 15 of the 31 questions in the questionnaire that was sent to the ward sisters were questions from the Ashridge study. On most occasions the original wording was maintained although this was adapted slightly to make it more nursing oriented, for example adding supervisor into the questions about

coaching. The scoring was adapted in six of the questions as it was thought that a Likert scale would result in more detailed responses. The validity of the questionnaire was not tested in this research study, this was not done because although the questionnaire had been altered the original questionnaire had been had re-test reliability having been completed by several thousand managers to date. The questionnaire was, however subject to a pilot test with a group of ward sisters.

The questionnaire used in phase III was also influenced by the literature that had been reviewed and included reference to Nicholson and West's (1988) transition model. Two studies in the literature review chapter (2) discussed the use of induction and internships. Internship is an American term for gaining practical experience in an occupation, this was found by Wendler (2009) to be an effective way for nurses to learn about the nurse manager role, and although the term intern was not used in my own study the sample was asked about their experiences of on-the-job development which is similar to an internship. Induction was not included in the questionnaire as although induction is a vital way to socialise new employees to a new organisation it is often not specific to the role. That is, a hospital trust for example, may provide the same induction programme for all new employees. It should also be noted that the Directors of Nursing did not mention induction as a method they use to develop and support new ward sisters when asked in phase I.

As described above Denscombe's (2007) framework guided the way in which the final questionnaire was developed. The questionnaire in phase III was longer than that used in phase I and it was therefore important to hold the respondents' attention to achieve as high as a response rate as possible. There was more variety in the type of questions, as well as having free text and multiple choice answers, there were questions that tested the degree of agreement (using a Likert scale) and questions that required a yes/no answer only. The order of questions is also an important feature as it affects the flow and also affects the willingness of participants to respond. The questionnaire in phase III started and ended with simple demographic questions, this was done so that when the respondent started the survey the questions required little thought and some were put at the end so that following the more thought provoking questions they would have an uncomplicated finish. In between there was a mix of questions that entailed thought and others which were factual yes or no answers. A table clarifying how the questions in the phase III questionnaire related to the conceptual framework (Figure 2.4) and Nicholson and West's (1988) transition model (Figure 2.3) is in appendix 1.

The final survey had a total of 31 questions; three about the organisation in which the respondent worked; seven demographic questions about the respondents; two about the organisations; 18 questions about the ward sisters' development; one free text question about the top challenges faced by ward sisters, and two about the transition to the ward sister role.

4.5.2 Ethics

As in Phase I, the ward sisters in my own and the three neighbouring acute provider trusts were excluded from the sample population in phase III. The survey in phase III (appendix 14) was resubmitted to the ethics committee via the chairman and was approved (ref 11/12.3.5.22).

Ensuring participants' confidentiality and protecting their identity is a major relationship concern between participant and researcher. The participants have to trust that the researcher has employed methods that will not allow their personal identity to be exposed; if this trust exists the participants in research are more likely to be truthful when answering questions, be that in an interview, focus group or responding to a questionnaire. This was an extremely important ethical issue and all participants' confidentiality was maintained in the four phases of the research because, in the main, the analysis of the data would be on a group basis rather than individualised; this was due to the use of questionnaires for the majority of the study. Where using individual quotes would add to the sense of the reporting, for instance in the focus group, I undertook not to use any identifiable information other than general descriptions.

Aligned to protecting participants' anonymity is ensuring that the data obtained from them is kept safe. To do this all data from the questionnaires were managed electronically on a password protected computer. Data Protection Registration for the researcher with the Information Commissioner's Office (ref Z3155825) was also obtained. These processes ensured the data received from the participants was held securely and lawfully.

It is possible to explore very sensitive issues with vulnerable people in social science research (Garner et al, 2009), but the research process used should always safeguard the participants. The sample population in all four phases of my study were educated professionals who were not perceived to be vulnerable, although it was understood that some may have felt vulnerable at work and/or at home. It was also recognised that although the subject of their development was not on the surface a sensitive subject, some of the participants may have had a complex transition to the role of ward sister and that the discussion may have brought back difficult memories. The risk of this could not be minimised but information was given to the participants

about where to get support if this was the case, and on the PIS details of the RCN counselling service were given; it is not known if anyone required these services.

4.5.3   Phase III pilot study, questionnaire to ward sisters

The purpose of phase III was to identify what preparation and support ward sisters had received and what had helped them in the transition to the role of ward sister. Once the questionnaire was developed and had received University ethics committee approval (ref 11/12.3.5.22) the questionnaire for phase III was piloted with a group of ward sisters from an NHS Trust in Kent. The Chief Nurse gave her consent to contacting the ward sisters to ask them to participate in the pilot. An invitation letter (appendix 15) was developed for the pilot participants; the Chief Nurse emailed the invitation letter to the ward sisters in the organisation and eight ward sisters agreed to participate. The pilot survey (appendix 16) was emailed to the eight ward sisters, six of whom completed the pilot survey (75 percent response rate). The questionnaire had five questions about the survey at the end seeking feedback about how the survey could be improved. The feedback questions are listed below:

- *How long did it take to complete the survey?*
- *Did you understand all the questions? If not, which ones need to be re-worded?*
- *Are there any questions that do not need to be included?*
- *Is there any aspect about preparation and support to be a ward sister that should be included that is not at the moment?*
- *Is there any other feedback you would like to give me about the questionnaire?*

The pilot respondents were able to complete the questionnaire in between 10 and 30 minutes with the majority (4) completing it in 10-15 minutes; five of the six respondents said all the questions were comprehensible and one did not answer this question.

4.5.3.1 Changes to phase III questionnaire in response to the pilot

The feedback from the pilot survey was very helpful and once the respondents' views were analysed the questionnaire was changed in the following ways:

One respondent said the questions about having a coach should have the word 'supervisor' added; I agreed this was a more nurse orientated word therefore 'supervisor' or 'supervision' were added to questions 5, 6, 16, 18, and 20.

One respondent said in question 23 there should be an option to have 'not yet reached' stabilisation; it was therefore made clearer in the question that the respondents could say that they had not reached stabilisation if that is how they felt.

One respondent highlighted that diploma level education was not included in question 27 so this was added, as was advanced diploma.

Two respondents said there should be a question about preparation at band 6; as this was the subject of question 5, and there was no reference to band 6 nurses in the question as drafted, a suitable amendment was made to clarify the point.

Question 24 was also added so respondents had the option to include some free text to express what would have helped them. This was added at the end of the survey so they would have read all the options beforehand, and the response would therefore act as a summary.

One respondent said that questions 20 and 21 were unnecessary as they thought no nurse would pay for a coach, however the questions remained in so the results could be compared to the middle manager research results, from which this questionnaire was adapted.

4.5.4   Implementing phase III, questionnaire to ward sisters

The purpose of phase III was to examine the ward sisters' perspective of their transition to the ward sister role. It was necessary to access a national sample of ward sisters and to do this I wrote to the Directors of Nursing requesting access to their ward sisters. Of the 139 Directors of Nursing that I had written to in the previous year, four had asked to be excluded from the survey; 11 had answered the survey but did not give consent to the ward sisters participating in phase III, and 20 had answered the Director of Nursing survey and already given consent for their ward sisters to be approached. I wrote to these 20 individuals again to confirm their agreement. Therefore a total of 123 Directors of Nursing were contacted for permission to invite their ward sisters to participate in the questionnaire (see Figure 4.2).

The Directors of Nursing were written to individually on 17 and 18 July 2013 and 50 (41 percent), including the 20 who had previously consented, agreed that their ward sisters could be invited. The invitation letter (appendix 17) was sent to the Directors of Nursing and they were asked to forward it to their staff. It is interesting to note that a higher percentage of directors gave consent for the ward sisters to participate in phase III than they themselves participated in phase I. Due to the snowball sampling method, sample size calculations were not possible. There were no responses from ward sisters in 10 of the 50 organisations, despite the Directors of Nursing having confirmed that the invitation had been sent to them. It is not known how many ward sisters were invited in total by the 40 directors, but 228 ward sisters responded saying they would be willing to participate, and 174 completed a questionnaire, which gave a response rate of those who agreed to participate of 76.3 percent. The responses ranged from $1 - 13$ per organisation, with a mean average of 4.45 per trust. The responses were submitted between 29 July 2013 and 14 January 2014. The survey was closed on 18 January 2014 and the results were

downloaded from Survey Monkey (Survey Monkey Inc) to SPSS (SPSS, IBM) format on the same day.

Figure 4.2   Respondents in phases I and III
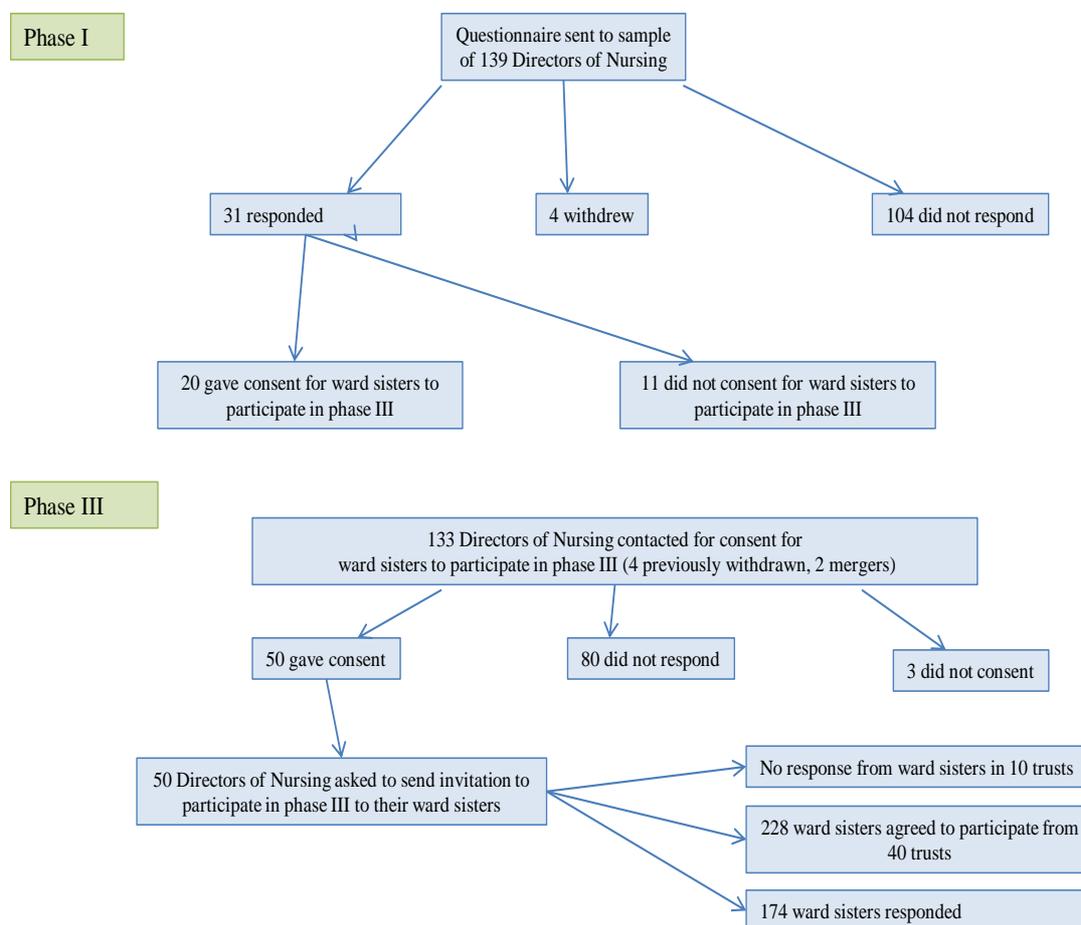
4.6   Data analysis strategy

It is important to have a data analysis strategy which facilitates a robust approach to understanding the data and interpretation of what the data means. This study employed a mixed method research approach that involved both qualitative and quantitative data collection and analysis, therefore different techniques were used to manage both types of data and later on to triangulate the findings. The data analysis strategy is explained below.

The surveys used in phase I and III collected both quantitative and qualitative data, the quantitative data analysis will be described first. The first step once the raw data were transferred from Survey Monkey to SPSS (SPSS, IBM) was to review the data and clean it. All of the results were calculated into frequencies and the codes checked to ensure accuracy and completeness,

where necessary missed data were coded so that it would be excluded from calculations. In phases I and IV, although not every respondent answered 100 percent of the questions all the data were included in the analysis. This however was not the case with the participants in phase III; it was found that one respondent had submitted the response but had not answered any of the questions, therefore this one participant was deleted from the data set. Once this review had taken place it was clear that either because

i). the question had asked for a numerical response rather than giving a choice, for instance *How long have you been in your current role*? The data were collated and coded into categories for ease of use, or

ii). Because there were too many answer options to make statistical testing viable, for instance *there were 10 options for geographical location*, the categories were amalgamated and recoded into different categories to make four regional areas.

It is recognised that by moving the raw data into different groups as described above it is likely to make it more manageable however it has been manipulated and therefore influenced by the researcher (Denscombe, 2007). When the data were changed from the raw state the researcher kept this to a minimum and endeavoured to collate the data into categories that would keep the sense of the data, an example of this is merging the North West, North East and Yorkshire and Humber regions to make the *North* region.

Following this data cleanse the quantitative data in the surveys were analysed by descriptive statistics or the chi square test using SPSS version 20 (SPSS, IBM). All of the chi square test, regression equations and independent t-tests assumptions were checked and satisfied. On the occasions where the chi square tests did not meet the criteria, for example more than 20% of the cells had an expected count of less than 5 and/or the minimum expected count was less than 1 the data were re-calculated using the Fisher's test in a 2 x 2 matrix; any statistically significant findings were then reported using Fisher's *p*. Generally the answers to demographic questions in both surveys were analysed using frequencies and answers illustrated using basic tables and charts for ease of reference. The remaining data were explained using chi square test results to investigate if there were relationships between opportunities for preparation and development offered in

- larger or smaller organisations
- NHS trusts or NHS Foundation Trusts and
- different geographical locations;

In phase III chi square statistical testing was also used to see if there were relationships between how the ward sisters responded and

·   their gender,

·   their highest educational attainment, and

·   how long they had been in their current ward sister post.

Qualitative data were collected in the surveys in phases I and III and in the focus group in phase II. All the qualitative data were analysed in the same way. There are a number of different strategies for analysing qualitative data which were considered, two being *constant comparative analysis*, this method is used mainly in grounded theory research and *phenomenological analysis* my own study did not investigate the lived experience of ward sisters so both of these techniques were discounted. A general inductive approach was therefore used, this is described by Thomas (2006:238) as a 'systematic procedure for analysing qualitative data'. In the surveys the qualitative analysis centred on the *challenges ward sisters face* and *what types of preparation and development would have supported them in becoming ward sisters*, there were also a number of more minor qualitative answers which were analysed in the same way. The data from the focus groups were analysed using the same strategy described below.

Thomas (2006) suggested that the analysis of qualitative data may occur within a framework, in my own study the conceptual framework (Figure 2.4) was used to help structure the analysis. The first stage in the qualitative analysis was to review the data and become familiar with it, this was achieved by extracting the text from the collection tools and reading it repeatedly. Once conversant with the text I started to code the data into categories. It is possible to code the same text into different categories, however this was not done in my own analysis. Once all the data were coded they were reviewed on five further occasions at different times, this allowed a more objective view of the coding and facilitated changes within categories until a final dataset was confirmed. It is usual to have two or more coders to review the data (Thomas, 2006), unfortunately due to time and resources this was not the case in my own study, however the multiple revisions of the data mitigated to a certain extent the limitation of having one analyst only.

4.6.1   Triangulation

Once the data from each of the four phases of the study were analysed the process of triangulation of the findings took place. Yeasmin and Rahman (2012) explain that triangulation is a method of verification that improves the validity of the data. Triangulation is when data from more than one data source or from more than one researcher is reviewed and compared with three possible outcomes. These outcomes are i) the results are similar and therefore are supported, ii) the data neither converge nor oppose the other data set(s) and iii) the data are

found to be contradictory (Yeasmin and Rahman 2012). Because my own study employed a mixed method research approach the process of triangulation included both qualitative and quantitative data. The findings of the triangulation are described in the findings chapter (5).

The triangulation strategy for the data in my own study was to compare

- Phase I with Phase III (p 144)
- Phase II with Phase III (p 149)
- Phase IV with phase III (p 151) and
- Phase IV with phase II (p. 114).

4.7   Phase IV: Ward sister focus group and questionnaire to ward sisters

4.7.1   The focus group

The focus group in phase IV of my own study was conducted in exactly the same manner as in phase II, described above. The purpose of this second focus group was to gain an assessment of the ward sister role in 2014, two years on from the initial focus group. Phase IV used a convenience sample of ward sisters from one NHS Trust only, the organisation was chosen as the Director of Nursing had shown interest in the research findings and wanted to develop a programme for the ward sisters. One organisation only was chosen to participate in phase IV for a number of reasons i) due to time constraints of the study, ii) it is very difficult to access ward sisters and ask them to have time off the ward as they are so busy, it was essential to work with a supportive Director of Nursing and iii) it was thought that the information gained from one group of ward sisters would fulfil the purpose of this phase of the study.

The participants for the focus group were ward sisters who had participated in the first part of an in house ward sister development programme. The Director of Nursing invited the ward sisters and eight replied that they would attend. On the day only six participated in the focus group, two did not attend because of work pressures. The focus group took place in a meeting room in the hospital and was audio recorded, and, notes of the meeting were written up on the same day (appendix 18) as the event and were compared with the RCN (2009) findings in the same way in which the first focus group was. These were later sent to the participants, who all agreed they were a true record of the discussion.

4.7.2   The questionnaire

The questionnaire used in phase III was sent to the population of ward sisters in the NHS Trust participating in phase IV. The sample was identified by the Director of Nursing, who asked that the ward sisters were treated as two cohorts because of their participation in the ward sister

development programme. Exactly the same procedure was used as in phase III, 27 questionnaires were sent on 10 August 2014, reminders to those who had not responded were emailed on 25 August and 4 September 2014; the second cohort of 18 questionnaires were sent on 4 September 2014, reminders to those who had not responded were sent on 21 September and 12 October 2014 and the survey was closed on 25 October 2014. The data were transferred from Survey Monkey (Survey Monkey Inc) to SPSS (SPSS, IBM) format on 25 October 2014.

4.8   Summary

This chapter described how the research design was implemented, demonstrating how the mixed methods of surveys and focus groups were used in both developmental and complementary ways (Greene et al, 1989). The survey in phase I was used to assess what preparation and support ward sisters were given across the country, the focus group in phase II offered a view on what the ward sister role involved and the information helped develop the survey in phase III. Triangulation of data from different sources is a positive aspect of a mixed methods research approach by having four phases in this study and therefore four sets of data the findings were strengthened by comparing one data set to another. The survey to ward sisters in phase III offered a unique view on professional development to support nurses in the ward sister role and this data was triangulated with both the data from the phases I and IV surveys and from the focus groups in phase II and IV.

FINDINGS

5.1   Introduction

The purpose of this study was to identify what preparation and support helps nurses in the transition to the ward sister role. The research questions were:

· What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
· What preparation and support helps nurses manage the transition to the ward sister role?

To answer these questions four phases of investigation were used and this chapter will describe the information provided from the data analysis of these phases of my own study as follows:

Phase I – Questionnaire to Directors of Nursing

Phase II – Focus Group of ward sisters

Phase III – Questionnaire to ward sisters

Phase IV – Focus Group and questionnaire to ward sisters in one NHS Trust.

The information from phase I will highlight the current preparation and support offered to nurses who want to be and who are ward sisters. The results of the focus groups, in phases II and IV will be compared with the results of the RCN (2009) report, and the findings from the questionnaire to ward sisters in phase III will highlight what preparation and support they have found to be helpful, what their current developmental needs are and the challenges nurses in ward sister roles face. Finally the data from the questionnaire in phase IV will serve to validate the information in phase III. The findings were triangulated, related to the four stages of the Nicholson and West (1988) transition model and presented in this chapter in the following way:

· Phase I

· Phase II

· Phase III

· Significant findings

· Phase IV

· Comparison to Middle Manager research results

· Summary

5.2   Phase I: Questionnaire to directors of nursing

5.2.1   Introduction

The purpose of phase I of my own study was to investigate what methods were used to help prepare nurses for the role of ward sister and what support was offered to ward sisters in England during the study period. To find this out it was thought that Directors of Nursing were the best people to ask about this as they are the people in NHS provider organisations who are responsible for nurses' professional development. For the purpose of my own study, Directors of Nursing were defined as the nurses who are executive members of NHS acute provider boards (such posts also exist in commissioning organisations) and are responsible for the quality of nursing care in these organisations (Burdett Trust, 2006).

A 15 question survey (appendix 2) was emailed to 139 Directors of Nursing; the final response rate was 22 percent (n=31). The results may also include bias, as the non-respondents may have answered in a different way to those who did (Bowling, 2005). A desirable response rate is noted by Johnson (2002) to be at least 60 percent, however Denscombe (2010) stated that it is more effective to review the responses in terms of

    i)   whether the response rate mirrors that of similar surveys;

    ii)   whether action was taken to reduce the non-response bias, and

    iii) whether the non-respondents differ significantly from the respondents.

Having posed this set of questions to my own study, it was found that there was no reason to believe that there was a material difference between the demographics of the Directors of Nursing who responded and those who did not. The late responses were compared to those received earlier in the process and there were no major differences found between the answers. Comparing early and late responses was proposed by Lindner et al (2001) as an action that should be taken when there is a low response rate, to ascertain whether or not there is any discernible difference between them. Lindner et al (2001) go on to state that if the responses are similar the results can be generalised across the population.

Reasonable action to increase the response rate (which included two emailed reminders both with links to the survey for ease of access) was taken. It was therefore determined that the results should be used, despite the low response rate, understanding that the findings gave a stakeholder view rather than a complete national picture. This view was supported by Johnson's (2002) assertion that if a survey's non responders are not significantly different, to the responders the researcher can continue with care. It was difficult to test how representative the small number of respondents was to the sample, however a comparison of the respondents' organisations' size

(using number of beds) to the nationally held dataset of bed numbers was done in 2016. The results are shown in Table 5.1 and it can be seen that although not exactly the same the percentages are similar, however there were disproportionately more respondents to the survey from larger organisations and fewer respondents from smaller organisations. When the categories were changed to 'more than 600 beds' and 'less than 600 beds' it can be seen that the respondents are more representative of the sample. It should be noted that there were fewer organisations in 2016 due to organisational mergers that occurred between 2013 and 2016.

Table 5.1 NHS Trust organisational size 2016

Number of beds	Organisational size in 2016. Percentage and number	Organisational size of respondents in phase I. Percentage and number
>800	38% (n=50)	42% (n=13)
600-799	24% (n=32)	16% (n=5)
400-599	28% (n=37)	23% (n=7)
<400	10% (n=13)	19% (n=6)
>600	62% (n=82)	58% (n=18)
<600	38% (n=50)	42% (n=13)

Nevertheless, the response rate was very disappointing. Potential reasons for this low response rate might include,

· Directors of Nursing are extremely busy people;

· the invitation to participate was not individualised;

· the potential respondents lacked interest in this research, or could not see its relevance to them;

· there is a high turnover rate amongst this group of staff and if a Director of Nursing was due to leave their post or were new to the organisation they may have thought they did not have anything to contribute

· the emails were not read, as Directors of Nursing generally receive huge volumes of emails

· the potential respondents were on holiday or otherwise absent from the office when the emails were sent.

A recently published study commissioned by NHS England from the RCN (Seers et al, 2015) collected data from Directors of Nursing from all NHS trusts in England. An online survey was

sent to 234 Directors of Nursing and 63 responded resulting in a 27 percent response rate. Although the response rate is slightly more than that of my own study the response rate is low, which may mean that this group of nurses is hard to engage in research.

There have been studies investigating response rates and how to increase them, Cycyota and Harrison (2006) found, by employing a meta-analysis of managerial research studies, that response rates from executives are lower than those amongst other populations. This is supported by Baruch and Holtom (2008) who found that executives responding on behalf of organisations rather than employees who reply on their own behalf, are much less likely to respond. Baruch and Holtom (2008) found that there was a significant difference ($p=<.001$) between the average response rate from executives (35.7 percent) and from individuals (52.7 percent). Baruch and Holtom (2008) put forward two reasons for this low response rate: i) the survey did not always reach the intended sample and ii) the research was not of interest to everyone in the sample. Although it is recognised that researchers find their own study to be of more significance than others (Baruch and Holtom, 2008), it is difficult to imagine that Directors of Nursing felt they did not find my own study potentially useful, as the results may have a direct impact on an aspect of the Director of Nursing role. However, the responses from the Directors of Nursing gave a unique and current national view of the preparation and support to nurses becoming ward sisters in England.

5.2.2 Demographics

The demographics of the respondents to the Director of Nursing questionnaire are set out below. The total sample (n=139) was 93 percent female, however out of the 31 that responded 97 percent were female. Due to the way in which Directors of Nursing are coded in the national electronic staff record it was impossible to benchmark this demographic to the national figure.

The respondents were asked to say which Strategic Health Authority area they worked in, the results are shown in table 5.2. Most respondents worked in the South West, followed by London and then the West Midlands; the geographical area that had the least responders was the North East; it is impossible to know why this was but it should be noted that the North East was the area with the highest percentage of NHS Foundation Trusts in the country.

Table 5.2 Geographical location of Directors of Nursing

Strategic Health Authority Region		Frequency	Valid Percent	Cumulative Percent
	East Midlands	2	6.5	6.5
	East of England	3	9.7	16.1
	London	5	16.1	32.3
	North East	1	3.2	35.5
	North West	3	9.7	45.2
	South Central	2	6.5	51.6
	South East Coast	3	9.7	61.3
	South West	6	19.4	80.6
	West Midlands	4	12.9	93.5
	Yorkshire and the Humber	2	6.5	100.0
	Total	31	100.0	

5.2.3   The Organisation

Respondents were asked to state whether their organisation was a NHS Foundation Trust or not. One person did not answer this, however as can be seen clearly in Figure 5.1, two thirds (n=19) of Directors of Nursing who responded worked in NHS Foundation Trusts. NHS Foundation Trusts have greater operational and financial freedoms than NHS Trusts (House of Commons, 2014) and are not directly accountable to the Secretary of State for Health, but are instead regulated by an organisation called Monitor. It was thought that this should be a variable as the Directors of Nursing in these trusts may have used their freedom more broadly to develop their ward sisters.

Figure 5.1   Is the organisation a NHS Foundation Trust? (phase I)

Q3 **Is your organisation a Foundation Trust?**

Answered: 30   Skipped: 1
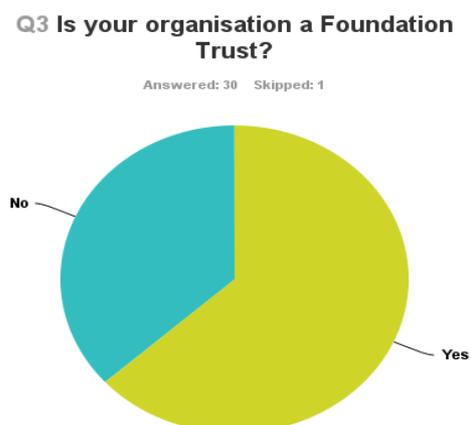
The Directors of Nursing were asked to report the size of their organisation in terms of the number of beds, rather than other variables such as monetary income or numbers of staff; this was because the focus of my study was on acute care rather than community care and some of these organisations would have also provided community care which would have increased their income and staff totals. As illustrated in Table 5.3, over 40 percent of organisations were reported to be very large with over 800 beds, the other three categories are fairly evenly spread between 16 and 23 percent each.

Table 5.3 Organisational size response from Directors of Nursing

Size of organisation (bed numbers)		Frequency	Valid Percent	Cumulative Percent
	<400	6	19.4	19.4
	400-599	7	22.6	41.9
	600-799	5	16.1	58.1
	>800	13	41.9	100.0
	Total	31	100.0	

5.2.3.1 Number of ward sisters

The Directors of Nursing stated the number of ward sisters their organisation employed; this number ranged from 3 to 200; despite the fact that a definition was given in the questionnaire to ensure clarity about the roles to include and exclude;

'*Ward sisters are defined as those who have 24 hour responsibility for a ward, they are usually band 7 and are primarily in charge of a ward. They may be called ward manager or charge nurse and includes both males and females. All ward sisters of acute medical, surgical and gynaecology wards only should be included. this study excludes paediatrics, critical care units (ICU, HDU), theatres, maternity and community care*'.

It is impossible to tell whether the Directors of Nursing made a mistake in reporting or misinterpreted the definition, as the numbers at either end of the range, (3 and 200) seem to be too few and too many respectively. The wide range of numbers reported gave a mean of 40 ward sisters per organisation whilst the median calculated to 26 per organisation. Whilst 26 would appear to be a more average number based upon my own experience, it should be remembered that 40 percent of respondents were from very large organisations and would therefore have a larger number of clinical areas.

5.2.3.2 Recruitment of ward sisters in organisations

The Directors of Nursing reported a range of total nursing and midwifery turnover rates in 2011 from 3 to 12 percent with the majority of organisations (n=6) reporting an 8 percent turnover (median, 9 percent).

Figure 5.2   Total nursing turnover in 2011
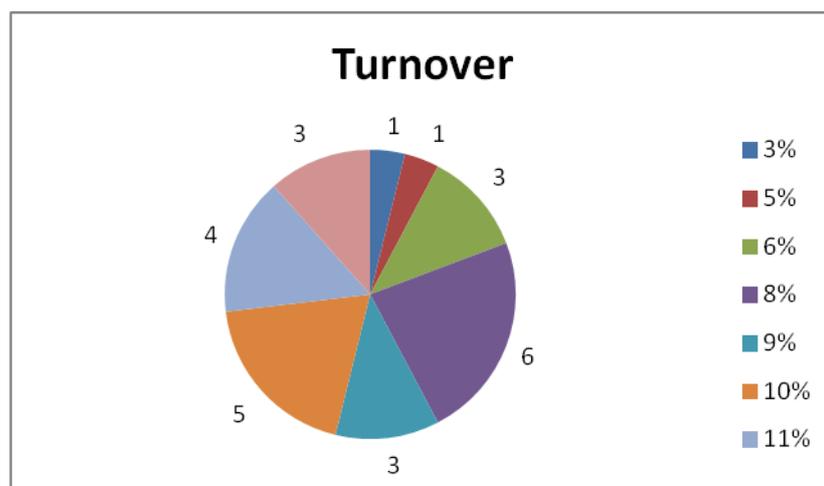
Twelve Directors of Nursing reported they had recruited two ward sisters during the previous year (2011), however there were some outliers: three Directors of Nursing had recruited to 11,

17 and 27 ward sister posts, which is a lot of activity in a year. Four Directors of Nursing had not recruited any ward sisters during the year, which demonstrated a level of stability in clinical leadership in those organisations. One reported that s/he did not know how many ward sisters the trust had recruited. This response is surprising in that it would be unusual for a Director of Nursing not to be aware of this figure, but it may be because the Director in question was new in post or had little direct influence on recruitment at this level. The high numbers (17 and 27) resulted in a mean average of recruiting four ward sisters in the year, whilst the median average was two.

Table 5.4 Number of ward sisters recruited in 2011

Sisters recruited	0	1	2	3	4	5	6	11	17	27
Number of Trusts	4	4	12	1	4	1	1	1	1	1

The Directors of Nursing were asked what methods they used to recruit ward sisters: as can be seen in Figure 5.3, 97 percent of organisations used an interview panel, 80 percent favoured presentations to the interview panel and some used supplementary methods, including practical tests and candidates' interaction with stakeholders.

Figure 5.3 Methods used to recruit ward sisters
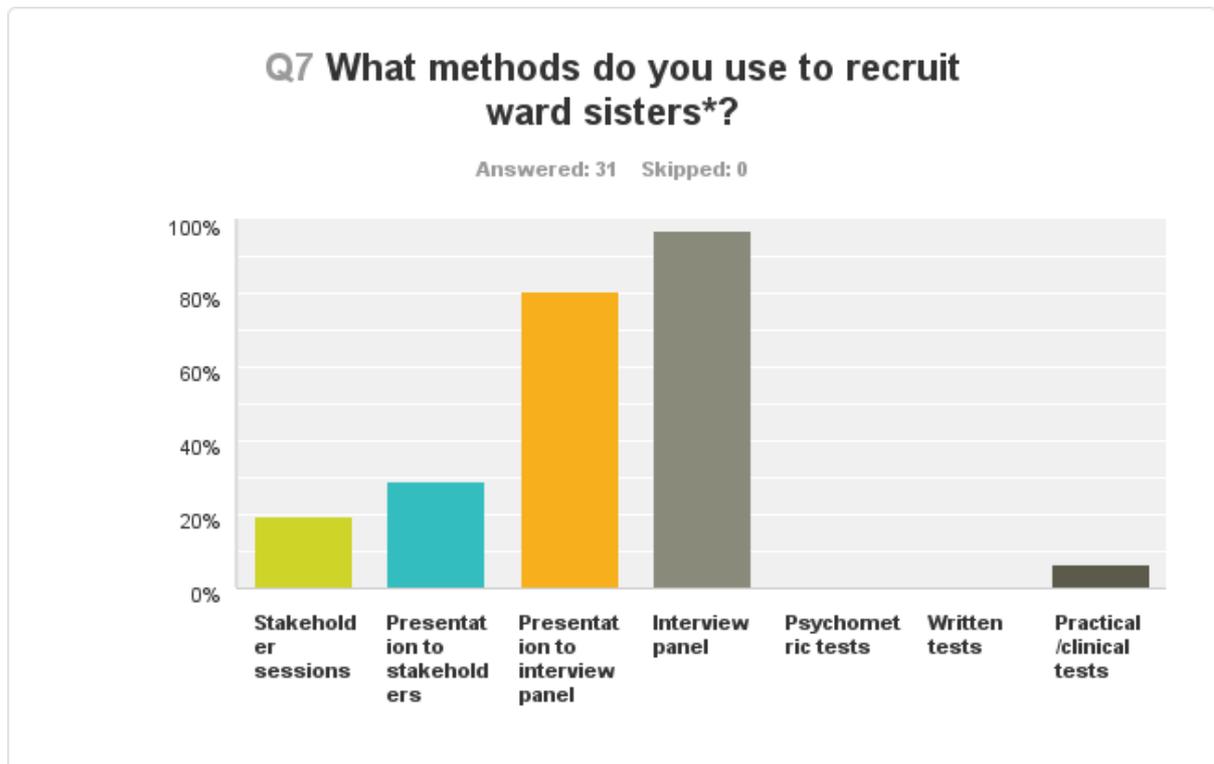
Directors of Nursing were asked to describe the essential criteria they required for nurses to be shortlisted to be ward sisters; the results are in Figure 5.4.

Figure 5.4 Essential criteria to become a ward sister
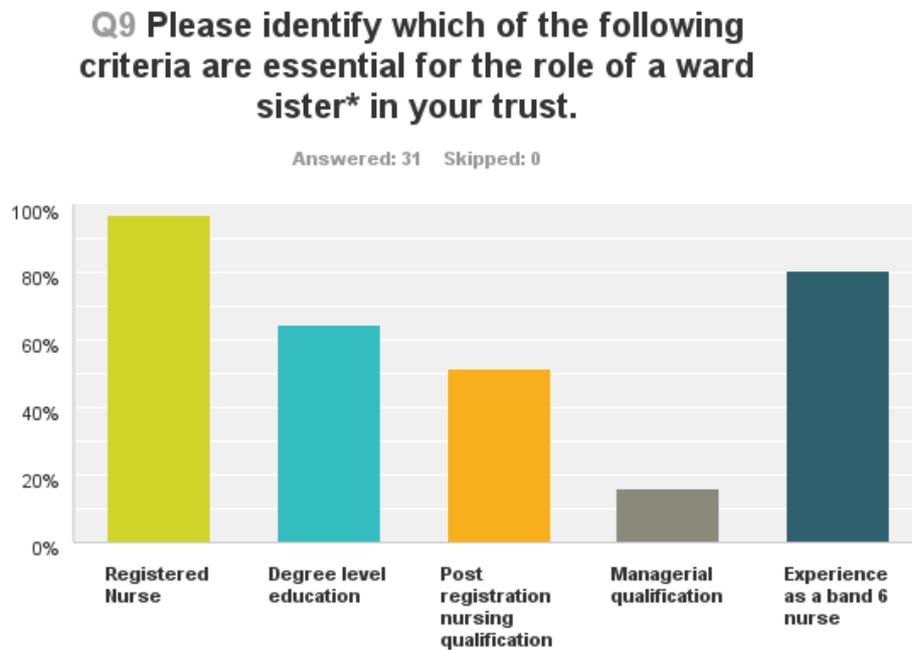
One Director of Nursing said that s/he would not expect a ward sister to be a registered nurse; this is unusual and may have been a mistake, although it is becoming more common for physiotherapists to manage clinical areas such as stroke units. The most common essential criteria after being a registered nurse was having experience at band 6 (senior staff nurse/junior sister level): 80.7 percent (n=25) of respondents identified this criterion. A degree was viewed as essential in 64.5 percent (n=20) trusts, a post registration qualification in 51.6 percent (n=16). Only five thought a managerial qualification to be essential.

Five respondents added the following essential ward sister criteria in their organisations; *evidence of advanced study, working towards a degree, speciality specific qualifications, minimum of three years' experience in a senior ward role* and *managerial experience*.

5.2.3.3 Preparation and support

The Directors of Nursing were asked to indicate what preparation they provided for nurses who aspire to be ward sisters and what support they offered for those nurses who are in their first year in a ward sister role.

Figure 5.5 Methods used to prepare nurses to become ward sisters

Q10 Does your trust offer any of the following methods in a systematic way to help nurses prepare for the ward sister* role?

Answered: 30   Skipped: 1
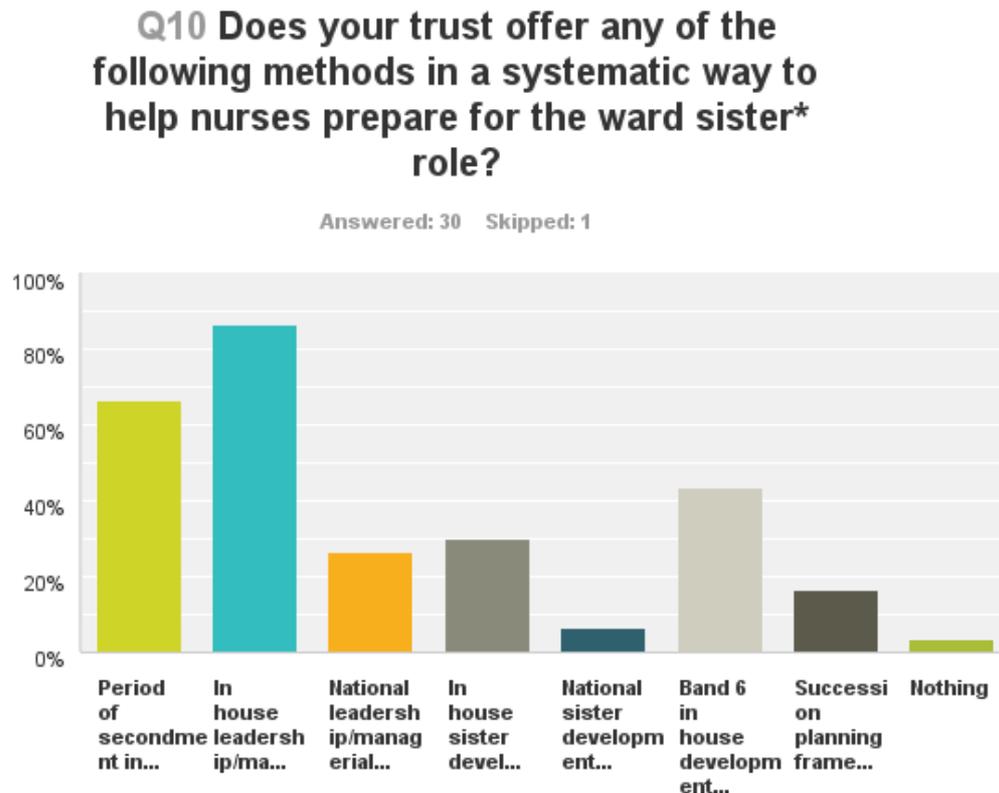
Figure 5.5 shows the preparation offered by 30 respondents. The two most popular ways to prepare nurses to become ward sisters were in house leadership/management courses which 86.7 percent of trusts (n=26) offered and a period of secondment to a ward sister role provided by 66.7 percent of trusts (n=20).

The results were statistically analysed using frequencies and it was found that there was no significant difference between the preparation offered to nurses in NHS Foundation Trusts and those who worked in NHS Trusts. There was one interesting difference which was that 72.7 percent of NHS Trusts offered periods of secondment whereas only 57.9 percent of NHS Foundation Trusts offered such secondment opportunities, however this was not statistically significant. This may have been because the NHS Foundation Trusts managed to fill vacancies faster and therefore there was no need to offer secondments, on the other hand the trusts that offered secondments may have encouraged deputy ward sisters to have the opportunity to be a ward sister on a temporary basis as part of an effective succession planning framework. There was a significant difference in the use of a succession planning framework to prepare nurses to become ward sisters. This approach was used more in trusts with 600 plus beds, and not used at all in smaller organisations. One respondent stated that his/her organisation did not use any of the methods to prepare nurses; this was an NHS Foundation Trust with fewer than 600 beds.

There were three additional comments: one Director of Nursing said that his/her trust *delivered a programme with a Higher Education institution*, one was *developing a programme*, and one had just commenced *a fast track programme*.

Having asked the Directors of Nursing what methods they used to help nurses prepare for ward sister posts, the questionnaire then asked them what support is provided for ward sisters in their first year. Figure 5.6 shows the results.

Figure 5.6   Methods used to support ward sisters in their first year

Q11 Does your trust offer any of the following to all new ward sisters* during the first year as a ward sister*?

Answered: 31   Skipped: 0
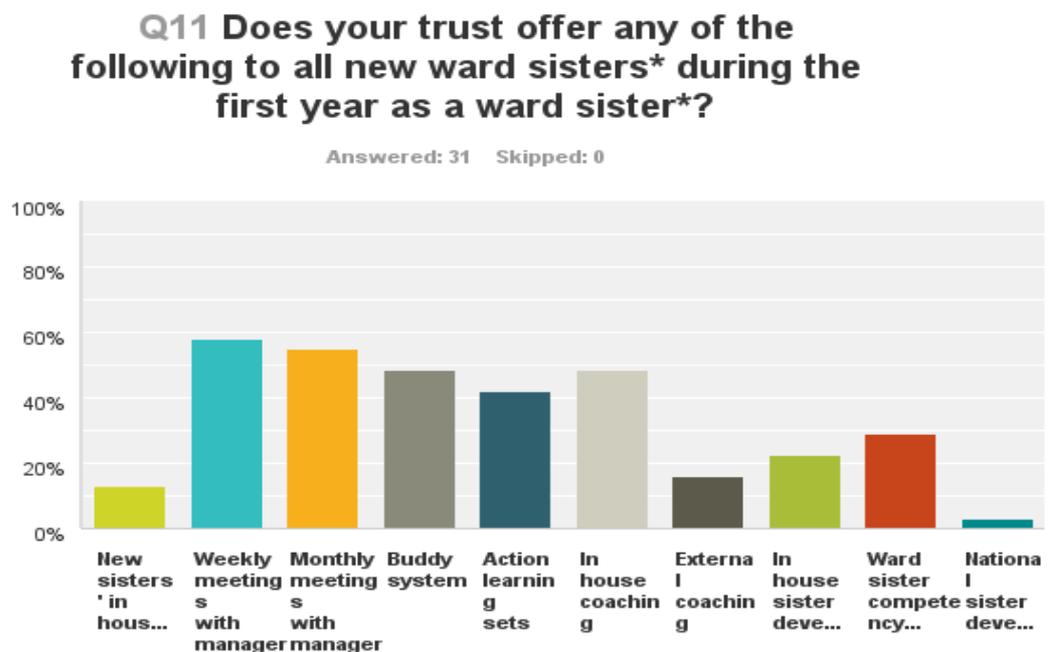
Figure 5.6 shows that weekly and monthly meetings with managers are the most often used method of support. This could be argued to be good managerial practice rather than development but good working relationships with managers has been shown in the literature to help new ward sisters and to improve their job satisfaction (Kath et al, 2012). Both buddy systems and in house coaching were reported as being used by 48.4 percent (n=15) of organisations, followed by action learning sets, established in 13 organisations. It is interesting to note that 26 organisations offered in house leadership courses to nurses before they became ward sisters but very few (n=7) offered in house development once they became ward sisters and only four trusts offered a bespoke development course aimed at new ward sisters.

When chi square statistical test was applied to the data there were no statistically significant differences between what was offered by NHS Foundation Trusts and NHS Trusts, or between large trusts (over 600 beds) to those with fewer than 600 beds. The biggest difference was in the offer of in-house coaching, which was reported to be available in 61 percent of large organisations, as opposed to 31 percent of smaller organisations and in 64 percent of NHS Foundation Trusts, against 37 percent of NHS Trusts. However neither of these results was statistically significant.

Five of the Directors of Nursing gave additional comments: one said there was an *informal buddy system in his/her organisation* and another said s/he was *developing one*. In one organisation the Director of Nursing said s/he had *quarterly meetings with the ward sisters*, and in another, a *ward sister programme had been developed with a Higher Education Institution*. One Director of Nursing reported that development was offered but was not mandatory.

The Directors of Nursing were asked to estimate how much money was spent on developing a new ward sister in his/her first year. Twenty-seven of the 31 responded, 19 of whom stated that less than £1000 was spent, seven reported a spend of £1000-5000, and one said £5000-10000. To put this into context, £400 is the approximate cost of a place on a ward sister national day conference, whilst £5,000-10,000 would pay for a national leadership course at a prestigious training organisation such as the King's Fund. There is no value judgement attached to these answers, but they do give a useful picture of the financial investment in these posts.

Supervisory status was a recommendation of the RCN's (2009) report, and of more recent reports including Francis (2013). Supervisory status means that the ward sister is not counted in the number of nurses giving clinical care on a shift but offers them the opportunity to work with their staff to supervise and develop nursing care in their area (RCN, 2011b). The Directors of Nursing were asked to what extent the ward sisters had supervisory status in their organisations.

Figure 5.7 Ward sister supervisory status

Q13 Do the ward sisters* in your organisation have supervisory status?

Answered: 31 Skipped: 0
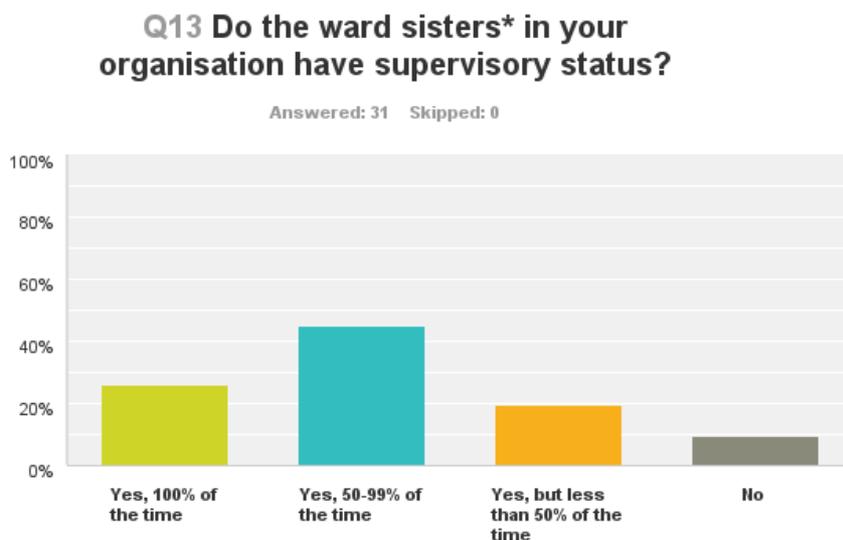
Ward sisters in eight trusts (26 percent) had supervisory status all of the time, most (n=14) had over 50 percent of their time designated as supervisory and three trusts (10 percent) had given their ward sisters no supervisory time.

The Directors of Nursing were offered the opportunity to give further comments about the ward sister role, five of them did so. One comment highlighted here was

> '*I think it is underestimated the enormity of this transition from nurses to a MD of a million pound company.*' - Director of Nursing, FT, Midlands

5.2.4   Challenges

The Directors of Nursing were asked to list the top three challenges for ward sisters in their first year. In total there were 93 comments;

The responses were analysed thematically primarily using the Nicholson and West (1988) transition cycle. However where responses did not reflect one of the four stages of the cycle secondary themes were used, originating from the conceptual framework (Figure 2.4), these themes were managing ward sisters' stress, leadership style, the ward sister role and competencies, and support. The total number of responses in each sub category was counted. The largest number of comments from the Directors of Nursing about the challenges ward sisters faced was about the *role itself* (36.6 percent, n=34), followed by *competencies* (32.2 percent, n=30), *managing ward sisters' stress* (17.2 percent, n=16) and *transition* (10.7 percent, n=10). *Support* and *leadership* had two and one comments respectively.

The majority of comments about the role focused on the responsibility for the quality of care (n=11, 11.8 percent); the text included the following observations

> '*Monitoring the quality standards of every shift*' - Director of Nursing, FT, North

> '*Improving quality in the tight financial environment*' - Director of Nursing, FT, North and

> '*Maintaining clinical standards through others*' - Director of Nursing, NHS Trust, Midlands

As demonstrated by the following statements, another aspect of the role highlighted by the Directors of Nursing was how nurses themselves understand the position of the ward sister

> '*Understanding the role & responsibilities*' - Director of Nursing, NHS Trust, London, and

> '*Recognising contribution to organisation's objectives*' - Director of Nursing, FT, South

Managing the budget was the competency that received the most comments (n=9, 9.7 percent). Within the perceived stress challenges, managing conflicting priorities was the top challenge with nine comments (9.7 percent), including:

> '*Balancing management & clinical role*' - Director of Nursing, NHS Trust, Midlands

> '*Balancing quality and finance*' - Director of Nursing, FT, North, and

> '*Too many priorities*' - Director of Nursing, NHS Trust, South

Ten (10.7 percent) of the challenges reported by the Directors of Nursing related to the transition itself, three citing 'the transition' as the key challenge and six the encounter phase of Nicholson and West's (1988) transition cycle illustrated by these comments:

> '*Stepping into their level of authority*' - Director of Nursing, FT, North

> '*Getting to know their teams strengths/weaknesses*' - Director of Nursing, NHS Trust, South, and

> '*The change from peer to leader and the ability to influence*' - Director of Nursing, FT, Midlands.

5.2.5   Summary

The findings from this phase of my own study cannot be accepted as representative of the population of Directors of Nursing however the data demonstrated variance across the country in relation to

i)   the pre-requisite criteria to become a ward sister (the exception being a registered nurse);

ii)   the preparation offered to aspiring ward sisters;

iii) the support given to nurses once in ward sister roles;

iv) the ward sisters' supervisory status.

It was also clear that there was no statistically significant difference between the development offered to employees in NHS Foundation Trusts and those in NHS Trusts, despite the NHS Foundation Trust's greater freedom to act or the size of the organisation; the lack of a consistent approach was evident across both these criteria. The Directors of Nursing identified many challenges that the ward sisters faced in their first year and focused particularly on having to deliver consistently high quality of care as the over-riding challenge.

5.3   Phase II: Ward sister focus group

The purpose of this qualitative phase of my own study was to gain an insight into the then current perceptions of ward sisters about their role, and compare them with the findings of the RCN (2009) study about the ward sister role. The focus group was repeated in phase IV to add to the information gained in the first focus group; results of both focus groups are described below. The Breaking Down Barriers (RCN, 2009) study was the largest published UK research study investigating the role of the ward sister since the 1980s. The RCN (2009) used a focus group method to gain the information about the ward sister role from ward sisters and more senior nurses.

5.3.1   Demographics of the participants in the focus group in phases II and IV

There were eight participants in the first focus group. One had retired and one worked in a private hospital; the remaining six worked in NHS acute hospitals, three in the East Midlands, one in South Central and one in West Midlands regions. It should be noted that there was a limited geographical spread of participants when compared with the samples of Directors of Nursing and ward sisters responding to the questionnaires in phases I and III, this was a result of the convenience sampling. The participants were all female. In the second focus group there were six participants who all worked in the same NHS Trust in the East Midlands and were all female.

Table 5.5 shows the participants' age distribution; most of them were aged between 30 and 39 in the first focus group and between 40 and 49 in the second.

Table 5.5   Age of focus groups' participants

Age range	30-39 years	40-49 years	50-59 years	>60 years
Frequency (2012) Phase II	5	2	0	1
Frequency (2014) Phase IV	1	3	2	0

Table 5.6 illustrates the number of years the participants had been registered nurses (RN).

Table 5.6   Years of RN experience of focus groups' participants

How many years been RN	<5	5-10	11-15	16-20	>20	Mean	Median
Frequency (2012) Phase II	0	3	2	2	1	14.5	14
Frequency (2014) Phase IV	1	1	2	0	2	16.6	13

The range of time the participants had been a ward sister was very comparable and the mean average only differs by one year between both groups. Table 5.7 gives details of how long the participants had been ward sisters, the tenure is remarkably similar.

Table 5.7   Years of ward sister experience of focus groups' participants

How many years been ward sister	<2	2-5	6-10	>10	Mean	Median
Frequency (2012)	2	4	1	1	5.8	3
Frequency (2014)	3	1	1	1	6.9	3

The proposed discussion focused on four issues, these were:

1. In its study 'Breaking down barriers' the RCN highlight the huge breadth of the ward sister role. I would like to explore what you think are the key skills, competencies and capabilities of ward sisters.

2. During the study the RCN found that there were certain pressures that the ward sisters experienced, what are the main pressures you face?

3. Most ward sisters in the RCN study said they had little education and training to prepare them for the role. Please put your hand up if you had no training or education that prepared you for the ward sister role. For those of you who had education and training, please tell the group what it was and how it helped you. The moderator will ask whether this training was funded by the employer or by themselves.

4. I would like to know when you look back to becoming a sister what do you think would have helped you manage the transition more effectively?

5.3.2 Skills and competencies

Using the data gained from the focus groups in its study the RCN (2009) described the ward sister role using five categories

- *Leader of people and care*
- *Manager of self and care environment*
- *Educator*
- *Nursing and clinical expert*
- *Researcher*

Within each of these aspects of the role there were descriptors of competencies which built a picture of the purpose of the role.

The responses from the ward sisters in my own focus groups were compared with the RCN (2009) study's findings listed above to investigate whether the situation had changed since 2009. The findings of the focus groups I conducted were also used in the development of the ward sisters' questionnaire used in phase III of this research.

When asked what the key skills and competencies of a ward sister were, the participants in my own focus groups talked freely about how they spent their time; the responses aligned well to the first three aspects identified by the RCN (2009) (Table 5.8). However there was little reference to being a nursing expert or researcher, in response to a supplementary question about whether the ward sisters thought their role incorporated research they unanimously said no explaining they did not have time to do so.

5.3.3 Pressure of the role

The second question prompted discussion about the pressures ward sisters faced in their role. The outcome can be summarised as:

- Time
- Prioritisation
- Working with other professionals outside of their team

- Lack of administrative support

- Support

Not having enough time and *time management* seemed to be an issue for most of the ward sisters in both focus groups; these issues were clearly linked to being able to prioritise what to do. *Prioritisation* was illustrated in a couple of ways; firstly by the conflict between whether ward sisters should spend their time clinically, or focus on administrative tasks. The ward sisters did not seem to have a productive way of working and appeared to allow their environment to control them. An example of this is demonstrated by a ward sister's comment that '*You are told to be visible and I want to be accessible, but it's another thing to do it*' (Ward Sister 1, 2012). Secondly they identified that other colleagues, including managers and Clinical Nurse Specialists, have different priorities to the ward sisters and the ward sisters had to accommodate these as well as manage what was happening in the clinical area.

Table 5.8   Role of ward sister responses in focus groups

RCN categories (2009)	Responses in focus group 2012	Responses in focus group 2014
Leader of people and care	*Leader* *Role is about nursing staff and managing them* *Performance management* *Know staff* *Deal with difficult people/stress/conflict* *Role model* *Confidence*	*Communication* *It is about succession planning* *Approachability*
Manager of self and care environment	*Sickness management* *HR policies* *Finances* *Workload and staffing* *Fairness* *Consistent* *Delegation*	*Time management* *Administration* *Approachability* *Delegation*
Educator	*Mentor* *Staff development* *Nursing policy awareness*	*Knowledge* *A good leader is someone who can nurture.* *Sisters should be Imparting their knowledge*
Nursing and clinical expert	*Sets ethos of the ward*	*Expertise*
Researcher	*Auditor*	*Don't think there's a lot of time for that*

The ward sisters in the first focus group talked about working with other professionals who came into their wards, particularly citing doctors; one said '*We're told to police the medics*' (Ward Sister 2, 2012) and she explained that this put extra pressure on the ward sister as she had to supervise her own team and supervise doctors as well. It was noted that the ward sisters had no managerial control over the doctors. This was not raised as an issue in the second focus group.

One concern reported in the RCN (2009) study was the lack of administrative support for ward sisters and this was reflected in both of my own focus groups. One ward sister explained '*It is a waste of my clinical skills doing admin*' (ward sister 3, 2012) another viewed it as '*an inevitable part of our job*' (Ward Sister 1, 2014). A number of the ward sisters had some administrative support but they thought it was inadequate.

There was no discussion about where they got support from, but a couple of the ward sisters alluded to lack of support when they said '*It's the organisation's ward when things are going well, and it's your ward when it's not*' (Ward Sister 4, 2012); this was echoed in the second focus group when the level of accountability was being discussed '[*we have a*] *certain amount of responsibility but certain things are out of our control, but we still get the blame if something happens*' (Ward Sister 2, 2014). Another said that if she told her manager about an issue, rather than getting help the manager would compare her to another ward sister with different issues, and this resulted in the ward sister feeling that she was the problem.

5.3.4   Preparation for the role

The third question asked the focus group participants about the preparation they had received before becoming ward sisters. One ward sister said 'You've got to train on the job' (Ward Sister 3, 2014). None of the ward sisters in the first focus group had any preparation for the role before they became ward sisters, however a number of them were able to report what support they received once in the post. The ward sisters in the second focus group reported that they had received some preparation and were clear that this included experience they gained in their previous roles. The ward sisters in the first group explained that they had received some support including having a mentor and regular meetings with their manager. The ward sister who worked in a mental health setting reported the most support: weekly supervision, feedback about her performance and she had a mentor. A number of the ward sisters in both groups gave details of courses that they had been on, including a first line management course, the leadership module of a degree programme, and learning about managing a budget, however the ward sisters highlighted that these were not specific to being a ward sister, and that there were no structured

development programmes for ward sisters. Only one reported that she had completed the RCN leadership course, but this was when she was established in her role rather than as she started.

5.3.5   The preparation and support that would have helped

The final discussion point was about what preparation and support would have helped the nurses prepare for and transition into the ward sister role. This prompted a lot of discussion, the key conclusions of which were that:

- *Participating in a personally defined in-house course*

- *Meeting peers*

- *Having an allocated support, to help reflect on behaviour, decision making and prioritisation*

- *Having time with the ward team and*

- *Having time to work clinically*

would have been very helpful.

5.3.6   Summary

The information from both focus groups supported the RCN (2009) findings in many ways, including identification of the key aspects of the role and describing a similar picture of lack of preparation and lack of support. This is interesting because it should be remembered that my own focus groups had a different purpose to those of the RCN; those in my study were to identify changes in the ward sister role since 2009, the RCN's study (2009) was to identify what the ward sister role entailed; the RCN (2009) study also had more participants, which may have affected the findings. It should be noted that the main differences between what was reported by the RCN in 2009 and by the ward sisters in my own focus groups were the prevailing view that research is not a main part of the ward sister's role, and the current absence of evidence to support ward sisters identifying themselves as clinical experts.

5.4   Phase III: Questionnaire to ward sisters

The purpose of phase III was to examine what preparation and support ward sisters had received and what had helped them in the transition to the role of ward sister. The method used to do this was a questionnaire, sent to a sample of 228 ward sisters. One hundred and seventy-four responded, giving a response rate of 76.3 percent, however one respondent submitted a response but did not answer any of the questions. The response with no answers was therefore removed, which gave a revised response rate of 75.9 percent. The response rate was calculated from the number of ward sisters who contacted the researcher to agree to participating and the number

who finally completed a questionnaire. The actual response rate is not known as the number of ward sisters that the Directors of Nursing sent the invitation to was not identified.

The statistically significant differences between variables identified have been noted below and will be summarised towards the end of the chapter; a significant finding may lead a researcher to believe that a similar finding would be discovered in future comparable populations (Rowntree, 2004). It should also be remembered when reading the findings that chi square test determined relationships rather than cause and effect.

5.4.1 Demographic summary of the respondents

The ward sisters were asked to state whether they worked in a NHS Foundation Trust; 53.8 percent did. There is a more equal distribution between the ward sisters who worked in NHS Foundation Trusts and those who did not, compared with the Directors of Nursing, of whom 63.3 percent worked in NHS Foundation Trusts.

Figure 5.8   Is the organisation a NHS Foundation Trust? (phase III)

Q2 Is the organisation a Foundation Trust
Answered: 173   Skipped: 1
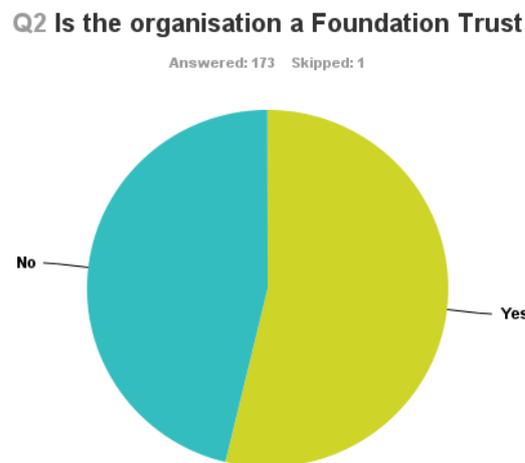
The ward sisters (n=169) were asked about the size of the organisation; 47.3 percent worked in large organisations with more than 800 beds; which is slightly more than the 41.9 percent of Directors of Nursing who worked in large organisations, as presented earlier in this chapter.

Table 5.9 Organisational size response from ward sisters

Size of organisation Number of beds		Frequency	Valid Percent	Cumulative Percent
Valid	0-400	15	8.9	8.9
	401-799	74	43.8	52.7
	>800	80	47.3	100.0
	Total	169	100.0	
Missing	System	4		
Total		173		

The respondents were asked to say which Strategic Health Authority area they worked in; the results (n=172) are shown in Table 5.10. Most respondents worked in the South Central region (20.3 percent), followed by London, the West Midlands and East of England. South East Coast region is the area represented by the fewest respondents, but that may be due to the fact that several trusts in the region were excluded from the study as they were neighbour organisations of the researcher's employer, and it was thought that their exclusion would reduce bias, as the researcher was known to them. Table 5.10 shows the spread of location; it appears to be a more even geographical distribution than amongst the Directors of Nursing but this may be due to the larger number of respondents.

Table 5.10 Geographical location of ward sisters

Strategic Health Authority Region		Frequency	Valid Percent	Cumulative Percent
Valid	East Midlands	13	7.6	7.6
	East of England	20	11.6	19.2
	London	21	12.2	31.4
	North East	14	8.1	39.5
	North West	15	8.7	48.3
	South Central	35	20.3	68.6
	South East Coast	8	4.7	73.3
	South West	17	9.9	83.1
	West Midlands	20	11.6	94.8
	Yorkshire and Humber	9	5.2	100.0
	Total	172	100.0	
Missing	System	1		
Total		173		

The ward sisters were asked demographic details about themselves and their career. The cohort was 90 percent female (n=172), which reflected the national position of ward sisters in England 89 percent of whom are female (NHS Electronic Staff Record, 2014).

The ward sisters were asked to identify their age range; as can be seen in the table below, almost half were aged between 40 and 49. The age groups recorded nationally are 25-34 (9 percent), 35-44 (31 percent), 45-54 (43 percent) and older than 55 (17 percent) (NHS Electronic Staff Record, 2014). Although the national age profile of ward sisters is collected in different categories the ratios were very similar to the age range of my own sample (NHS Electronic Staff Record, 2014).

Table 5.11   Age range of ward sisters in phase III

Age range		Frequency	Valid Percent	Cumulative Percent
Valid	21-29	9	5.2	5.2
	30-39	50	28.9	34.1
	40-49	84	48.6	82.7
	50-59	29	16.8	99.4
	60 or older	1	.6	100.0
	Total	173	100.0	

When asked about their highest level of educational attainment, 61.7 percent of respondents reported that they had a Bachelors or a Masters degree. It is not surprising that the number is not higher, as it is only since 2013 that nursing has become a degree prepared profession, and therefore it is likely that a significant level of self-funding (in terms of time and/or money) would be necessary to achieve a degree level education.

Table 5.12   Highest educational attainment by ward sisters in phase III

Level of education		Frequency	Valid Percent	Cumulative Percent
Valid	Certificate of Higher Education	9	5.4	5.4
	Diploma	43	25.7	31.1
	Advanced Diploma	12	7.2	38.3
	Bachelor degree	91	54.5	92.8
	Masters degree	12	7.2	100.0
	Total	167	100.0	
Missing	System	6		
Total		173		

The ward sisters were asked how long they had been a Registered Nurse (RN) and how long they had been in their current ward sister post. The ward sisters (n=173) reported that they had been RNs on average for 17 years (mean) (median average was 18 years); the range of experience was 3-40 years. Table 5.13 shows how long the ward sisters (n=169) had been in post. There is a

good range of experience, with 48.5 percent being in their positions for less than three years, and 14.2 percent for over 10 years.

Table 5.13 Number of years in current post

Number of years to stabilisation phase of transition cycle		Frequency	Valid Percent	Cumulative Percent
Valid	Less than one year	23	13.6	13.6
	1-2 years	30	17.8	31.4
	2-3 years	29	17.2	48.5
	3-4 years	18	10.7	59.2
	4-5 years	17	10.1	69.2
	5-10 years	28	16.6	85.8
	over 10 years	24	14.2	100.0
	Total	169	100.0	
Missing	System	4		
Total		173		

The ward sisters were asked to estimate how long it had taken them to reach the stabilisation phase as described in the Nicholson and West's (1988) transition model. A brief description of the stabilisation phase was given, explaining that it is when the new job becomes routine and established. When analysing the answers it was noted that the majority of respondents had either stated as an exact number of years or had said they had not yet reached stabilisation, however another group indicated that they did not think they would ever reach this stage as the job and priorities kept changing. This group was categorised under the 'change' title. Nicholson and West (1988) described transition as a cycle so that when one reaches stabilisation the transition cycle starts again at a different level; it is likely that this is what this particular group of ward sisters described – a continuous cycle of learning. The results in Table 5.14 demonstrated that over half (51.9 percent) of the ward sisters perceived that they reached the stabilisation stage in less than two years, with 13 percent of the remaining ward sisters having stated it took longer than two years. Almost a quarter of the respondents (23.5 percent) felt they had not reached that stage yet and 11.7 percent stated that they did not think they would ever reach that stage as the job as the environment in which they worked was constantly changing.

Table 5.14   Number of years as a ward sister before achieving stabilisation

Number of years		Frequency	Valid Percent	Cumulative Percent
Valid	<1	43	26.5	26.5
	1-2	41	25.3	51.9
	2-8	21	13.0	64.8
	change	19	11.7	76.5
	Not yet	38	23.5	100.0
	Total	162	100.0	
Missing	0	11		
Total		173		

5.4.2   Organisational culture

The sisters were asked a range of questions about how they were prepared and supported for the role of ward sister, what their challenges were and what their development needs were. As described above the answers were tested statistically using chi square test with the following variables; size of organisation, whether it was a NHS Foundation Trust or not, geographical location, their gender, their highest educational attainment, and how long they had been in their current ward sister post.

The ward sisters were asked a number of general questions about how the organisation supports their professional development. The overall results are illustrated in Table 5.15.

Table 5.15   Organisational support for development

Statement	Total number	Strongly agree	Agree	Disagree	Strongly disagree
In my organisation sufficient time is allocated to MY learning and development	173	17 (9.8%)	91 (52.6%)	48 (27.7%)	17 (9.8%)
Career planning is mostly down to me	173	55 (31.8%)	94 (54.3%)	21 (12.1%)	3 (1.7%)
There is little support for career development in my organisation	171	10 (5.8%)	34 (19.9%)	100 (58.5%)	27 (15.8%)
I have my own personal development plan	172	44 (25.6%)	104 (60.4%)	23 (13.4%)	1 (0.6%)
My personal development plan is useful for me	160	34 (21.3%)	100 (62.5%)	24 (15%)	2 (1.3%)
In my organisation professional development is seen as a luxury	172	10 (5.8%)	28 (16.3%)	98 (57%)	36 (20.9%)
Within the past 12 months I have been involved in discussions about my own career development needs	173	48 (27.7%)	92 (53.2%)	26 (15%)	7 (4%)
Within the past 12 months I have had enough personal or professional development to help me to do my job effectively	172	33 (19.2%)	83 (48.3%)	43 (25%)	13 (7.6%)

The first question covered whether or not there was *sufficient time in the respondents' organisation for their development*, almost two thirds agreed or strongly agreed with this statement. The answers showed there was no statistically significant difference amongst the variables apart from when gender is compared: 61.1 percent (n=11) of males either disagreed or strongly disagreed that there was sufficient time for development in their organisation compared with 35.1 percent (n=54) of females (Chi-Square= 4.651, df= 1, *p*=.031).

When asked whether or not they agreed with the statement that *career planning is mostly down to me*, 86 percent agreed or strongly agreed meaning that the organisation did not take a lead in

career planning for this group of employees. There is a highly statistically significant finding (Chi-Square= 16.296, df= 4, *p*=.003) in relation to the age of the ward sister and whether they agreed that career planning is down to them; only 19 percent of 40-49 year olds strongly agreed with this statement as opposed to 40.7 percent and 50.0 percent of under 40 and over 50 year olds respectively. One may assume that the longer a nurse has been registered, the older s/he would be, however this result does not follow that logic; the older group had the highest disagreement figure at 16.7 percent (see Table 5.16).

Table 5.16   Frequency table for age and career planning

Career planning is mostly down to me	How old are you?					
	<40		40-49		>50	
Strongly agree	40.7%	24	19.0%	16	50.0%	15
Agree	44.1%	26	69.0%	58	33.3%	10
Disagree/strongly disagree	15.3%	9	11.9%	10	16.7%	5
Total	100.0%	59	100.0%	84	100.0%	30

There were no statistically significant relationships between the variables in the responses to the question about support for career development. There was also a positive outlook in that only a quarter (25.7 percent, n=171) either agreed or strongly agreed with the statement *there is little support for career development*. Fourteen percent (n=24) reported that they *did not have a personal development plan*, but there were no statistically significant findings in relation to personal development plans. However, 16.3 percent (n=26) of those who had personal development plans reported that they disagreed that their *personal development plans were useful*, although not statistically significant (Chi-Square= 9.333, df= 4, *p*=.053) 25 percent (n=19) of those aged 40-49 also disagreed.

The ward sisters were asked if *professional development was seen as a luxury* by the organisation. Twenty two percent agreed or strongly agreed with this statement; there were no statistically significant relationships between the variables. The ward sisters were asked whether they had been *involved in discussions about their career development needs* in the last 12 months, 19.1 percent (n=33) reported that they had not and there were no statistically significant differences between variables. It is interesting to note however, that following these fairly positive responses when asked whether they had *received enough personal or professional development to do their job effectively*, almost a third (32.6 percent, n= 56) of them disagreed or strongly disagreed.

Six further comments were given by the ward sisters, two of which are highlighted below and offered two different perspectives on organisational culture; the first is very positive and shows that she appreciated the support:

'*Knowing people had trust and faith in your ability to progress'*- Ward Sister, FT, North

The second comment shows that development was lacking and they had to get on with the job without it.

'*Not had a lot of the above, mainly "off you go"'* - Ward Sister, NHS Trust, Midlands.

5.4.3 Methods of education and training

The next set of questions enquired about the extent to which the ward sisters found different methods of education and training helpful before and after they took up their role. Table 5.17 shows the overall results; the methods shaded green were the most effective and those shaded red were the least effective (using the very helpful score); a more in depth review of the findings in relation to each of the methods follows.

The first method discussed was in-house development programmes. There were two statistically significant findings in relation to geographical location and educational attainment. Twenty-five (41.7 percent) of those ward sisters who did not have a degree reported that they found in-house programmes to be 'very helpful' in preparation to become a ward sister, compared with 20 percent (n=19) of those with degrees (Chi-Square= 8.511, df= 2, p=.014) however the total from both groups who found them to be 'helpful' or 'very helpful' were similar. Although not statistically significant it should be noted that zero percent of the ward sisters working in London found in-house programmes to be 'not helpful' or 'not at all helpful', whereas the comparable rates were 6.4 percent, 10.5 percent and 11.1 percent in the Midlands, North and South respectively. As will be explained later this is contrary to other findings where nurses in the North of the country were on the whole more positive about other methods of development. The respondents were not asked to justify their answers but there may have been a more positive response from the London cohort due to many of them working in teaching hospitals or they may have had better quality programmes.

When looking at the results for in-house development programmes for nurses once they are in ward sister posts there were no statistically significant findings, however it is of note that 12.8 percent (n=6) of ward sisters who have been in post for less than two years reported that in-house programmes were 'not helpful' or 'not at all helpful'. This compared with 3.5 percent (n=2) of their colleagues who had been in post between three and five years; both results are positive however the less experienced may have been slightly more negative than their

colleagues because in the first two years they were establishing themselves in the post and depending on what the content of the in-house programme they may have seen this as a distraction.

Table 5.17   How effective were methods of training before and after becoming a ward sister

Methods of education and training	Before or after becoming a ward sister	Total number	Very helpful	Helpful	Not helpful	Not at all helpful
In house programme	Before	159	44 (27.7%)	102 (64.2%)	8 (5%)	5 (3.1%)
	After	156	57 (36.5%)	88 (56.4%)	11 (7.1%)	0
External course	Before	142	49 (34.5%)	80 (56.3%)	10 (7%)	3 (2.1%)
	After	135	54 (40%)	72 (53.3%)	9 (6.7%)	0
On the job development	Before	168	80 (47.6%)	78 (46.4%)	6 (3.6%)	4 (2.4%)
	After	161	20 (49.7%)	67 (41.6%)	13 (8.1%)	1 (0.6%)
Coaching	Before	124	57 (46%)	52 (41.9%)	13 (10.5%)	2 (1.6%)
	After	126	55 (43.7%)	57 (45.2%)	12 (9.5%)	2 (1.6%)
Peer support Discussion	Before	146	62 (42.5%)	73 (50%)	8 (5.5%)	3 (2.1%)
	After	163	75 (46%)	78 (47.9%)	8 (4.9%)	2 (1.2%)
Supervision	Before	116	38 (32.8%)	62 (53.4%)	11 (9.5%)	5 (4.3%)
	After	119	49 (41.2%)	57 (47.9%)	11 (9.2%)	2 (1.7%)
Electronic learning	Before	123	10 (8.1%)	49 (39.8%)	52 (42.3%)	12 (9.8%)
	After	145	14 (9.7%)	56 (38.6%)	65 (44.8%)	10 (6.9%)
Formal qualifications	Before	152	34 (22.4%)	96 (63.2%)	18 (11.8%)	4 (2.4%)
	After	119	33 (27.7%)	68 (57.1%)	15 (12.6%)	3 (2.5%)
Training by professional bodies	Before	125	26 (20.8%)	78 (62.4%)	18 (14.4%)	3 (2.4%)
	After	125	33 (26.4%)	73 (58.4%)	16 (12.8%)	3 (2.4%)
Books	Before	147	14 (9.5%)	96 (65.3%)	35 (23.8%)	2 (1.4%)
	After	138	22 (15.9%)	79 (57.2%)	32 (23.2%)	5 (3.6%)
Conferences	Before	144	33 (22.9%)	98 (68.1%)	11 (7.6%)	2 (1.4%)
	After	147	39 (26.5%)	92 (62.8%)	13 (8.8%)	3 (2%)
Shadowing	Before	127	59 (46.5%)	55 (43.3%)	10 (7.9%)	3 (2.4%)
	After	110	53 (48.2%)	43 (39.1%)	11 (10%)	3 (2.7%)

Pre-appointment e*xternal courses* were viewed quite positively with a total of only 9.1 percent (n=13) of ward sisters finding them 'not helpful' or 'not at all helpful'. There is one highly statistically significant finding (Chi-Square= 15.000, df= 4, p=.005) in that 61.9 percent of the ward sisters over 50 years old found external courses to be 'very helpful' whilst 24.3 percent of those aged 40-49 and 37.3 percent of those under 40 years old felt the same way, see Table 5.18. Post appointment external courses were viewed in a similar way in these age groups: zero percent of ward sisters over 50 years old found external courses to be 'not helpful' once in a

ward sister post whilst 12.5 percent of those aged 40-49 stated they were 'not helpful', this is a statistically significant finding (Chi-Square= 9.803, df= 4, *p*=.044).

Table 5.18 Frequency results for age and external courses

Were external courses...	How old are you?					
	<40		40-49		>50	
	Percent	Number	Percent	Number	Percent	Number
Very helpful	37.3%	19	24.3%	17	61.9%	13
Helpful	58.8%	30	60.0%	42	38.1%	8
Not very helpful/unhelpful	3.9%	2	15.7%	11	0.0%	0
Total	100.0%	51	100.0%	70	100.0%	21

External courses were found to be more helpful once in post by ward sisters in the Midlands and the North (96 percent) than those in London and the South (84.8 percent), this is a statistically significant finding Fisher's *p*=0.022.

Having the opportunity to develop skills *on the job* was found to be the most helpful method to prepare for and to be supported when in a ward sister position (96.4 percent, n=168 before being a ward sister, 91.9 percent n=147 post being a ward sister). Geographical location was the topic of statistically significant findings both pre and post becoming a ward sister; ward sisters in the Midlands and North reported that they found on the job training to be more helpful than their colleagues in London and the South. Almost all ward sisters in the Midlands and the North (97.7 percent) reported that on the job training was helpful in the preparation phase and 95.3 percent of them agreed with this once in the ward sister post, Fisher's *p*=0.037 and Fisher's *p*=0.049 respectively.

It is also of note that 17.6 percent (n=9) of those who have been a sister for less than two years found post appointment on the job development to be 'not helpful' or 'not at all helpful' whilst one colleague only (2.1 percent) who had been in post for more than five years found the same. This was found to be statistically significant when comparing ward sisters who had been in post less than two years (82.4 percent) with those in post over two years (95.3 percent), Fisher's *p*=0.011. This may be because it was viewed as an extra responsibility when they were establishing themselves in their ward sister post, whereas colleagues who were settled and confident might relish the opportunity of a new challenge.

Far fewer ward sisters responded to the question about *coaching* (n=124 pre appointment, n=126 post appointment) and it appears that coaching was not as widely used to prepare and support nurses to be ward sisters. There were no statistically significant results in relation to coaching either before or after becoming a ward sister, however, of those who had been coached, 87.9 percent found it to have been 'helpful' or 'very helpful' in preparing them to be ward sisters and

slightly more, 88.9 percent had found this to be the case once they were in post. These were very positive results and add to the knowledge about what strategies should be used to prepare and support nurses in these roles.

Peer support was the next method, and 92.5 percent (n=135) either found this to be 'helpful' or 'very helpful' before they became ward sisters. This figure rose to 94.8 (n=163) percent once the nurses had taken on ward sister roles. There were no statistically significant results, but a regional difference is worth highlighting: 97.3 percent (n=35) of ward sisters working in the North found peer support to be 'helpful' or 'very helpful' in preparation to become a ward sister, whereas only 82.3 percent (n=14) in London agreed with this. This result is similar to the response to questions about the usefulness of peer support for those actually in ward sister posts in that 100 percent (n=38) of ward sisters in the North and 85 percent (n=17) in London had found peer support 'helpful' or 'very helpful' after they had been appointed. Although these are very positive results, the differences might be due to the more transient workforce in London and that committing to a peer network may be more challenging in this environment.

Having *supervision* gave no statistically significant results between the variables when focusing on the preparation stage of a ward sister's career, overall 86.2 percent (n=116) of ward sisters found supervision to be 'helpful' or 'very helpful'; and there was near consistency of opinion on this point between those who did not have a degree (82.2 percent, n=37) and those who did have a degree (89.6 percent, n=60). There was a statistically significant finding (Chi-Square= 12.790, df= 4, *p*=.012), however, in relation to the views on how supervision supports nurses once they are ward sisters; 47.1 percent (n=24) of those ward sisters who had been in post for over five years found supervision to be 'not helpful' or 'not at all helpful'; and 20.8 percent (n=11) of their colleagues who had been in post for less than two years reported the same. This result would appear to demonstrate that those who were new in post appreciated having a supervisor in whom they could confide and from whom they received guidance but this was not so important once confident in the ward sister role.

Using *electronic learning methods* was viewed as one of the least helpful ways to prepare to become a ward sister, with 52 percent (n=64) finding it to be 'not helpful' or 'not at all helpful'. Similarly, 55.2 percent reported that it was 'not helpful' or 'not at all helpful' when in ward sister posts. The findings for all the variables reflected this overall result, however there was one very statistically significant finding. Forty-six (62.2 percent) of the sisters with degrees found e-learning to be 'not helpful' or 'not very helpful', whilst only 35.6 percent (n=16) of their colleagues without degrees agreed; they instead found this method to be 'helpful'. Similarly, 51 (60 percent) ward sisters who had a degree found electronic learning 'not helpful' or 'not at all

helpful' to their on-going development, while 22 (40 percent) of their colleagues without a degree found e-learning to be 'not helpful' or 'not at all helpful': this is a statistically significant finding (Chi-Square= 5.353, df= 1, p=.021). This conclusion may have been produced because the nurses who had studied for degrees had been exposed to a range of teaching methods and they might have been more critical in terms of how their development needs were met.

Having *formal qualifications* was seen by most (85.6 percent, n=130) to be either 'helpful' or 'very helpful' in preparing to be a ward sister, a similar figure (84.8 percent, n=101) reported this to be the case once they were ward sisters; there were no statistically significant findings. It should be noted that more ward sisters with degrees reported that they found formal qualifications to 'not be helpful' or 'not at all helpful' than those without a degree; 16.1 percent (n=15) and 11.1 percent (n=6) respectively. This gap widened when it related to the usefulness of obtaining formal qualifications to the development of ward sisters once they were in post: 18.8 percent (n=13) of those with a degree found formal qualifications 'not helpful' or 'not at all helpful', as did 10.9 percent (n=5) of those without a degree. This result was not statistically significant, however it would appear to be counter intuitive as more nurses with formal qualifications than those without did not find them to be beneficial to carrying out their role. This also reflected the findings from Kleinman's (2003) study when 51 percent of the nurse managers in the study reported that a degree education was not necessary to be in the role.

Training by external bodies was found to be 'helpful' or 'very helpful' by 85.5 percent (n=104) of ward sisters before, and 84.8 percent (n=110) after becoming a ward sister. There was a statistically significant finding (Chi-Square= 7.442, df= 2, p=.024) regarding training by external bodies in relation to preparation to be a ward sister is related to age; 100 percent (n=21) of ward sisters over 50 years old found this training to be 'helpful' or 'very helpful' whilst only 75 percent (n=45) of their colleagues aged 40-49 agreed. This result is repeated, although not to a significant level, in those who found training by external bodies helpful once they were in ward sister roles; again, 100 percent (n=23) of those aged over 50 years old found this to be 'helpful' or 'very helpful', compared with 78.3 percent (n=47) of their colleagues aged 40-49. A second statistically significant finding (Fisher's p=0.015) in relation to geographical location in that 23.3 percent (n= 14) of ward sisters in London and the South found this method not 'helpful' or 'not at all helpful' whereas only 7.8 percent (n= 5) of their colleagues in the Midlands and North reported the same. It was noted earlier that a higher percentage of ward sisters working in London found in house courses to be helpful, therefore this result may be linked, in that they have good quality in house courses in London and consequently do not rate external courses as highly as their colleagues elsewhere in the country.

Three quarters of the ward sisters overall (74.8 percent, n=110) found *reading books* 'helpful' or 'very helpful' in preparing for the ward sister role, and a slightly lower 73.1 percent (n=101) of ward sisters found this exercise useful when in the role. Despite this being the second least helpful method of preparation and support, there are a number of interesting results. Ward sisters in NHS Foundation Trusts were less likely to find books 'helpful' or 'very helpful' in preparing to be a ward sister than their colleagues in NHS Trusts, 68.4 percent (n=54) and 83.6 percent (n=56) respectively; this is a statistically significant finding (Chi-Square= 4.525, df= 1, *p*=.033). Although not statistically significant, this pattern was replicated in the answer for 'once in a ward sister role'. There is a statistically significant finding on this point (Chi-Square= 13.321, df= 6, *p*=.038); 84.4 percent (n=27) of ward sisters working in the North found books to be 'helpful' or 'very helpful' to support on-going development, compared with 41.2 percent (n=7) in London. It is impossible to infer why these differences occurred and as reading books was not one of the favoured methods for preparation or support, the results though statistically significant, are unlikely to have any practical significance when planning ward sister development.

Attending conferences was reported as 'helpful' or 'very helpful' by 131 ward sisters, to both the preparation for ward sister roles and development of those already in post (91 percent and 89 percent respectively). It was found that more ward sisters in the Midlands (97.6 percent) found conferences 'helpful' or 'very helpful' to the preparation phase of the ward sister role than their counterparts elsewhere in the country; this is a statistically significant finding (Chi-Square= 12.871, df= 6, *p*=.045). This result was replicated when ward sisters were asked about how helpful conferences were to them once they were in ward sister posts: 93.3 percent (n=42) of ward sisters working in the Midlands found them 'helpful' or 'very helpful' compared with 68.8 percent (n=11) of colleagues in London. Although not a statistically significant difference it is worthy of note that 96.5 percent (n=55) of ward sisters without a degree, compared with 87.8 percent (n=72) with a degree, found conferences to be 'helpful' or 'very helpful'. This was found to be highly statistically significant when looking at how conferences support nurses once in ward sister posts; 14.1 percent (n=12) of ward sisters with degrees as opposed to 5.4 percent (n=4) without found conferences 'not helpful' or 'not at all helpful' (Chi-Square= 12.837, df= 2, *p*=.002). More graduate ward sisters may have found external courses unnecessary compared with their colleagues without degrees due to the knowledge they had gained on their degrees. Another statistically significant finding, (Chi-Square= 10.755, df= 4, *p*=.029) was that 96.4 percent (n=53) of ward sisters who had been in post between two and five years reported that they found conferences 'helpful' or 'very helpful' once they were in ward sister roles, but that only 78.6 percent (n=33) of their colleagues who had been in post for less than two years did so.

Shadowing a ward sister was the final method to be investigated. 91 percent (n=144) of ward sisters found this to be 'helpful' or 'very helpful' in preparing nurses for the ward sister role and 87.3 percent (n=96) found it to be 'helpful' or 'very helpful' once they were in post. A highly statistically significant result, (Chi-Square= 11.186, df= 2, p=.004) was found in relation to shadowing as an aid to preparation for ward sister roles: 38.8 percent (n=31) of ward sisters with a degree found shadowing 'very helpful', 55 percent (n=44) found it 'helpful' and only 6.2 percent (n=5) 'not helpful' or 'not at all helpful'; however amongst ward sisters without a degree, shadowing was thought to be 'very helpful' by 61.9 percent (n=26), 'helpful' by 23.8 percent (n=10) and 'not helpful' or 'not at all helpful' by 14.3 percent (n=6). This result (in Table 5.19) indicated that shadowing is helpful, however it would appear that the graduate ward sisters appreciated this method of support more so than their colleagues and this might be due to their ability to link theory to practice.

Table 5.19   Frequency table for Graduate and Shadowing

Did you find shadowing...	Certificate/diploma		Bachelor/masters degree	
	Percentage	Number	Percentage	Number
Very helpful	61.9%	26	38.8%	31
Helpful	23.8%	10	55.0%	44
Not very helpful/unhelpful	14.3%	6	6.3%	5
	100.0%	42	100.0%	80

There was a second highly statistically significant result (Fisher's p=<0.005) relating to geographical location; 100 percent of ward sisters working in the Midlands and the North (n=65) found shadowing to be 'helpful' or 'very helpful', compared with 78.7 percent, (n=48) of their colleagues in London and the South. This might reflect the more transient London workforce that was illustrated earlier and the fact that it might not be as easy to find someone to shadow in London or there might be a more independent attitude amongst the nurses working in London. A final observation which is not a statistically significant finding is that 100 percent (n=19) of ward sisters aged over 50 found shadowing to be 'helpful' or 'very helpful' in preparation to be a ward sister. This contrasted with 12 percent (n=13) of their younger colleagues who did so.

Twelve comments were written to support the response to this question; six about the preparation phase and six about support in the on-going role. The two quotes set out below show the disparity of support ward sisters received in different organisations, the remaining four comments described a lack of support.

'New management supportive - in last 2 years' - Ward Sister, FT, Midlands

'There is very little development offered in terms of shadowing or mentoring by another matron. A lot depends on who your manager is and how much they want you to be developed or if you are more experienced than them' - Ward Sister, NHS Trust, South

The ward sisters were also asked if they had had any formal classroom or on the job development. In relation to formal classroom teaching 135 (78 percent) ward sisters said they had received some form of this. When chi square statistical test was applied the only highly statistically significant difference, (Chi-Square= 15.155, df= 2, $p=.001$), was that 60.4 percent (n=32) of less experienced ward sisters had received this compared with 82.8 percent (n=53) and 90.4 percent (n=47) of ward sisters who had been in post for between two and five years, and over five years, respectively, see Table 5.20. This may mean that as the ward sisters became more experienced in their post that they had more opportunity for this type of education experience, it may also be interpreted that formal classroom teaching is a more traditional method and not used so frequently as it had been. On the whole, ward sisters found this method of development effective, with 84.8 percent (n=128) stating it was 'helpful' or 'very helpful'.

Table 5.20   Frequency table for length in current post and classroom based teaching

Have you had classroom based learning?	How long in current post?					
	Less than 2 years		2-5 years		Over 5 years	
	Percent	Number	Percent	Number	Percent	Number
Yes	60.4%	32	82.8%	53	90.4%	47
No	39.6%	21	17.2%	11	9.6%	5
Total	100.0%	53	100.0%	64	100.0%	52

When asked to explain why they found classroom teaching helpful, 133 comments were offered. These were grouped into themes and the most popular reasons were that;

· it gave the ward sisters *confidence to lead* (n=22);

· it was *good to have time to network with peers and share good practice* (n=20) and

· *HR training* was specifically helpful (n=8).

However there were also less positive comments: 11 said that they had *no formal development* and eight said that they had *received classroom teaching but it had not been very informative.*

In response to questions about whether the ward sisters had received on the job training, 116 (67.8 percent) said they had, and when these results were statistically analysed using the chi square test there were no statistically significant findings. Of the 137 who responded, 115 (84 percent) found this type of development effective or very effective, there were no statistically

significant findings when analysed using chi square test. Once again, the respondents were asked to explain their answer, and 110 comments were given. The most frequent response was that the ward sister had been *seconded to a position and was then able to take skills and knowledge back to their original area of work*; ten ward sisters stated it was *good to see how things were done elsewhere*; they also explained that it *helped to realise their potential* (n=8). Some recognised that on the job training *helped them to face new challenges* (n=7) and four said they *had been recruited to the ward sister post into which they had been seconded*. Thirteen ward sisters confirmed that they were *not given the opportunity to be mentored*. It is clear from the comments made in respect to on the job training and the formal classroom teaching that both were popular, but that they both offered different forms of development. From the language used in the comments is clear that on the job training gives experience that is much more practical.

5.4.4   Regression

Multiple regression is an equation of two or more continuous or categorical predictor (independent) variables. Regression analysis enables a prediction to be made in relation to a dependent variable and a number of predictor variables (Cookes et al, 2010).

Regression was used to test the hypothesis that a number of independent variables would have a positive impact on the length of time it took a ward sister to report that they had reached the stabilisation phase of the Nicholson and West (1988) transition cycle. Fourteen independent variables were used, basic descriptive statistics of these variables are shown in Table 5.21. To determine whether and to what extent an independent variable had an effect on the length of time a ward sister took to become established in the role a simple linear regression was calculated. Regression was used initially to identify the strength of the relationship between each individual independent variable and the dependent variable (time to achieve stabilisation phase in Nicholson and West (1988) transition model). The results are reported below, the univariate regression demonstrated the order of strength of the relationship that each independent variable had with the dependent variable some of which were statistically significant. Following these calculations, multiple regression was used to learn more about the relationship between all 14 independent variables and the dependent variable. It should be noted that the multiple regression model using the pre ward sister data was not statistically significant (F (14,39) = 1.806, *p* =.073) but the model using the data when a nurse was in a ward sister role was significant (F (14,35) = 2.52, *p* =.013).

Table 5.21 Descriptive statistics of the independent variables

Variable	M	SD	N (pre)	N (post)
The length of time the ward sister had been a RN	18.1	8.22	173	173
Development using in house programmes	1.84	.65	159	156
Development using external courses	1.76	.67	142	135
On the job development	1.61	.67	168	161
Being coached	1.68	.73	124	126
Development via peer support	1.67	.67	146	163
Development via supervision	1.85	.76	116	119
Development using e-learning	2.53	.78	123	145
Studying for formal qualifications	1.94	.67	152	119
Development by external professional or industry bodies	1.58	.67	125	125
Studying using books	2.17	.60	147	138
Development via conferences	1.87	.59	144	147
Shadowing an experienced person	1.66	.73	127	110

Whether the ward sister was a graduate	Yes 63% (n=76)	No 37% (n=45)

In the first instance a simple linear regression was calculated with the dependent variable (the number of months it took for ward sisters to reach the stabilisation phase of the Nicholson and West (1988) transition cycle) and 13 of the 14 predictor variables individually. These variables described the interventions to help prepare nurses for the role of ward sister.

Table 5.22 Linear regression of 13 independent variables before a nurse became a ward sister (preparation phase of the Nicholson and West 1988 transition model)

Variables	R^2	F	b	95%CI for b	*p*-value
Time RN	2%	1,122=2.55	0.32	-0.78 to 0.73	.113
In house programme	2.6%	1,114=3.00	4.71	-0.68 to 10.10	.086
External course	5.4%	1,103=5.88	6.29	1.14 to 11.43	.017*
On the job	2.1%	1,120=2.58	4.14	-0.96 to 9.24	.111
Coached	0.6%	1,91=0.52	1.77	-3.12 to 6.66	.473
Peer support	<0.005	1,107=0.03	0.51	-3.11 to 8.35	.366
Supervision	1%	1,84=0.83	2.62	-3.11 to 8.35	.366
E learning	1.6%	1,90=1.51	3.05	-1.89 to 7.99	.223
Qualifications	6.5%	1,107=7.44	6.53	1.79 to 11.27	.007**
Professional bodies	1.1%	1,92=0.99	2.39	-2.39 to 7.16	.323
Books	0.5%	1,103=0.52	2.14	-3.76 to 8.04	.474
Conferences	2.8%	1,103=2.97	5.14	-0.77 to 11.05	.088
Shadowing	0.3%	1,91=0.25	1.22	-3.61 to 6.06	.617

These findings demonstrated that external courses and studying for formal qualifications before becoming a ward sister (in the preparation phase) have a positive effect on the time nurses take to reach the stabilisation phase of the Nicholson and West (1988) transition cycle. The regression coefficient of 6.53 for the predictor variable of studying for formal qualifications means that for every one unit increase in the Likert scale the ward sister would reach the stabilisation phase 6.5 months earlier than colleagues *p* = .007, 95% CI [1.79, 11.27] (table 5.22).

The same individual linear regression analysis was performed to investigate whether the predictor variables whilst in a ward sister role had an effect on the speed of which a nurse reported they had become established in the ward sister role.

Table 5.23 Linear regression of 13 independent variables whilst in the ward sister role (encounter and adjustment phases of the Nicholson and West 1988 transition model)

Variables	R^2	F	b	95%CI	p-value
Time RN	2%	1,12=2.55	0.32	-.078 to 0.72	.113
In house programme	1.4%	1,11=1.57	3.66	-2.14 to 9.46	.213
External course	2.4%	1,96=2.38	4.62	-1.32 to 10.56	.126
On the job	0.3%	1,114=0.33	-1.56	-6.98 to 3.86	.569
Coached	<0.005	1,89=0.01	0.39	-5.65 to 6.34	.909
Peer support	0.4%	1,115=0.43	-1.68	-6.78 to 3.42	.515
Supervision	0.2%	1,84=0.14	0.97	-4.11 to 6.06	.705
E learning	1.4%	1,105=1.47	2.87	-1.82 to 7.57	.228
Qualifications	4.7%	1,85=4.15	4.52	0.11 to 8.93	.045*
Professional bodies	3.0%	1,85=2.80	4.52	-0.73 to 8.51	.098
Books	2.2%	1,97=2.13	3.96	-1.42 to 9.35	.147
Conferences	4.2%	1,105=4.59	6.00	0.45 to 11.55	.034*
Shadowing	6.8%	1.76=5.54	6.02	0.93 to 11.12	.021*

These findings identified that three of the predictor variables; studying for formal qualifications; conferences and shadowing a more experienced ward sister have a positive effect on the dependent variable (the time it takes for a ward sister to reach the stabilisation phase of the Nicholson and West (1988) transition model) once a nurse is in the ward sister role. This differs from the preparation stage in that external courses were no longer statistically significant but attending conferences and shadowing a more experienced ward sister were.

The regression coefficient of 6.02 for the predictor variable of shadowing a more experienced ward sister means that for every one unit increase in the Likert scale the ward sister would reach the stabilisation phase six months earlier than colleagues p= .021, 95% CI [0.93, 11.12] (Table 5.23).

The predictor variable which defined the ward sisters as graduates or not was categorical. Categorial variables cannot be calculated using linear regression therefore an independent samples *t*-test was used to identify if being a graduate nurse affected the length of time it took a

nurse to reach the stabilization phase in a ward sister role. There was no statistically significant difference between graduate nurses (M=21.8, SD=15.0) and non-graduate nurses (M=28.0, SD=22.1) in the mean number of months it took to reach stabilisation t (119) = -1.8 p=.069.

Multiple linear regression analysis using the same 14 independent variables (table 5.21) was performed to develop a model to predict the effect of the independent variables on the dependent variable, however the multiple regression model using the data before a nurse becomes a ward sister **was not statistically significant** (F (14,39) = 1.806, p =.073) with an adjusted R^2 of 17.5%, and therefore the findings were not used, but are reported below in Table 5.24.

Table 5.24   Multiple regression of 14 variables before a nurse becomes a ward sister (preparation phase of the Nicholson and West 1988 transition model)

Variables	b	95%CI	p-value
(Constant)	1.53	-26.40 to 28.50	.939
Time RN	0.65	-.041 to 1.34	.064
Graduate	-0.27	-13.53 to 8.12	.617
In house programme	-2.32	-13.94 to 9.30	.689
External course	15.90	2.35 to 29.45	.023
On the job	11.43	.87 to 22.00	.035
Coached	-1.98	-14.54 to 10.58	.752
Peer support	-3.29	-18.90 to 12.28	.672
Supervision	-5.13	-19.47 to 9.21	.474
E learning	3.92	-3.01 to 10.85	.260
Qualifications	7.74	-1.67 to 17.14	.104
Professional bodies	-13.95	-26.81 to -1.10	.034
Books	-2.60	-15.63 to 10.43	.688
Conferences	2.31	-8.11 to 12.72	.675
Shadowing	-4.70	-14.96 to 5.57	.360

A second multiple regression was then performed on the data post becoming a ward sister. and the model was found to be statistically significant (F (14,35) = 2.52, p =.013) with an adjusted R^2 of 30.3%, the findings are shown in Table 5.25.

Table 5.25   Multiple regression of 14 variables after a nurse becomes a ward sister (encounter and adjustment phases of the Nicholson and West 1988 transition model)

Variables	b	95%CI	p-value
(Constant)	4.75	-18.26 to 27.76	.678
Time RN	0.39	-0.15 to .93	.151
Graduate	-0.30	-9.79 to 9.18	.949
In house programme	6.67	-2.10 to 15.44	.132
External course	-4.39	-12.85 to 4.07	.299
On the job	-12.28	-26.00 to 1.44	.078
Coached	-3.61	-16.95 to 9.73	.586
Peer support	-2.56	-14.21 to 9.09	.858
Supervision	-0.66	-13.03 to 11.71	.915
E learning	-4.26	-12.53 to 3.40	.302
Qualifications	7.01	-2.49 to 16.51	.320
Professional bodies	0.93	-8.17 to 10.03	.837
Books	1.70	-7.94 to 11.34	.723
Conferences	5.51	-5.51 to 16.54	.317
Shadowing	10.73	2.90 to 18.57	.009**

In this model only one highly statistically significant regression predictor variable was found which was that shadowing an experienced ward sister whilst in the encounter and adjustment phases of the transition into a ward sister role had a positive effect on when the ward sister would report to be in the stabilisation phase of the Nicholson and West (1988) transition model. It is interesting to note that when a multiple regression was performed studying for formal qualifications and attending conferences were found not to be statistically significant as they had been when individual regression was performed. In the multiple regression the regression coefficient for shadowing demonstrated that for every one unit increase in the Likert scale the ward sister would reach the stabilisation phase 11 months earlier than colleagues $p= .009$, 95% CI [2.90, 18.57] (Table 5.24).

5.4.5   Barriers to development

The next section of questions asked the ward sisters to judge the extent to which the following variables were barriers to their own development:

- · Family commitments

- · Job pressures

- · Financial constraints

- · Lack of organisational support

- · Lack of confidence

- · Lack of time

- · Not a priority

- · Lack of motivation

- · Just finished a course

- · Poor past experience

The respondents rated the variables on a scale of i) no barrier, ii) small barrier, iii) significant barrier and iv) most significant barrier. The results were analysed using chi square statistical test with the same population variables as in previous questions. Table 5.26 shows the overall frequency of responses in order of most significant barriers.

Table 5.26 Barriers to development

Potential barrier	Total number respondents	No barrier	Small barrier	Significant barrier	Most significant barrier
Job pressures	170	6 (3.5%)	4 (27.1%)	73 (42.9%)	45 (26.5%)
Lack of time	170	16 (9.4%)	49 (28.8%)	67 (39.4%)	38 (22.4%)
Financial constraints	170	35 (20.6%)	60 (35.3%)	53 (31.2%)	22 (12.9%)
Lack of organisational support for learning and development	170	66 (38.8%)	61 (39.4%)	33 (19.4%)	4 (2.4%)
Family/personal commitments	171	72 (42.1%)	67 (39.2%)	23 (13.4%)	9 (5.3%)
Not a priority	170	92 (54.1%)	49 (28.8%)	26 (15.3%)	3 (1.8%)
Just finished course	167	145 (86.8%)	8 (4.8%)	7 (4.2%)	7 (4.1%)
Low personal confidence	171	118 (69.0%)	47 (27.5%)	3 (1.8%)	3 (1.8%)
Poor past experience of education	169	150 (88.7%)	14 (8.3%)	2 (1.2%)	3 (1.8%)
Lack of motivation/ interest	170	132 (77.7%)	3 (19.4%)	5 (2.9%)	0

Job pressure was reported as the overall highest barrier to development, with 69.4 percent (n=118) reported it as a significant or most significant barrier, followed by lack of time as the second highest barrier to development.

Financial constraints were reported as the third overall barrier to development and within that there were three statistically significant results of interest. Thirty percent (n=23) of ward sisters working in large organisations reported that financial constraints were no barrier to their development compared with 12.4 percent (n=11) of their colleagues working in smaller hospitals. It was found that 45 percent (n=27) of ward sisters who worked in the South reported that financial constraints were a significant barrier to development this compared with 29.7 percent (n=11) in the North, 22.6 percent (n=12) in the Midlands and 15.8 percent (n=3) in London. Finally, it was interesting to note that 29.4 percent of males, compared with 45.4 percent of females, reported that financial constraints were either significant or the most significant barrier to development.

Most ward sisters were quite positive about organisational support for development, but there was one finding which related to organisational culture. Ward sisters in NHS Foundation Trusts reported more organisational support, with only 15.4 percent (n=14) of them citing a lack of organisational support as a significant or the most significant barrier to development, as opposed to 28.2 percent (n=22) of their colleagues in NHS Trusts. This appears to highlight a difference in cultures of the two types of organisations in that the NHS Foundation Trusts understand how important staff development is to the success of the organisation.

Family and personal commitments were not reported to be a substantial barrier to development, however it was found that for 45 percent (n=9) of ward sisters working in London family and personal commitments were a significant or highly significant barrier to development; the range for their colleagues in other regions was 11.3-18.3 percent.

Reporting that development is not a personal priority may be a difficult thing to do, however it was found to be in the middle of the table in terms of overall barriers. A finding worthy of note was that 72.5 percent (n=37) of ward sisters who had been in post for less than two years reported that development not being a priority was a small or no barrier to their development compared with 93.8 percent (n=60) and 80.4 percent (n=41) of their colleagues who had been in post between two and five years and more than five years respectively. This reflects the finding above that the group of more less experienced ward sisters said they did not find shadowing to be as helpful as their more experienced colleagues. This might be because they are in the

adjustment phase of the Nicholson and West (1988) transition cycle and want to focus on becoming established in their role rather than their professional development.

There was general agreement amongst the ward sisters that lack of confidence was not a barrier to development. A finding which illustrated this point, was that 85.7 percent of the ward sisters who self-reported that it took them less than one year to transition to the ward sister role stated that lack of confidence was not a barrier, and zero percent of them reported it as a significant or the most significant barrier. This compared with the following range of results from their colleagues who self-reported taking between one and eight years to transition, 57.9-80 percent and 2.4-25.8 percent respectively. This might be related to the personal characteristics of the group of ward sisters who reported to manage the transition faster than their peers and therefore have more confidence in their own abilities.

A lack of motivation, just having finished a course and having a poor past experience of development were reported as three of the least significant barriers to development. However, as may have been expected a poor previous experience was less of a significant barrier for those ward sisters more recently registered, those who had been in their post for less time or were younger than their colleagues (zero percent, 5.9 percent and 6.8 percent respectively); this would be expected due to their colleagues having had more time and opportunity to have had poor developmental experiences.

Three comments were made by the ward sisters, all highlighting how difficult it was to study when in a sister role; a typical example is set out below;

> '*Time isn't protected for ongoing development. The pressure to do the job and manage in the role I'm in makes it impossible for me to have any time to manage anything else as I take a significant percentage of my work home at night and spend about 2-3 hours doing work just to keep on top of everything.*' - Ward Sister, NHS Trust, South.

5.4.6   Current developmental needs

The ward sisters were then given a list of possible developmental needs and asked to identify those they felt were currently relevant to them. Table 5.27 below sets out the top 14 overall most commonly cited development needs shown in column one. Columns two and three separate out the analysed responses of newly promoted ward sisters (in post for up to two years) and their more experienced colleagues (in post for more than two years) respectively.

It can be seen from Table 5.27 that nine of the top ten overall development needs appear in the top ten of the ward sisters with less than two years' experience. 'Innovation' was ranked at seven overall but at 14 by the most recently appointed ward sisters, who identified 'people

management' as fourth most important development need, compared with its overall position of number 11. Those with more than two years' experience did not include 'influence' in their top ten developmental needs and had 'HR management' instead (overall 12th position). It is interesting that both sub-groups had included people and HR management as these are similar issues, but were not in the top ten overall. Table 5.28 demonstrates the remaining development needs.

Table 5.27 Current ward sister development needs 1-14

	All	<2 yrs in post	>2yrs in post
1	Regulatory compliance	Regulatory compliance	Regulatory compliance
2	Leadership	Finance	Change
3	Clinical effectiveness	Leadership	Leadership
4	Change	People management	Innovation
5	Finance	Clinical effectiveness	Clinical effectiveness
6	Personal impact	Patient experience	Personal impact
7	Innovation	Patient safety	HR management
8	Patient experience	Influence	Patient experience
9	Patient safety	Change	Patient safety
10	Influence	Personal impact	Finance
11	People management	Recruitment	Influence
12	HR management	Time management	Strategy
13	Strategy	Conflict resolution	Coaching
14	Clinical skills	Innovation	Clinical skills

Table 5.28 Current ward sister development needs 15-27

	All	<2 yrs in post	>2yrs in post
15	Coaching	Clinical skills	People management
16	Recruitment	Strategy	Recruitment
17	Time management	Communication	Research
18	Conflict resolution	Coaching	Time management
19	Research	HR management	Conflict resolution
20	Communication	Research	Communication
21	Rostering	Delegation	Computer skills
22	Computer skills	Rostering	Rostering
23	Delegation	Computer skills	Delegation
24	Action learning	Action learning	Action learning
25	Marketing	Marketing	Marketing
26	Virtual working	Virtual working	Virtual working
27	Sales	Sales	Sales

Ninety-one ward sisters gave between them 97 additional responses to this question; 33 said they had *no other developmental needs*; 47 suggested subjects which had already been included in the question; four identified *specific clinical courses*, two highlighted the need to be able to *motivate staff*. There were two comments about *business planning* and others put forward *project management, presentation skills, negotiation, learning more about the organisation as a whole, assertiveness, sustainability of patient care standards* and one said *'everything'*.

5.4.7   Coaching

There was then a series of questions about coaching; 80 (46.5 percent) ward sisters indicated that they did have a coach; there were no significant differences between the variables. The ward sisters who did not have a coach were asked to explain why this was; 85 ward sisters gave a reason. The two over riding reasons were that the organisation had not encouraged a system of coaching and therefore it was thought not to be possible (n=39), and 19 said they received coaching from their line manager. Other explanations included not having enough time, not having thought about it and preferring to use peer support.

There was a large majority of 89.6 percent (n=146) of ward sisters who said that if they were offered a coach they would take up the opportunity to use one. There were no statistically significant findings but it is interesting to note that 91 percent (n=131) of female ward sisters, as compared with 77.8 percent (n=14) of male colleagues, would take the opportunity of having a

coach. Of the ward sisters who said they would not accept the offer of a coach, 21 gave extra comments; most were of the opinion that they were happy with their current arrangements for support.

When asked if they would have a coach if they had to pay, 138 (82.1 percent) said no; there were no statistically significant findings, however 91.4 percent (n=53) ward sisters working in the South reported that they would not pay, compared with 66.7 percent (n=14) of their colleagues in London. This result reflected the views of the ward sisters working in the South who had previously said that financial constraints were a significant barrier to development. When asked to explain why they would not pay, 123 ward sisters commented; the main reasons were that they could not afford it (n=71, 58 percent) and a further 24 (20 percent) were clear that it should be paid for by the organisation as it would benefit the employer to have improved clinical leaders.

5.4.8   Challenges for ward sisters in their first year

The ward sisters were asked to list the top three challenges they had faced during their first year in the role. In total there were 516 comments; the results were analysed using thematic analysis in the same way as described in phase I earlier in this chapter. As with the Director of Nursing responses to the same question in phase I, the themes were analysed in relation to Nicholson and West's (1988) transition cycle however as there were themes that did not necessarily correspond to transition the secondary themes were drawn from the conceptual framework (Figure 2.4) which summarised the literature review. Therefore in addition to transition the themes were: perceived stress, leadership, the ward sister role, ward sister competencies and support. No additional themes became apparent. The increased number of comments received from the ward sisters resulted in more sub themes emerging than in the Director of Nursing analysis, and therefore the thematic framework (appendix 6) was developed from the one used in phase I of the study.

The largest number of comments from the ward sisters about the challenges they faced was about the *competencies required for the role* (29.8 percent, n=154), followed by *perceived stress* (23.6 percent, n=122), the *role itself* (16.9 percent, n=87) and *transition* (15.5 percent, n=80). *Support* and *leadership* had 41 and 32 comments respectively. Table 5.29 illustrates the slightly different order of the categories of challenge when the data were triangulated with that reported by the Directors of Nursing in phase I and the ward sisters in phase III. The outcome of this triangulation is neither convergence nor contradiction. The process of triangulation was useful to get a broader picture of the challenges faced by ward sisters and showed that people in different jobs are likely to have different perspectives.

Table 5.29 Order of perceived challenges for ward sisters

Directors of Nursing	Ward Sisters
The ward sister role	Ward Sister Competencies
Ward Sister Competencies	Managing ward sisters' stress
Managing ward sisters' stress	The ward sister role
Transition	Transition
Support	Support
Leadership style	Leadership style

Amongst the ward sisters, *managing nurse staffing* was the top challenge identified within the competencies of the role category with 64 comments (12.3 percent of all answers). Many included *people management* within this category as illustrated by the following statements;

'*Managing a team, especially if you had been promoted from the same team*' - Ward Sister, FT, North

'*HR issues with not much support from Trust HR team*' - Ward Sister, FT, South and

'*HR issues such as recruitment and sickness*' - Ward Sister, NHS Trust, North.

Managing budgets was another competency that attracted a lot of comments (n=24). Within the perceived stress category, *time management* was the most frequently cited issue, identified by the majority of respondents. The statements below are examples of the comments made:

'*Finding time to make a difference*' - Ward Sister, NHS Trust, North and

'*Time pressures to fulfil all aspects of role & feel you have performed duties effectively and to best of ability*' - Ward Sister, FT, North.

Being able to *prioritise* featured highly for the ward sisters with 5.4 percent (n=28) of all comments; it appeared that most found it difficult to balance the clinical and managerial aspects of their role as exemplified in these comments;

'*Balancing needs of patient with needs of office work*' - Ward Sister, NHS Trust, Midlands and

'*Being able to prioritise time, being able to balance being visible to your team and office management*' - Ward Sister, NHS Trust, North.

Staffing featured in the perceived stress category, as well as in the list of required competencies, but was differentiated by the language used: the 'staffing' element in the competencies was

about general management of people, whereas the 'staffing' aspect of perceived stress is about managing staffing levels on a daily basis, as described below.

> '*Too few nurses*' - Ward Sister, NHS Trust, Midlands.

> '*Vacancies - very difficult to manage staff when they are so understaffed and still having to cope with heavy work load*' - Ward Sister, FT, Midlands.

In relation to the ward sister role the majority of comments (n=19) focused on the *quality of care* aspects and included, patient safety, patient experience and care standards; as summarised below:

> '*Maintaining high standard of care despite constraints within the NHS*' - Ward Sister, NHS Trust, Midlands.

Quality of care was closely followed by the challenge of actually *understanding the ward sister role*, as described below;

> '*Expectations of the role and understand what is required*' - Ward Sister, NHS Trust, South and

> '*Finding your feet - you think you know it as you've deputised, but that is only skimming the top*' - Ward Sister, NHS Trust, South.

The transition process itself provided 80 comments, most of which were about the encounter (when they first start the post) and the stabilisation (when they become established in a post) stages. The ward sisters' view of the encounter stage features in the comments below;

> '*Transition between a nurse and a manager*' - Ward Sister, FT, London

> '*Staff reactions to your new pos*t' - Ward Sister, FT, South and

> '*Management of change in role/position in team*' - Ward Sister, NHS Trust, Midlands.

The challenges of the stabilisation stage are highlighted in these comments;

> '*Integrating into the team and getting them all to buy into change that you would like to make*'- Ward Sister, FT, South

> '*Earning respect from other staff*' - Ward Sister, FT, Midlands

> '*Believing that you are in charge and that others see you as that*' - Ward Sister, FT, North and

> '*Making the ward 'your own''* - Ward Sister, FT, London.

Appendix 19 contains examples of the raw data from the responses in phase I and III to illustrate the type of language being used to describe the challenges related to the four stages of the Nicholson and West (1988) transition cycle. This evidence is strengthened further when triangulated with the information from phases II and IV focus groups about the pressures the ward sisters experience. The ward sisters in the focus groups expressed concern about time

management, lack of support and ability to prioritise. Although fewer challenges were raised during the focus group, perhaps due to time and the method of data collection, the issues were similar to the challenges highlighted above. One issue that caused discussion within the phase I focus group was the pressure groups of staff other than nurses caused the ward sister. This was not recorded as a challenge in either phase III or IV responses.

5.4.9 Support required

Having reported on the challenges faced by ward sisters in their first year the ward sisters were asked to state what would have helped them achieve stabilisation in their role more effectively; 159 responded to this question. When their answers were analysed there were 211 different elements that were then coded and grouped in themes. The majority of themes are included in Table 5.30 below. The remaining themes, not included in the table, had between one and seven comments.

Table 5.30 Methods of support that would have helped transition to ward sister role

Action that would have helped transition	Number of comments	Percentage of comments
Having a coach/mentor/supervisor	31	14.7%
Support from manager	25	11.8%
Shadowing	14	6.6%
Handover from ward sister	13	6.2%
Development programme	13	6.2%
Specific development	12	5.7%
More development when a band 6	12	5.7%
Support from peers	12	5.7%
Being supernumerary/supervisory	10	4.7%

The majority of responses (n= 31, 15 percent) suggested that having a mentor or coach would have helped; it was also clear from the answers that having a mentor who was independent from the specialty in which the ward sisters worked would be helpful. The quote below shows how these roles can improve a ward sister's confidence by supporting them at a time when they feel completely inexperienced again (albeit at a different level) and that mentoring was viewed as a support measure that could be as helpful as preceptorship is to newly registered nurses;

> '*Mentoring, I feel newly qualified [this time as a manager rather than nurse]*' - Ward Sister, FT, London.

Support from their manager was important to the ward sisters and the majority of them gave examples where the support should have been better than that which they had experienced. Most also wanted to meet their managers more frequently. The extract below also demonstrated that

ward sisters do not want someone just to empathise with them, but to help them develop by appraising their performance thoroughly;

> '*To be given regular feedback by a senior c*olleague' - Ward Sister, NHS Trust, South.

A suggestion made by one ward sister was to have the opportunity to shadow an experienced ward sister:

> '*Shadowing another ward sister for a month prior to starting.*' - Ward Sister, FT, Midlands

Being able to have time with the previous ward sister appeared to be quite important to the respondents, as described below;

> '*A period of time where you are in post before the other leaves to understand what is required*'- Ward Sister, NHS Trust, South and

> '*I never had any sort of "handover" from the previous sister and was in essence thrown in at the deep end*' - Ward Sister, NHS Trust, South.

Thirteen commented that a development programme would have helped their transition, and 12 described specific issues on which they would have welcomed having training, such as finance and people management. Although 'development programme' and 'specific development' were described as two separate entities in the Table 5.26 they are essentially the same issue and a development programme would therefore represent 11.8 percent of the comments. It would appear that a development programme would help build nurses' confidence and understanding of the ward sister role;

> '*A formal training program, knowing that I have received all the knowledge especially around systems and processes to be able to have the confidence to use them*' - Ward Sister, FT, South and

> '*A band 7 development scheme that would introduce the skill and provide clear expectations of the role*' - Ward Sister, NHS Trust, South.

It is interesting to note the comments about the desirability of gaining more experience when in deputy sister roles (band 6 or F grade). One of the ward sisters described how she had instituted this practice with her deputy sisters:

> '*More experience of the role whilst at band 6-getting opportunity to take part in ward sister roles and responsibilities etc before taking on the job "for real"*' - Ward Sister, NHS Trust, North and

> '*Firstly as an F Grade [band 6], It would have been more beneficial if I had been involved in more management duties. I now ensure my F Grades have training on management, and are involved in all aspects of people management on this busy war*d' - Ward Sister, FT, Midlands.

Better support from managers was a clear front runner in terms of helping the transition, but the respondents also expressed a desire to have peer support;

> '*Having support from a peer- having time to meet and discuss concerns, difficult decisions*' - Ward Sister, FT, Midlands and

> '*Better peer support*' - Ward Sister, FT, North.

Having adequate time to manage the role appears to be an issue with ten comments related to being supernumerary or having supervisory status. The comment made below is typical:

> '*In my current role my main feeling at the moment is that as a ward manager if I were supervisory and not in clinical numbers my role would be much more effective.*' - Ward Sister, FT, South.

There were a small number of positive comments (n=6) expressing the view that nothing would have helped as they had been well supported, and five commented that they thought the way a ward sister managed the transition to the role depended on the individual's own ability to manage the move. The comment below is an example of this perspective:

> '*For me it was just doing the job and getting over each challenge brought a new learning for me. I do not think anything could help I just had to do it and believe in myself*'' - Ward Sister, NHS Trust, North.

Once again when triangulated with the information from the focus groups in phases II and IV the data converge to add confidence to the overall findings. The ward sisters in the focus groups agreed with the proposals above with particular reference to peer support, time to work with the team, and a specific training programme.

5.4.10 Significant findings

As stated earlier in this chapter the chi square statistical test was applied to a number of the responses from the ward sisters in phase III, as a result of which the following variables were assessed:

- · size of organisation,
- · whether the organisation was an NHS Trust or an NHS Foundation Trust,
- · geographical location,
- · the ward sisters' gender,
- · the ward sisters' highest educational attainment, and
- · how long the ward sisters had been in their current ward sister post.

The findings for these have been described above and will now be summarised. There were very few differences associated with the following variables:

- · working in NHS Trusts and NHS Foundation Trusts;
- · working in large and smaller organisations;

- age

- gender

Although this is not surprising particularly in respect of the size of organisations, one might have thought that NHS Foundation Trusts may have used their freedoms to invest more in their staff than their NHS Trust counterparts. It is also interesting to note that there were few major differences between the opinions of male and female ward sisters. Proportionately there are more men in the top nursing jobs than women (Vere-Jones, 2008) and one might have expected their ambitions to have distinguished their responses from those of their female colleagues.

From the data gathered in phase I (Director of Nursing questionnaire) two thirds of organisations made having a degree a pre requisite to becoming a ward sister and it was therefore important to see if degree educated nurses had different opinions from those who did not have degrees. It was clear that the majority of degree educated ward sisters did not find e-learning helpful either before or after becoming a ward sister, which was contrary to the views of their colleagues who did not have degrees. More of the ward sisters with degrees than without thought that shadowing was helpful preparation for becoming a ward sister. Ward sisters without degrees thought external courses were more helpful support when in a ward sister role, than those who were degree educated. A larger number of degree educated ward sisters stated that finance was a barrier to development, this is surprising and it is impossible to say why this should be so. More ward sisters with a degree said that they needed training on personal impact and influence. This may be because they had greater insight and understood better the need to be able to influence at a higher level in the ward sister role.

There were a number of differences between the North (Midlands and North) and the South (London and the South) of England in terms of how the ward sisters perceived the different methods of development. On the whole the ward sisters in the Midlands and North as a group were more positive about development than their colleagues in the South, the reason for this is not known and it may be that ward sisters in London and the South already have more developmental opportunities and are therefore less grateful than their colleagues, however this should be taken into account when developing ward sister programmes.

There were few differences across the country in respect of perceived barriers to development. 'Family and personal commitments' were not generally seen as barriers, however in London, as many ward sisters said that they were the most significant barrier as said they were no barrier. The ward sisters in the North did not see finance as a barrier as much as their colleagues elsewhere, particularly in the South, where finance was identified as a significant barrier to development, this may be due to the more expensive cost of living in the South. There were also

differences between the views of relatively recently appointed ward sisters and their more established colleagues in respect of development.

Those in post longer than five years said that supervision was not helpful once in a ward sister post. More of the ward sisters who had been in post for less than two years reported that development was not a priority than those who had been in post for longer; this is surprising as one might have thought that newly appointed ward sisters would want as much development as possible, but maybe their priority was to concentrate on establishing themselves in the role before attending courses. There were a number of differences associated with the tenure of post in relation to the development needs section, which have been discussed above and are documented in Tables 5.23 and 5.24.

The above summary demonstrated that there were differences between the various categories of ward sisters and although minor in most cases the diversity should be acknowledged when designing ward sister development programmes.

5.5   Phase IV: Ward sister focus group and questionnaire to ward sisters

5.5.1   The Questionnaire
The purpose of repeating the questionnaire with a sample of 45 ward sisters from an NHS Trust in the Midlands was to validate the results from phase III by triangulating the data from both cohorts of respondents (phase III and IV). This section reviews the findings from this second questionnaire. The questionnaire was emailed to 45 ward sisters, 25 responded (56 percent response rate).

When compared with the national sample the respondents in phase IV had a greater percentage (42 percent) in the over 50 years' old category whilst this was only 17 percent in phase III. Sixty-two percent of nurses in both samples had a degree at either bachelor or masters level, however in the phase IV sample a higher proportion of them (40 percent compared with 12 percent) had a master's degree. There was a similar number of ward sisters in phase III and IV who had been in their current role for less than two years (31 percent and 39 percent respectively), however there were more in phase IV than phase III who had been in their current role longer than five years (43 percent compared with 31 percent).

Due to the small number of respondents in phase IV the data were statistically analysed in frequencies only and no chi square test was applied. The results of the main questions in the questionnaire are reported below.

When reporting on the organisational support for their learning and development the majority of the findings were similar in phase IV to those in phase III. However, the sample in phase IV appeared to be even more positive about organisational support than was found in the national results; an example of this is that 72 percent reported they were given sufficient time for their development compared with 63 percent in phase III. It was explained earlier that although the national sample was very upbeat about the organisational culture a third of them said that they had not received enough development to do their job effectively, this was slightly less in the phase IV sample; 28 percent agreed with this statement.

The respondents in phase III reported that shadowing and on the job development were the most helpful methods to prepare for a ward sister post and as support once in the ward sister post. These findings differ slightly to the sample in phase IV who, whilst agreeing that shadowing was the most helpful method to prepare for a ward sister post they also found coaching to be more helpful than on the job development. In terms of what helped them when they were in a ward sister post, the phase IV sample agreed that shadowing was the most helpful alongside peer group discussion, rather than on the job development; both of which had 100 percent of the sample agreeing that they were 'helpful' or 'very helpful'. In relation to the methods that were not helpful in preparing for a ward sister post or as support when in such a post, both groups agreed that these were electronic learning and reading books.

Both groups cited the same issues in the same priority order as the most significant barriers to development, those being

i)   job pressures

ii) lack of time

iii) financial constraints

iv) lack of organisational support.

The top eleven development needs as reported in phase IV are in Table 5.31.

The results are interesting and it can be seen that most of the top ten from the national findings in phase III are in this list with the exception of influence and personal impact (these were rated 12th and 15th respectively by phase IV). The respondents in phase IV also included people management, HR management and strategy, which were graded 11th, 12th and 13th respectively nationally). It should also be noted that when the national data were analysed in relation to how long ward sisters had been in post, people management and HR management were included in the top ten and were incorporated into the proposed ward sister leadership categories (see Table

6.1). The outcome of the triangulation of data from phases III and IV is consistency and this has helped to support the results from the ward sister questionnaire in phase III.

Table 5.31   Current ward sister development needs, phase IV

	Development need
1	Finance
=2	People management
=2	Clinical effectiveness
=4	Patient safety
=4	Patient experience
6	Strategy
7	HR management
8	Innovation
9	Regulatory compliance
=10	Change management
=10	Leadership

The challenges raised by the sample in phase IV were remarkably similar to those reported by the national sample and the top three categories were the same in both groups, thus demonstrating a level of convergence between the two datasets. These were:

i)   ward sister competencies

ii) managing sisters' perceived stress

iii) ward sister role.

These findings serve to positively validate the findings in phase III and also give assurance of the reliability of the questionnaire used.

5.6   Middle manager research

As explained in the method chapter (4) the questionnaire in phase III was based on one used in a research study by Ashridge Business School (Armstrong and Russell, 2012) that investigated the development needs of middle managers. The participants of the Ashridge study worked in industries including retail, pharmaceuticals and financial services, the sample did not incorporate the healthcare sector. This section of the chapter compares the findings from the Ashridge study with those of my own.

In relation to the organisational culture 73 percent of managers in the Ashridge study and 74 percent of ward sisters reported that they worked in organisations that were supportive of their own development. However, 50 percent of the managers felt they were not given enough time to pursue development opportunities, whilst 63 percent of ward sisters recounted that they did have sufficient time. This is a positive result particularly when one might imagine that employees in a publically funded service, such as the NHS would perceive they have less time. A very similar number of Ashridge managers and ward sisters (78 percent and 81 percent respectively) stated that they have had discussions about their career. However, both groups have a large majority, 80 percent of Ashridge managers and 86 percent of ward sisters, who believe that career planning is down to them rather than a joint venture with their employers.

Twice as many ward sisters (47 percent) than Ashridge managers (24 percent) reported that they had a mentor or a coach. When asked if they would pay to have a mentor or coach 18 percent of ward sisters said they would, compared with only 2 percent of the Ashridge managers. This is an interesting finding in that the nurses were more likely to pay for a mentor or coach than those colleagues working in the private sector. The reason for this was not identified but may be due to a more supportive culture in the NHS than in the private sector.

There was a high level of congruency in terms of developmental needs between the two groups. *Influencing, leadership, personal impact* and *change management* were all in the top 10 of both groups. The two subjects that were in the ward sisters' top 10 and not in the Ashridge managers' list were *finance* and *innovation.* The remaining items in the ward sisters' top 10 were specifically healthcare related and were added to the questionnaire for my own study, and as such were not part of the Ashridge research.

It is very interesting to find that *on the job* development and *shadowing* an experienced person were recognised as the most effective ways to develop skills by both respondent groups. Likewise *e-learning* and *reading books* were found to be the least effective ways to help development by both cohorts. Another similarity was that the top three barriers to development identified by both respondent groups were the same, albeit in a slightly different order. As reported above the ward sisters said that *job pressures, lack of time* and *financial constraints* were the most significant barriers in that order; whilst the Ashridge managers categorised them as *lack of time, job pressures* and *financial constraints*.

These results demonstrated that generally the ward sisters had little disparity with the middle managers in the Ashridge (Armstrong and Russell, 2012) research study in relation to their perceptions about professional and personal development. This is particularly fascinating as the

ward sisters and the Ashridge managers work in very different cultures which may have more in common than one might have thought.

5.7 Summary

This chapter set out the data analysis from the four phases from my own study. Acknowledging the limitations of the low response rate the questionnaire to Directors of Nursing provided a picture of the development offered to nurses who aspire to be ward sisters and the support given once they are in post. The data from the focus group offered a perspective on the ward sister role consistent with that described in the RCN report (2009). Finally the data from the questionnaire sent to ward sisters provided a national view on current developmental needs, preferred methods of training delivery and the challenges faced by ward sisters when transitioning into their new role.

The conceptual framework introduced in the Literature Review chapter (2) was revisited in light of the findings and further developed in Figure 5.9 to highlight (in grey) the new knowledge that has been uncovered in my own study.

Figure 5.9   Conceptual framework incorporating research findings
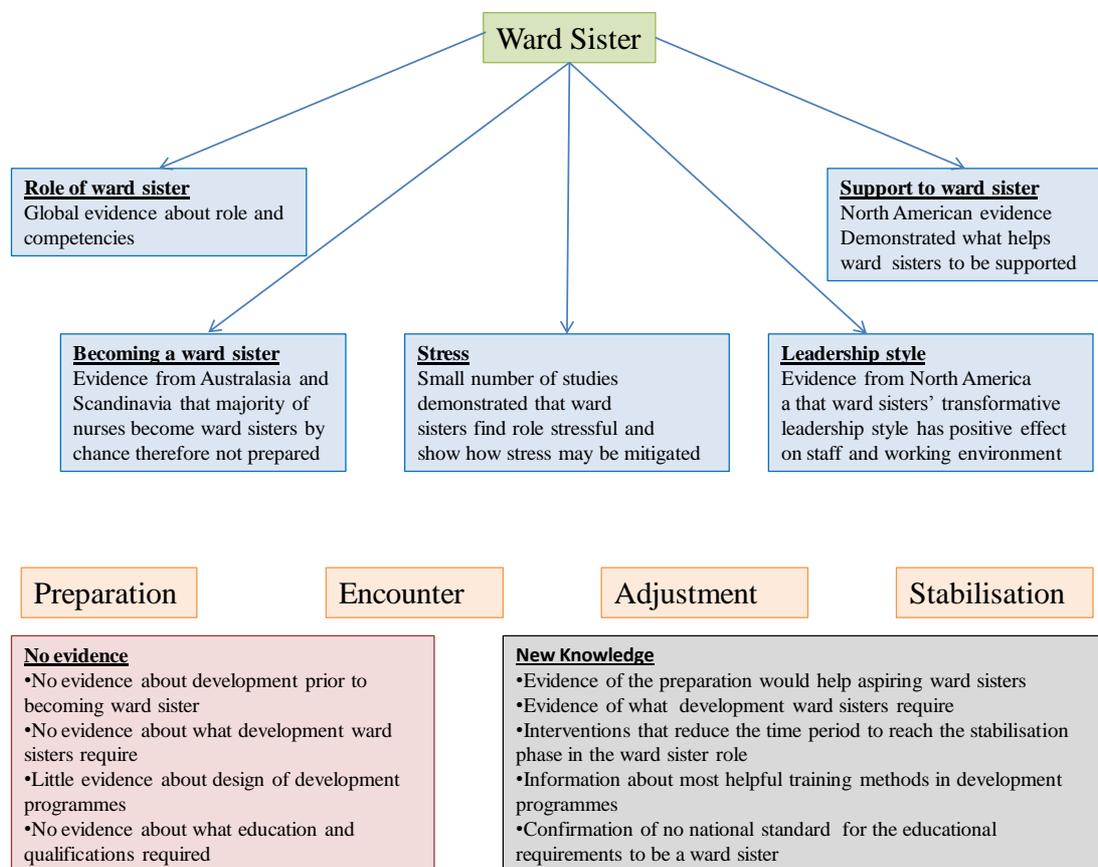
A summary of the findings are set out below.

- An inconsistent national standard of experience and qualifications to become a ward sister

- A lack of consistency in preparation programmes to become ward sisters and the support they receive once in these posts

- Confirmation that the ward sisters in my own study concurred with the findings of the RCN (2009) study, in relation to agreeing that the ward sister is a leader, manager of the care environment and an educator, although the participants did not agree that the role included research

- Attending external courses and studying for formal qualifications before becoming a ward sister are interventions that were found to have a positive effect on the time period a nurse takes to reach the stabilisation phase of the Nicholson and West (1988) transition model in the ward sister role. Likewise studying for formal qualifications, attending conferences and shadowing a more experienced peer as a new ward sister was found to have a similar positive effect on the length of transition.

- The ward sisters' development needs and their preferred ways of learning were established

- That ward sister development is a joint responsibility shared between the employer and the nurse

The findings from this study support many of the studies published in the UK and globally, particularly reinforcing what is already known about the actual role of the ward sister.

To conclude the new knowledge that my own study has contributed (shown in grey in Figure 5.9) is:

- *The preparation required for aspiring ward sisters*

My own study reported the development needs of nurses aspiring to become ward sisters and described what methods of training and education they found to be most useful.

- *The development needs once in a ward sister role*

My own study reported the development needs of inexperienced and experienced ward sisters and described the methods of training and education they found to be most useful

- *Interventions that reduce the time period to reach the stabilisation phase in the ward sister role*

The regression analyses demonstrated that whilst preparing to become a ward sister studying for formal qualifications and external courses had a positive effect by reducing the time period to reach the stabilisation phase when in the ward sister role. Studying for formal qualifications, attending conferences and shadowing a more experienced ward sister, were shown to have a similar positive effect once in the ward sister post.

- *The design of development programmes*

This was not the purpose of my own study, however information was gained to demonstrate what methods of training and education ward sisters found to be most useful in their development. The evaluations of ward sister development programmes in the literature review chapter (2) were based on programmes delivered in house whilst this study has shown that a multi method approach more reflects the needs of the ward sisters.

- *The qualifications required to be a ward sister*

A small number of studies that were reviewed in the literature review chapter (2) referred to the qualifications required to be a ward sister. My own study did not attempt to address this issue but did confirm that there was no national standard, and that indeed not all ward sisters were educated to degree level.

DISCUSSION

6.1   Introduction

The starting point for this study was the realisation that despite the fact that NHS policy since 1966 has recommended that nurses should be adequately prepared for, and supported once in, ward sister posts, there is no consistent approach to ward sister preparation or development across the English NHS, and in many instances nurses are not prepared or supported in these roles at all.

The research questions that this study sought to address were:

- ·   What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- ·   What preparation and support helps nurses manage the transition to the ward sister role?

Both questions were investigated by using questionnaires, the first sent to Directors of Nursing (phase I) and the second to ward sisters (phase III). The questionnaire addressed to the ward sisters was influenced by the findings of a focus group (phase II) with ward sisters. The focus group in phase II and the questionnaire in phase III were repeated in phase IV to add to the data and to validate the phase III questionnaire results. The findings were presented in the previous chapter (5) and will be discussed in this chapter, with particular reference to the Nicholson and West (1988) transition model that was used as a theoretical framework in this study, how the respondents answered the research questions and what new knowledge they provided to the published literature on the subject of preparation and support for nurses in ward sister roles. Throughout this thesis the study has been discussed in relation to the four phases, in this chapter the information from the findings has been triangulated and is displayed in themes rather than individual phases.

6.2   The transition

The transition from deputy ward sister to the ward sister role has been described by the ward sisters, and to a lesser extent by the Directors of Nursing, as a demanding period. Most reported that they had managed the transition in less than two years but that period may stretch up to eight years. Nicholson and West's (1988) transition cycle offered a useful context in which to discuss the transition to the role from the ward sisters' perspective. Nicholson and West (1988) provided a theory of a transition cycle with four stages; *preparation; encounter; adjustment* and *stabilisation* which were defined in the literature chapter (2). When listing their challenges the ward sisters described all four of these stages; the statements about the preparation stage described the lack of preparation they had received for their new role, and in relation to the adjustment stage they focused on the process of establishing themselves in their new role. It is

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evident from their responses that the ward sisters found the encounter stage (when they first start the role) and stabilisation stage (when they become established in the role) the most testing.

The issues preoccupying the ward sisters when they start their new job (encounter stage) focused on their lack of knowledge about the area, their move to a managerial role, others' expectations and how others will react to them. This reflected the ward sisters' desire to know HR policies and the principles of budget management. The ward sisters were going into a new situation and felt vulnerable as they did not know how people were going to interact with them. They were also very aware that this job meant moving away from being a 'clinical' nurse and that new managerial skills would be necessary. Matthews (2002) suggested that the ability of an individual to manage the adjustment stage was more likely to be successful if the preparation and encounter phases were positive. This is interesting because to a greater extent the success of the preparation and encounter stages will be dictated by the quality of the employer's communication with the nurse before s/he starts the new job and of the induction programme and managerial support provided once the ward sister has started in the post.

In relation to the adjustment and stabilisation stages the ward sisters' language changed, and emphasised concerns about how people react to the new ward sisters, whether they will be respected and accepted by new colleagues; some of the participants in my study also reported that ward sisters themselves have difficulty accepting their position and having confidence in themselves. Much of what has been said about the challenge of ward sisters managing themselves through this job role transition is about their identity.

The work of Ibarra and Barbulescu (2010), who explained how important work role is to personal identity, was introduced earlier in this thesis and it is worth exploring identity theory briefly within this part of the study. Ibarra (2003) offered a framework to reinvent oneself during a job transition; she explained that working identity is characterised by:

- · '*What we do*
- · *The company we keep*
- · *The story that links who we have been to who we will become*' (p18)

Taking this into consideration, the issues identified by the ward sisters were not surprising; the work they do has changed with increased responsibility and the company they keep at work will have changed, this is true even if they are promoted within the same team because the relationship with colleagues will alter, they will have a different peer group and a different relationship with managers. Having peer support was found to be important to the respondents in my own study, and having time with people in the same role and experiencing similar issues can have a positive influence on a person's identity (Dobrow and Higgins, 2005). Therefore

facilitating a professional ward sister network is likely to be a helpful employer intervention, this was also supported in Kath et al's (2012) study however in my own study peer support was not found to have a positive effect on the time it took ward sisters to reach the stabilisation phase.

The concept of nurses' management of their self-perceptions, and their awareness that others are likely to react to them differently during a career transition was noted by Jones (2011). However, Jones' (2011) study did not specifically focus on ward sisters or promotion job change, my own study added to the knowledge about how promotions affect identity and the need to prepare nurses for this. It has been noted in the literature regarding career transitions that an aspect that has not been focused on to a large extent is the transition element of job promotion (Thorne-Chan, 2009); my own findings add to this particular piece of literature because it focused on how nurses prepare for a managerial job promotion.

An aim for all employers should be to ensure that staff reach their potential and are able to perform competently and confidently. The transition to any role can be a very stressful experience and one of the aims of this study was to find what type of support would improve the experience of nurses becoming ward sisters and enable them to function at the required level faster and therefore have a shorter transition time. The regression analyses described in the findings chapter (5) demonstrated that in the preparation stage, *studying for formal qualifications* and *external courses* had a statistically significant impact on the transition to the ward sister role. It was also found that once in the ward sister role *studying for formal qualifications*, *attending conferences* and *shadowing* more experienced ward sisters had a positive impact on the length of time it took the ward sisters to reach the stabilisation phase of the Nicholson and West (1988) transition cycle.

The reasons that these interventions have a positive effect on the time of the transition cannot be ascertained from the study however a proposition may be that those nurses studying on post registration courses and formal qualifications are self motivated to be educated. They may also be self motivated in their career goals and therefore coupled with the education they were able to become established in their roles faster than other colleagues due to this. Once in the ward sister role studying for formal qualifications and attending conferences were found to have a positive impact on the time it took them to become established. Shadowing a more experienced ward sister was also found to have a statistically significant impact on the time period a ward sister took to reach the stabilisation phase. Managing human and financial resources was reported as a challenge for new ward sisters and these aspects of the role were also in the top ten development subjects, it would therefore seem reasonable to suggest that being able to shadow a more

experienced ward sister to learn how they manage such situations would help the ward sisters become more confident in the role as they would learn through experience.

Although there were a number of limitations in the regression analyses (see limitations chapter) the ward sisters reported a number of development methods they found to be helpful both before and after becoming a ward sister (Table 5.17). There were, however only four developmental interventions - studying for formal qualifications and studying on external courses whilst preparing to become a ward sister, whilst studying for formal qualifications, attending conferences and shadowing a more experienced ward sister were found to accelerate the transition period once in the ward sister post. The results may be explained by the fact that a large majority of the ward sisters reported that they found at least ten of the 14 training methods to be helpful both in preparation to become a ward sister and once in the post and therefore they did not differentiate between the interventions. Once in the ward sister job, shadowing a more experienced ward sister was found to significantly aid the transition period. When reviewing the challenges the ward sisters reported they had in their first year, they focused on the tasks of the role such as managing the finances, the staff and being able to prioritise. It is understandable that having access to someone who is skilled through experience to manage these challenges would be an effective way to develop into the role and would also offer a level of support to a new ward sister. It is therefore essential that this relationship between new and more experienced ward sisters is facilitated by the employer.

6.3   A stakeholder perspective

The first research question required investigation of the preparation aspiring ward sisters received and the support new ward sisters were offered. The information from the questionnaire sent to the Directors of Nursing across the country gave a picture of the development on offer, due to the disappointing response rate the results do not illustrate a complete national picture. The recruitment of ward sisters was investigated and the results revealed a lack of consistency about the experience and qualifications required to be appointed to a ward sister post. Being an RN is the one national constant qualification, but this was accompanied by a variable view of the experience and qualifications necessary to become a ward sister; for example, two of the Directors of Nursing surveyed expected that applicants be RNs only, with no further post-registration qualifications.

These results are interesting because, they proved that there is no national standard in terms of essential criteria to be a ward sister. They also demonstrated a lack of infrastructure for the future of nursing because, as highlighted before, in England since 2013, nursing has become a degree prepared profession, and if ward sisters, as clinical leaders, are not expected to have

degrees there will be a lack of clinical academic role models in clinical practice for the current undergraduate student nurses. A large majority (85 percent) of ward sisters in my own study stated that formal qualifications (albeit not necessarily degrees) were helpful preparation to become a ward sister. When triangulated this data was supported by the findings of the regression analyses that found that studying for formal qualifications had a statistically significant effect both before and after a nurse became a ward sister on the time it took them to reach the stabilisation phase. Although there is no national standard for pre-requisite qualifications to be a nurse manager in the USA, the Council on Graduate Education for Administration in Nursing (2012) published a position statement recommending that nurse managers should be educated to Masters degree level; such a statement has not been published in England and consequently there is no national vision or consistent approach to academic qualifications.

Building on this the results from the respondents showed there was very little formal preparation to help nurses become ward sisters or development and support for nurses when they became ward sisters, which represents a minimal financial investment in their future. The preparation offered appeared to be generic, and although there is a case to be made for nurses being developed with other staff groups to improve multi-professional working and better understanding of different roles, there are specific learning needs for aspiring ward sisters. It was disappointing to see that fewer than half of the organisations employing the questionnaire respondents offered a specific band 6 development programme, and fewer than a quarter of them had ward sister development programmes. These findings from phase I demonstrated that there is little preparation for nurses who are aspiring ward sisters. Nicholson and West (1988) are clear that the preparation stage of job transition is important and if people are well prepared for the transition they are more likely to manage the whole job transition.

Having a ward sister development programme or a specific development programme for new ward sisters had quite a lot of support, and disappointingly just over a fifth of Directors of Nursing said their organisations offered an in-house development programme. It should be remembered that the majority of ward sisters said that they required development on many issues even when they had been in the post for over two years, therefore this type of development may not be a 'one off' offer but a continuous support requirement, the ideal of having constant development for ward sisters was supported in studies led by Mackoff and Klauer Triolo (2008a) and Balasco Cathcart and Greenspan (2012). A number of studies in the literature review suggested the subjects that should be in such a programme and other studies described how development programmes had been evaluated. My own study gave a perspective of current developmental needs as assessed by ward sisters and a view of the many challenges facing ward

sisters as identified by both the ward sisters themselves and Directors of Nursing. When this information was triangulated it gave a clear view of what should be covered in ward sister development programmes (see Table 6.1).

Disappointingly, a third of respondents reported they did not ensure that ward sisters met regularly with their managers. Meeting with managers has been shown in the literature and explained in the findings chapter of this study to be a very supportive management tool to help ward sisters (Kath et al, 2012). Understanding what is expected of them in the new role was identified as a challenge by the ward sisters. One way to ensure that the ward sister and the manager are both clear about each other's roles and what is expected to be achieved is by having regular meetings. This will be discussed later in more detail, however it should also be noted that meeting managers was raised by the ward managers in phase III as a method that would have helped them manage the transition more effectively.

The number of development opportunities both before and after nurses become ward sisters demonstrated a very mixed picture in the respondents' organisations and confirmed there is no nationally agreed framework for Directors of Nursing to follow to help prepare nurses to become ward sisters or to develop them once they are in post. It also demonstrated that nurses were dependent on their employers for development and whilst generally the opportunities were few, some nurses were offered a lot of development opportunities.

The information from the Directors of Nursing adds to nursing knowledge about preparation and support for ward sisters, as these results give the first representation of what is offered in terms of preparation to become a ward sister and ongoing support for appointed ward sisters. Before this the most recent published literature was the RCN report (2009). Whilst this report also painted a picture of a lack of consistent preparation and support opportunities it was from the perspective of ward sisters, and not, as in the case of my own study, from the perspective of the employers, who are responsible for ward sister development.

6.4   Role of the ward sister

As depicted in the conceptual framework (Figure 2.4) which summarised the literature review the role of the ward sister is well documented globally. From the information collected at the focus groups it is clear that the ward sisters in this study agreed with the majority of the RCN (2009) findings that the ward sister role is about managing a team of nurses, being a role model and developing the staff. However apart from one participant saying that the ward sister 'sets the ethos of the ward' there was no conversation about the ward sister being a clinical expert. On the contrary, the participants did say that they were spending less time being 'clinical' and that it

was hard to balance meeting the clinical needs against the administrative requirements of the role, a sentiment also reflected in the challenges identified by the ward sisters in phase III.

My own study has built on the RCN (2009) findings in a number of ways, firstly the RCN (2009) stated that there was very little preparation to become ward sisters, my own study provided a perspective from the ward sisters about what development would have helped them transition into the role more effectively. My own research also offered a view of the ward sisters' development needs and further demonstrated that even experienced ward sisters identified that they needed ongoing training. The recommendations in this study also developed the themes from the RCN (2009) recommendations, including a review of the ward sister person specification, to define the parameters of ward sister supervisory status and a formal training programme for ward sisters.

Towards the end of the focus groups the ward sisters were asked if they would agree that the ward sister was expected to be a researcher. This was met by an overwhelming view that with all the other priorities there was no time to participate in research. One ward sister agreed that research was important (her background was in research) but said that she did not do any as a ward sister. They all agreed however that there was a lot of audit work attached to the role, and they do lead this in their areas. It would appear from my focus groups' findings triangulated with the data accumulated in phases III and IV, that ward sisters did not perceive that research was part of their role. Research was also found (in phases III and IV of my own study) to be a low priority in terms of ward sisters' current development needs. Although there is a growing evidence base for nursing care, it is in its infancy and it is unlikely to gain impetus if nurses such as ward sisters who have great influence over the quality of care, do not value such evidence and do not take time to read, share and implement it for the benefit of patients. There is a clear role for nursing leaders to ensure research is given the recognition it deserves, as nurses are more likely to be interested in research if their role models demonstrate its importance. However unless research activity and impact is given more priority and is seen as an equal to organisational priorities including access targets, finance and agency staffing it is unlikely that research will be given the focus it should have by leaders and ultimately in clinical areas.

The focus groups were helpful in reviewing the findings of the RCN (2009) study to gauge whether the findings were still current. The majority of the information shared in my focus groups did reflect the findings of the RCN (2009) study, and that is both positive and negative. It is positive in that the role of the ward sister was described in much the same way three and five years on so there is a consistency of approach to these clinical leader roles. This is helpful in terms of the preparation and encounter phases of the Nicholson and West (1988) transition

theory meaning that nurses who have worked with sisters for a number of years are likely to know what the key parts of the new role will be as it has not changed dramatically. The preparation stage is likely to be influenced by anxiety about expectations and self doubt about one's ability to do the job, however this anxiety can be used positively to get ready for the job, to clarify what the job entails, plan how to act and to set key objectives for the first few months. It is not positive to realise that despite national recommendations being made by the RCN, nurses are still not being prepared or supported adequately for this important role. It is not known why there has been a lack of political and professional will to lead the changes that were recommended in the RCN (2009) report, however it may demonstrate the lack of political influence nursing has on health service policy. It may also be that nursing does not have a professional royal college (the Royal College of Nursing is both a trade union and a professional body) in the same way that the medical profession does to set the required standards across the various levels of the career path. A national ward sister development programme may be perceived as too expensive to implement in the current context of austerity. The dearth of UK based research about the productivity and influence of ward sisters may also be a reason for inactivity as there is little empirical evidence of the importance of this role to quality of patient care and staff experience.

The findings from my own study served to support previous descriptions of the ward sister role, as it confirmed that the role has not changed dramatically in the last decade and was similar to its counterpart in the USA, the nurse manager.

6.5   Managing the ward

Learning how to do the job is seen by the ward sisters to be a challenge in itself, especially with regard to managing a team and the ward budget, this was supported by both focus groups and responses to the questionnaires. The ward sisters seemed to think it was very important that they knew and understood HR policies so they could manage the staff effectively; not having HR support in some instances made this more challenging. Likewise the ward sisters appeared to understand how important financial issues were and they highlighted that this was one of the most difficult matters for them; the financial aspect of the role was also reported as a key challenge for ward sisters by the Directors of Nursing. The staff, and being able to manage them, were found by Shirey et al (2010) to be a cause of perceived stress by nurse managers. These challenges relate to the encounter phase (Nicholson and West, 1988) when nurses become ward sisters it is usually the first time that they have responsibility for managing staff and finance. In the first few months of the job, ward sisters are likely to be involved in a number of complex situations which will require them to understand organisational policy and have the skills to negotiate, influence or guide people through to a satisfactory conclusion. Without preparation

and ongoing support ward sisters may find themselves in situations that they are unable to navigate which may result in negative consequences for the organisation, themselves and others involved. Nicholson and West (1988) suggested that the level of culture shock experienced by a person in the first months in a new job is related to the way in which they were prepared for the job move, thus demonstrating how one stage of the transition cycle may be influenced by another. It is not surprising that the ward sisters suggested they required support and development to help them to do this to the best of their ability, even when experienced.

6.6   Prioritisation

The ward sister role is usually the first experience a nurse will have of being responsible for other peoples' work 24 hours a day. Being an RN, even at deputy ward sister level means that they may direct people clinically, are accountable for what they do and may manage a small number of people, but these responsibilities are minor compared with that shouldered by ward sisters, as evidenced by the findings of this study. A large number of responses from both the participants in the ward sister focus groups and the respondents to the Director of Nursing questionnaire cited time management and the skill of prioritisation as the major challenges of the role. The language used by the ward sisters painted a picture of having to work either clinically (caring for patients) or managerially (attending meetings or doing paperwork) and that they found it difficult to balance patient care with paperwork. The picture was not very sophisticated as the ward sisters did not appear to understand that the work would flow on a spectrum between both of these extremes or that time could rarely be delineated simply as being 'clinical' by the bedside, or 'managerial' in the office.

Having supernumerary or supervisory status was recognised by the ward sisters as something that would have helped them manage their time more effectively and enable them to get the balance right between being 'clinical' and 'managerial'. Most of the Directors of Nursing said that ward sisters had supervisory status for over 50 percent of their time, and this is also reflected in the ward sisters' responses but the stated desire to increase supervisory time demonstrated that ward sisters perceive themselves to be less effective when they do not have this status.

The ward sisters' inability to prioritise how to spend their time is likely to have consequences for their performance. At times, they may be 'too' clinical and therefore not give sufficient attention to the administrative aspects of the role, which may be perceived negatively by managers; conversely, if they are not working clinically they may be perceived by staff as unsupportive, thus reducing their ability to be a clinical role model. The ability to manage one's own time may change through the transition cycle, once in a new post (encounter phase), ward sisters may spend more time clinically not only because this is the part of the role they understand but

because, as the findings demonstrated they want to get to know their team and become credible. As they become more confident in the role (adjustment and stabilisation phases), they may be less clinical and more focused on the coordination of the ward and contributing to organisational meetings outside of the clinical area. It is important that through support and development that ward sisters gain the skills to move seamlessly between the administrative and clinical managerial/leadership aspects of the role to lead the team and assure themselves of the quality of care delivery for which they are responsible.

6.7   Nurse staffing

Nurse staffing has been the subject of much publicity in the last couple of years, accompanied by the publication of new national guidance (NICE, 2014), and the ward sisters involved in my own study highlighted that managing staffing to ensure the ward is safe is a major concern for them. This concern not only encompassed maintaining staffing numbers, but also managing difficult staff, managing temporary staff and how all of these factors affect the quality of care. Being responsible for the quality of care at all times was seen as a key issue for the ward sisters, which the Directors of Nursing felt to be the number one challenge for ward sisters. It is important that ward sisters have well developed management skills to run all aspects of the ward effectively: as McGuire and Kennerly (2006) demonstrated, staff nurses who had a good relationship with their nurse manager are more likely to have job satisfaction and allegiance to the organisation.

6.8   Expectations

Understanding what exactly is expected of the ward sister once in the role, and what the role entails is another aspect that the ward sisters found challenging. Earlier in this study it was noted that Paese and Mitchell (2007) identified that being very clear about expectations was a crucial action organisations should make to support leaders in transition. This linked to having a good working relationship with managers; it is essential for ward sisters to meet their managers regularly, and to discuss what is expected of them so they have a framework in which to work. In theory, knowing what to do should not be as difficult as it would appear from the findings of my own study to be because as described above, there is a well-established body of literature about the ward sister role. However, the RCN (2009) highlighted that there was an element of role confusion, rather than role clarity, and having regular meetings with one's manager would help to address any confusion that existed. Having unambiguous expectations from all stakeholders is vital if ward sisters are going to manage the encounter phase well. The encounter phase consists of the first months in the new role and although a good preparation for the new job will help the encounter stage is often characterised by *surprise* (Nicholson and West, 1988) and may be the most stressful stage of the whole transition. During the encounter stage the person will be

working in a new environment, managing situations they have not experienced previously, working with different managers, peers and subordinates, all of which may be difficult to manage. This is particularly so if expectations of the individual are ambiguous, which is one of the ways in which the organisation and managers can help the ward sister by being clear about short term goals and ensuring that regular supportive meetings do happen.

6.9   In hindsight

The ward sisters in the focus groups and the ward sister respondents to the questionnaires in phases III and IV gave a view as to what would have helped nurses transition into the ward sister role more effectively. The ward sisters gave many examples, often more than one each in a response, of what they thought would have helped them when they first became ward sisters.

Coaching was the most popular support identified. Taking into account the fact that almost half of the respondents had received some coaching, almost half of the Directors of Nursing said coaching was available from people who worked in the organisation and almost a fifth said it was offered by external coaches, this demonstrated that not enough of the ward sisters had had the opportunity to receive all the coaching that they felt would have helped them. Having someone to talk things through with and reflect on experiences was highlighted by the ward sisters in the focus groups as something that would have helped them. However, there was an apparent lack of pro-activity on the ward sisters' behalf in finding a coach; some of their answers depicted a group that thought their employers should pay for and assign them a coach, despite many of them understanding how helpful coaching can be. The responsibility of employers in relation to staff development is discussed in more detail below.

As discussed earlier, there is a growing evidence base to demonstrate the impact of the quality of relationship between staff and their managers on the job satisfaction experienced (Huseman, 2009). This relationship should not be underestimated and throughout the focus groups and the ward sister questionnaire there were many references to how poor the managerial relationship often was and how the ward sisters felt they were left alone without an appropriate level of managerial support. Gabarro (1987) stated that the two most common reasons for failure in new jobs was not having previous experience upon which to draw, and having weak relationships with significant people; these two criteria of failure may be counteracted if the ward sister has good relationships with his/her manager as the manager can coach the new ward sister through the events s/he encounters for the first time.

The ward sisters' opinions above counter the perceptions of the Directors of Nursing, 90 percent of whom said that ward sisters met weekly, monthly or both with their managers. This highlights that it is not the fact that the meetings take place that is important per se, it is what is discussed

during them that creates value. A 30 minute meeting that includes feedback, reflection and short term objectives would be much more helpful than a two hour slot during which the conversation is not focused on performance or helping the ward sister carry out his/her day to day activities.

It was highlighted as early as 1980 by Pembrey that role modelling can be a very good tool when learning new skills and knowledge. Being able to spend time with an experienced ward sister who knows how to manage a ward, is well networked and manages stakeholders such as doctors effectively was raised as something that would have helped the transition phase. Working with someone more experienced may help ward sisters develop their approach to the clinical and managerial role dichotomy discussed above, and in the regression calculation was one intervention found to have a positive impact on the transition period once in encounter and adjustment phases. Socialisation is one way to help people identify with a new work role or work group: Marquis and Huston (2009) suggested that this may be effective when using role models and mentors and should accompany management training. The results of the ward sister questionnaire, the regression analyses and the focus groups would support the use of mentors and role models as well as more traditional educational methods to help ward sisters transition into their role, this will be discussed further in the conclusion chapter (8). In phase III those ward sisters who had shadowed someone found it to be very helpful as preparation for becoming ward sisters (although this was not noted as a particularly useful developmental tool for ward sisters once they were in post).

An interesting finding from the ward sisters was the support amongst them for having a handover period with the previous ward sister. If the new ward sister is being promoted within the same ward team and is working with the current ward sister this may be possible, but if this is not the situation it would be much harder to facilitate due to the lengthy average duration of the recruitment phase (from resignation to commencement of new incumbent). Having said that, the premise of a handover is not one that has featured in the published literature before; it was also not raised as a supportive tool by the Directors of Nursing when they described the development they offered. Having a handover period has not been mentioned in any of the published literature globally about ward sisters and therefore adds to the knowledge about the ward sister role.

It is widely acknowledged in the literature that there is little preparation for nurses to become ward sisters. This view is supported by the results of my own study and reflects the findings in the RCN (2009) study, in which it was clear that the ward sisters involved had had no preparation before taking on this challenging role. The ward sisters identified that, in hindsight, more preparation as a deputy ward sister would have been useful to aid the transition to the ward

sister role, and one indicated that as a result of this reflection she was consciously giving more responsibility to her deputies to maximise their experience. Although the majority of Directors of Nursing offered secondments as a way to prepare nurses to become ward sisters, none of them identified shadowing as a developmental offer.

The ward sisters were able to give a number of potential activities that would have given them more effective preparation for the transition to the ward sister role. An effective preparation stage is more likely to aid an effective job transition (Nicholson and West, 1988) which can only benefit an organisation as the ward sisters may reach the stabilisation stage with more confidence and more quickly.

6.10   Organisational culture

Important information was gained about the culture of the organisations in which the ward sisters worked. The ward sisters on the whole were very positive about the fact that they received support from the organisation for their professional and career development. This is encouraging as organisations do direct people's careers to an extent (Baruch, 2004) and it is good to know that generally the ward sisters worked in supportive environments where their careers could flourish. Having said this though, a third of the ward sisters then reported that they did not think they had received appropriate development to support them to do their job effectively. This is an interesting perception; despite having painted a picture in which it appeared that the ward sisters were working well in partnership with their managers regarding their development, they felt that they had not had the development they needed to be effective in their role. This sentiment is supported by the needs assessment carried out in phases III and IV of my own study, where an overwhelming majority of the ward sisters identified numerous learning needs. This finding links to the fourth stage of the Nicholson and West (1988) transition cycle, the stabilisation stage is when people have made the adjustment to the new role, they have successful routines, are established in their new role and are able to carry out the role with increased confidence and minimal supervision. As described earlier in the study the Nicholson and West (1988) transition model is cyclical so once the stabilisation stage has been reached, people may find that they wish to develop new skills or broaden the scope of their role and the cycle starts once more. This was reflected in the findings from my own study as it concluded that even when nurses reach the stabilisation stage in a ward sister role they continue to require development and support; therefore this adds to nursing knowledge in that continuous development should be offered to ward sisters and not only focused on newly appointed ward sisters.

An interesting dichotomy is the difference in perception between the Directors of Nursing and the ward sisters of the challenges faced by ward sisters. Whilst the points of view of the two

groups converged on a number of issues including quality of care and being able to prioritise, the Directors of Nursing, as may be expected, gave a broader view of challenges such as understanding how the ward sister contributes to the organisational objectives. Only one Director of Nursing raised time management as a challenge whereas it was one of the top challenges from the perspective of the ward sisters. This raised an important issue for ward sister development because in most organisations the Director of Nursing is the one person who is responsible for ward sister development and if they base the development offer on what they think these nurses need, they may miss a number of aspects that are critical to ward sister success.

The fact that the ward sisters identified their key challenges as *managing the ward, prioritisation, nurse staffing, expectations* and *the transition* itself added new knowledge to what has previously been ascertained about the ward sister role in the UK. The RCN (2009) study highlighted a number of pressures felt by ward sisters: not having supervisory status; lack of clarity about the role and different expectations from stakeholders; people management; lack of authority to act and an absence of support roles. My own study reflected these previous findings; however because at the centre of my own study was the transition to the ward sister role which is unique in UK literature the findings added two key themes;

· learning how to do the role with specific concentration on *how to prioritise the use of their time* and *how to manage the ward* and

· to prepare nurses for *identity changes* in relation to the transition.

It should be noted that although role transitioning was found to be a developmental need for nurse managers by Sullivan et al (2003), this was not identified in the published UK literature and my study was the first to find this in the UK.

It goes without saying that a positive transition to a ward sister role will be partly dependent on the person making that job role change, and partly on the managers supported by the organisational culture (Fischer, 2009). It is impossible to delve into intellectual capital theory in any depth but it would be remiss of me to not to mention it as a concept that the ward sisters introduced themselves in their responses by suggesting that their employer had a shared responsibility for their development. It is well accepted that for most organisations its staff are its greatest asset. Covell (2008) described organisations employing people for their intellectual capital; in other words they hire people with the right knowledge and skills to be of benefit to the organisation, and by doing so they increase the organisation's human capital. Likewise when people leave the organisation it is likely to deplete its human capital, this means that not only is there a loss in the number of staff when a person leaves but they also take their knowledge (intellectual capital) with them. Covell (2008) clarified that this is the same for healthcare

organisations and that Nursing Intellectual Capital is gained from academic courses, continuous professional development activities and experience. Covell (2008) puts forward a number of organisational relationships associated with Nursing Human Capital, including

- *'Employer support for nurse CPD is directly associated with nursing human capital.*
- *Nursing human capital is directly associated with patient outcomes.*
- *Nursing human capital is directly associated with organizational outcomes'* (p98).

This spelled out the benefits gained not only for organisations but for patient care if organisations invest in their human capital and support their staff to develop their intellectual capital. It also supports the notion that employers have a responsibility not only to recruit well but to invest in their human capital for the sake of positively enhancing outcomes for patient and organisational objectives. Laschinger et al (2006) also supported this in their study which found that a high rate of perceived organisational support related to a higher retention rate of nurse managers. The concept of developing nursing human capital is disappointingly not reflected in the responses from the Directors of Nursing in phase I, who described a lack of development opportunities for ward sisters and an associated lack of investment in developing the intellectual capital of their ward sisters.

6.11   Aspiring ward sister framework

In response to the question about what would have helped nurses to make the transition to ward sister effectively, it was clear that there was no one 'magic' intervention. It is reasonable to surmise from triangulation of my own data including the regression analyses that a multi-method approach with classroom training to support on the job training, with sufficient supervisory time, would be what most ward sisters would find helpful. Anthony et al (2005) concluded that the multi-method development approach was effective; they recognised that whilst on the job experience was useful, it was not enough to support new nurse managers and should be supported by a professional development programme. This approach has also been found to be effective in non-nursing environments as reported by Hill (2003) in a study into general management transitions.

From these findings it is clear that to ensure the preparation stage (Nicholson and West, 1988) for the new role is effective, the preparation offered aspiring ward sisters should consist of facilitating their continuous professional development through external courses and formal qualifications; giving them more responsibility within their day job; this would allow them to develop knowledge and skill under the supervision of their manager and could also include secondment to a ward sister role for a period of time. Aspiring ward sisters should also be

offered time to shadow an experienced ward sister other than their own manager as this would give them the experience of observing a different style to that which they are used to.

Figure 6.1 Aspiring ward sister preparation framework
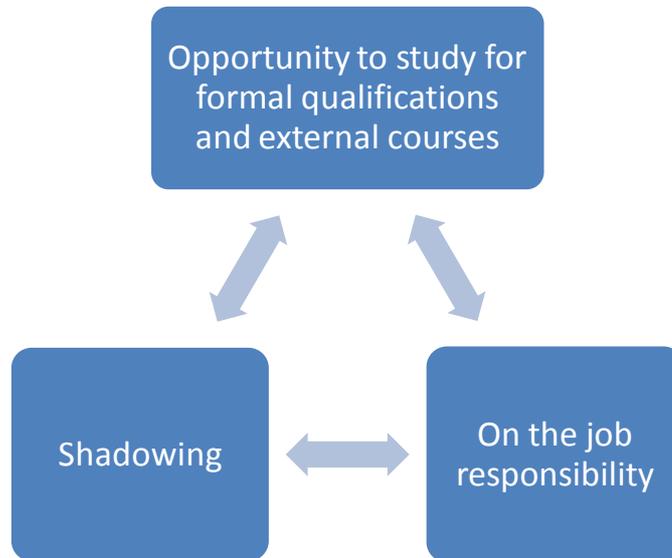
6.12   Development needs

Understanding current developmental needs is essential to help ward sisters perform well in their role and to aid them through the encounter and adjustment stages of the Nicholson and West transition cycle (1988). The adjustment stage is the time when the person understands the role and tasks required and following the initial months in the role has the confidence to make adjustments to the way in which they work to make the role their own. The process of adjustment enables the person to 'fit in' with the people, the organisational culture and finally having confidence in oneself to be in the role. Effective support and coaching from managers and peers have been found to help a successful adjustment stage (Nicholson and West, 1988). Combining the "top ten" priorities of all the respondents, those priorities of ward sisters with less than two years' experience and for ward sisters with more than two years' experience, demonstrated a clear prioritised list of developmental needs:

- Regulatory compliance

- Leadership

- Clinical effectiveness

- Change

- Finance

- Personal impact

- Patient experience

- Patient safety

- Influence

- People/HR management

This list is interesting as it combines theoretical areas such as finance and human resources management, with practical management skills such as influence and personal impact. A quality of care theme, comprising of regulatory compliance and patient safety also emerged. The data were analysed to determine whether there were differences between the order of priority for those new to the post and those with more than two years' in post, but the results were found to be very similar. However, the less experienced group were significantly more likely to express a need for finance and people management skills than were the more experienced group, who were more likely to stress the need for innovation and personal impact (but not to a statistically significant level).

It is important to note that the findings of my own study suggested, that development should not only be offered to new ward sisters, but should also be provided for the more experienced ward sisters who continued to have developmental needs. All the development subjects in the "top ten" of the more experienced ward sister group were chosen by more than 75 percent of them, demonstrating a perceived training need. This is a disappointing finding; although life-long learning as a characteristic of a professional is generally supported there must be a reason for the fact that such a high proportion of respondents identified that they required development in managing people and finances. This may be because not only is there a lack of preparation for, and a lack of support during the transition to ward sister roles, but there is also a lack of continuous professional development for this group of nurses. Another reason may be that expectations change and experienced ward sisters recognised that they required updating.

Sullivan et al (2003) carried out a developmental needs assessment for nurse managers. Apart from financial and people management skills training, their findings were quite different to my

own, however this may be due to the age of the study (12 years) and its USA base, but also to the quality of care revolution that has been seen in the NHS in the last decade. The number one developmental need in all three categories in my own study was *regulatory compliance* which means learning how to ensure that standards set by the Care Quality Commission (CQC) (2010) are maintained and that the ward and organisation are found to be compliant during CQC inspections; it is unlikely that this would have featured so highly even three years ago.

The results were analysed statistically to investigate whether development and support needs would require a different approach dependent on a number of variables including gender, age, tenure and geographical location. The analysis in the previous chapter offered a small number of nuances in terms of what different groups of ward sisters preferred, however those nuances were not numerous or deep enough to suggest that a diverse development offer, in terms of both content and delivery methods, should be made, however organisations may want to use these differences to reflect their own ward sister population.

Table 6.1 Leadership categories for ward sister development

Leading the team	Leadership
	Change management
	Finance
	People/HR management
	Time management
	Prioritisation
	Team building
Leading for quality	Regulatory compliance
	Patient safety
	Patient experience
	Clinical effectiveness
Leading oneself	Managing oneself through job transition
	Personal impact
	Identity
	Influence
Leading the organisation	Expectations for the role
	Organisational values and objectives

6.13 Ward sister development framework

This developmental needs assessment is a unique insight into what ward sisters in England currently view as requisite knowledge and skills to do their roles effectively. Amalgamating this list with a number of the key challenges (Table 6.1) gives employers and institutes of higher education a clear steer for curricula development. It should be noted that the framework is designed by using the priorities and has therefore omitted a number of subjects such as research and delegation. However such subjects are important and rather than be forgotten are likely to be included in other modules, for instance research would be part of clinical effectiveness and delegation part of time management.

The way in which nurses are prepared to be ward sisters and how they receive ongoing support may be flexible, and as described in the previous chapter a development programme which includes the subjects in Table 6.1 should be supported by the opportunity to shadow more experienced ward sisters and to study for formal qualifications. Good managerial relationships to guide and offer feedback on performance are essential, and a facilitated peer network with a handover from the previous ward sister were reported by the ward sisters to be helpful. This approach added new knowledge to what is already known about how to prepare and give appropriate support to ward sisters, there have been more recent evaluations of ward sister development programmes (Enterkin et al, 2013) but no evidence to support the suggested multi method approach has been produced. The framework is diagrammatically described in Figure 6.2.

Figure 6.2 Ward sister development framework

Leading the team	Leading for quality	Leading oneself	Leading the organisation

Ward sister development programme

Supported by

Ward sister network forum, with opportunity of shadowing

Opportunity to study for formal qualifications

Supportive managerial, coaching relationships

Handover from outgoing ward sister
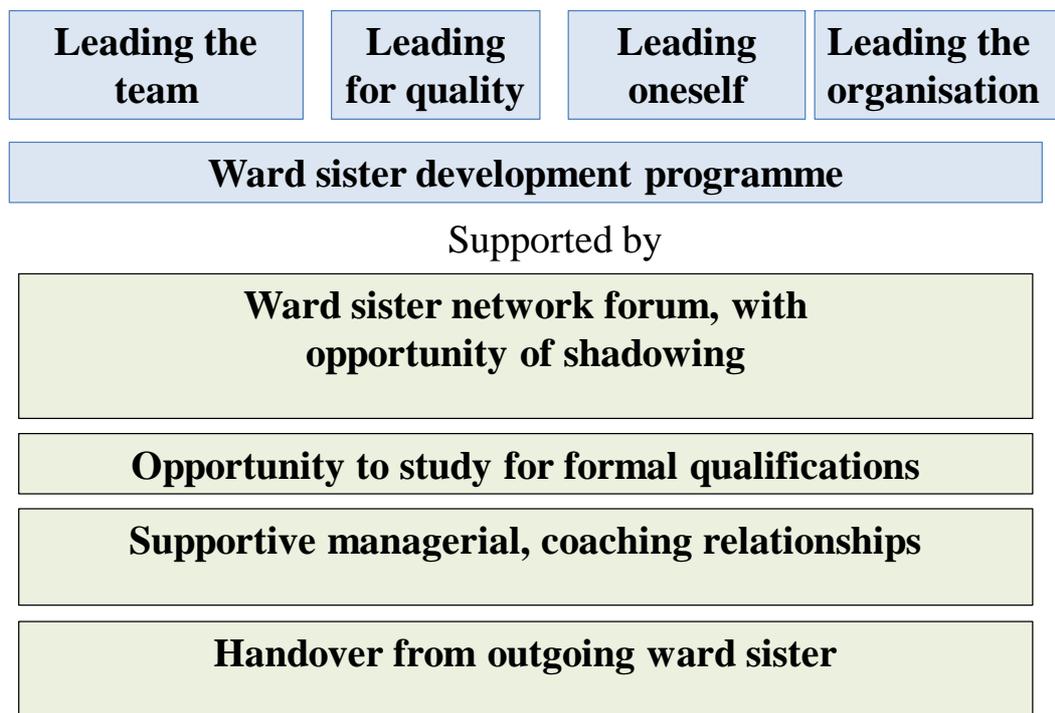
6.14   Conclusion

This chapter has discussed the findings set out in the previous chapter, with particular focus on how my own study answered the research questions

- What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- What preparation and support helps nurses manage the transition to the ward sister role?

The discussion chapter also demonstrated where my own study either added to and supported what is already known, or discovered new knowledge about what would help nurses manage the transition to the role of ward sister more effectively.

The methods of preparation and support that were offered to newly appointed ward sisters were ascertained, however as discussed earlier due to the poor response rate to the questionnaire in phase I the findings cannot be viewed as representative of the whole population. The study added to nursing knowledge by identifying the current ward sisters' developmental needs and their preferred methods of learning. These findings resulted in the creation of a potential development framework (Figure 6.2) for use by employers and higher education institutions in developing and supporting nurses to become effective ward sisters. The framework included managerial and leadership theory, quality of care elements and personal behavioural techniques.

This is the first time such a framework has been developed using information from ward sisters and Directors of Nursing working in multiple organisations across the country.

Although in house development was not found to have a statistically significant and positive impact on the period of time taken for nurses to become established in the ward sister role, the ward sisters did report that an in house programme was helpful to their ongoing development. The ward sister development programme (Table 6.1) is one element of continuing support for ward sisters and should be offered in conjunction with good managerial, coaching relationships, a peer network, and where possible a handover between the outgoing and incoming ward sisters. One of the goals of any organisation should be to ensure that its employees are able to function to their full capability, for nurses transitioning into ward sister roles, this means that they manage all aspects of the role competently and with confidence. The key issues relating to the transition from the findings discussed above were that there should be more preparation offered to aspiring ward sisters when they are in junior ward sister roles (preparation) this should include supporting them to study for formal qualifications. When new in post, ward sisters should be set clear expectations by their key stakeholders and should have knowledge of and support to implement organisational policies to support good people and resource management, they should also have access to shadowing more experienced ward sisters (encounter); ward sisters should be supported to manage how they are perceived by others in their new role (adjustment) and finally should receive ongoing support and development once established in their role (stabilisation). The findings from my own study have been used to design a developmental programme that if used would support all four stages; *preparation*; *encounter*; *adjustment* and *stabilisation* of the Nicholson and West (1988) transition cycle.

The study offered a unique insight into how nurses manage the transition to the ward sister role; it provided information about ward sisters' self-awareness through the process and the need for new ward sisters to become confident in their role and understand how to manage their relationships with staff, peers and other colleagues whilst establishing themselves in their new posts. This supported the recognised literature about job transitions and presented new knowledge about the transition to the role of ward sister. A number of limitations (chapter 7) have been identified in this study which restricts the way in which the results can be said to be reliable and also minimises their generalisibility to the population.

LIMITATIONS

The purpose of this study was to investigate the preparation and support given to ward sisters in the 21st century NHS and to discover from the ward sisters' perspective what preparation and support would help them through the transition to the role. The research questions in this study were

- What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- What preparation and support helps nurses manage the transition to the ward sister role?

The research methods were carried out to a high standard, but as with all research there were several limitations that have constrained the effectiveness of the study, and these will be discussed below.

The most prominent limitation, which has been discussed earlier in this thesis, is the low response rate to the questionnaire sent to the Directors of Nursing sample in phase I. Possible reasons for the low response rate were suggested in the findings chapter (5), including potential respondents being too busy to reply, a lack of interest and their absence from the office at the time the questionnaire, a high turnover rate and covering email were sent to them. It could be argued that the low response rate resulted in the findings from the Director of Nursing questionnaire not being representative of the population. However, as highlighted in the findings chapter there is no reason to believe that the non-respondents would have been very different from the cohort who did respond, and when the late responses were compared with the early responses there were no tangible differences. One of the main weaknesses of the small response rate was the associated limitation on the number of challenges for ward sisters identified by the Directors of Nursing. The questionnaire elicited 93 pieces of data from the respondents but if the response rate had been raised this would have enabled a better comparison with the ward sisters' perceptions. As described earlier the Directors of Nursing were reminded on a couple of occasions to complete the survey and in hindsight another possible action would have been to contact them or their secretaries directly rather than email requests. However, I was cognisant of the fact that repeat emails may be viewed as a nuisance if a person is busy or not interested. The response rate limited the national perspective offered on how organisations prepare and support nurses to be ward sisters.

The regression analyses were important to this study to investigate whether any developmental intervention, age or being a graduate had an impact on the transition period, however there were a number of limitations associated with these calculations. The first was that 49 participants'

data were not used because they had not answered the questions about how long it took them to reach the stabilisation phase; or they had answered the question but did not give a number of months because they either reported that they had not yet reached the stabilisation phase or they thought they would never reach it because of the ever changing environment. The result of this was that rather than have a sample of 173 there was 124. Miles and Shelvin (2001) highlight three possible ways to calculate the sample size for a regression analysis. The first is to have more than 100 in the sample, the second to have $104 + k$ (where k is the number of independent variables) and the third is $50 + 8k$. As stated in the findings chapter there were 14 independent variables and therefore the sample would attain the minimum level for the first two but not the third method. The sample was therefore adequate however a larger sample would have increased the probability of discovering a significant association.

The second limitation was that most of the independent variables were measures of how helpful the method of development had been as reported by the ward sisters. The ward sisters had been given four choices 'very helpful', 'helpful', 'not helpful' and 'not at all helpful'. This is not a continuous range and although the four categories flow it would have been better to calculate these questions by a Likert scales which would have given results on a continuous scale. However Miles and Shelvin (2001) suggest that a flexible approach may be taken with interval data and state that a risk of using continuous data only would mean that regression analysis would rarely be used.

When compared with previously published studies, the sample in phase III was one of the largest used in ward sister research. However, recruitment might have been even more successful if the ward sisters had been invited to participate in the study directly rather than asking Directors of Nursing to forward the invitation. Having reflected on this it would have been difficult to gain direct access to the ward sisters and the method used was practical in terms of the time limit of the study and as already highlighted the sample was large enough to gain the information required. Another limitation of this method was that a record of how many ward sisters received the invitation to participate was not kept and therefore an accurate response rate could not be calculated. The Directors of Nursing were not asked to record this number as I did not want to add further to their workload.

The study was a cross-sectional study, in that it investigated the subject of preparation and support for nurses who became ward sisters at one point in time only. The findings from my own study added to what was already known about this subject and also discovered new knowledge, including the developmental needs of ward sisters, how development should be delivered and how a transition may affect their identity. The findings offered a developmental framework to

nurse leaders to ensure nurses are prepared effectively and well supported in the ward sister role; however, if this study had taken a longitudinal approach it would have taken the findings a step further and this may be an option for future research.

The study investigated the preparation and support given to nurses working in the adult acute sector only and did not include those nurses who had similar roles in community, paediatric or mental health settings. Including different settings would have given the study a broader reach in terms of audience and would have enabled comparisons between different types of organisations which might have demonstrated different systems in relation to the preparation and support given to ward sisters.

Alongside the decision to base the research in the acute sector only was the decision to limit the participants to Directors of Nursing and ward sisters. These two groups were determined because ward sisters were the focus of the study and Directors of Nursing currently influence ward sisters' access to professional development to a greater extent. There are other groups who have a perspective on the development of ward sisters, including policy makers, Higher Education Institution leaders and other professional groups whose views were not taken account of in this study. There is no doubt that not including these groups is a limitation of the study, however a number of the recommendations reflect the importance of involving these stakeholders in future dialogue about the ward sister role.

The major limitation in phase II was that there was only one focus group and there were a number of weaknesses in how the focus group was facilitated that should be acknowledged. The purpose of the focus group was to review the findings of the RCN (2009) study, three and five years on in relation to the dimensions of the ward sister role, rather than gain new knowledge. The focus group in phase II was a small part of the whole study and it was decided that two focus groups would be sufficient. It was unfortunate that a second focus group could not be held as ward sisters at a conference did not want to participate and therefore to be pragmatic and due to time constraints one focus group only was held with a follow up in 2014.

As described in the method chapter (4) the focus group was held in a corner area of a bar, which although gave privacy there was the potential for the participants to be distracted during the focus group. The discussion could not be heard on the audio-record and therefore the data capture was reliant on the notes of the facilitator only. The fact that there was one facilitator only so only one person's version of the narrative was available is another limitation of the study as the facilitation and note taking were dependent on one person. Having a second facilitator would have helped to manage the focus group and may have recorded the conversation more accurately. These limitations were mitigated to a certain extent in that the notes of the focus

group were written up within six hours of it taking place and a transcription was sent to all of the participants to check for accuracy. None of the participants asked for changes.

The focus group in phase IV was audio recorded and the facilitator also took notes. Once transcribed the facilitator's notes were a good reflection of the verbatim notes with all key data being noted. This was helpful in that although it is inevitable that some data will not have been recorded in the first focus group the experience of the second focus group suggests that the main points in the first focus group were captured. The issue of confidentiality should also be addressed, the first focus group was facilitated in a public place and as such there was a risk that the conversation may have been overheard and therefore the participants' right to confidentiality breached. Although the focus group was not held in a private room the space was cordoned off from other people and because of the background noise it is very unlikely that anyone other than the participants heard the conversation. None of the participants raised any concerns that people were listening to the discussion.

The advantages and disadvantages of insider research have been highlighted earlier in this study, however it is important to reiterate that my status within the NHS is a limitation to the study. Due to being a national nursing leader, my position in relation to the participants and my in depth knowledge of the subject had the potential to bias the research process and the interpretation of the results. Understanding this possibility was one factor that led me to a quantitative dominated mixed methods research approach, as in this model I held a more objective role than that in interpretive research where the researcher plays a much more integrated role in the investigation.

There can be no doubt that there was a level of researcher bias in my study due to my own experience and knowledge; this included my belief that the ward sister is a vital position both in terms of safeguarding patient care but also to contribute to the success of the organisational business. It was therefore disappointing to me that a small number of Directors of Nursing chose to participate and that there was such variability in the type of development available to ward sisters. However, noting that, the data resulted in findings that I had not anticipated, such as the ward sisters' very positive perception of organisational support for their development and the desire for a handover between the outgoing and the incoming ward sisters. The use of questionnaires as the main method of data collection helped to minimise the chance of my own perceptions affecting the findings.

The data from the focus groups and from a small number of the questions in the questionnaires were thematically analysed by me only. This may be construed as a limitation of the research because it has not been validated by a second, more objective person. The data were analysed

using the themes in the conceptual framework that was developed following the literature review and although the data were coded by myself; this was done five times in total until I was clear that the primary and secondary codes were correct. The thematic framework evolved as the data were coded and it changed a number of times in response to the recoding of data. Once the framework was finalised the information provided by the participants was interpreted a further time and this enabled a consistent approach throughout the process.

CONCLUSION

8.1 Introduction

The purpose of this study was to answer the following research questions

- · What methods of preparation and support for new ward sisters are used in NHS acute hospitals in England?
- · What preparation and support helps nurses manage the transition to the ward sister role?

The study recorded the preparation and support given to ward sisters in the 21st century NHS and discovered from the ward sisters' perspective what preparation and support would help them through the transition to the role. The study was underpinned by the Nicholson and West (1988) transition model, how the findings relate to the cycle is described later. This chapter draws the study to a close, in that it sets out the new knowledge obtained from the findings, the recommendations for policy makers, organisations and ward sisters; a personal reflection on the research process, suggestions for further research and finally a conclusion.

8.2 Findings and new knowledge

This study is unique to the UK as it was the first study that has investigated what preparation and support would aid nurses to have a positive transition into the role of the ward sister. The findings were reviewed in the discussion chapter (6), to summarise, the findings were:

- An inconsistent national standard of experience and qualifications to become a ward sister

- A lack of consistency in preparation programmes to become ward sisters and the support they receive once in these posts

- Confirmation that the ward sisters in my own study concurred with the findings of the RCN (2009) study, in relation to agreeing that the ward sister is a leader, manager of the care environment and an educator, although the participants did not agree that the role included research

- Attending external courses and studying for formal qualifications before becoming a ward sister are interventions that were found to have a positive effect on the time period a nurse takes to reach the stabilisation phase of the Nicholson and West (1988) transition model in the ward sister role. Likewise studying for formal qualifications, attending conferences and shadowing a more experienced peer as a new ward sister was found to have a similar positive effect on the length of transition.

- The ward sisters' development needs and their preferred ways of learning were established

- That ward sister development is a joint responsibility shared between the employer and the nurse

The findings not only supported a lot of what has already been published in the UK and globally but also offered new knowledge as set out below about the preparation and support nurses require when they become ward sisters; this reflects the conceptual framework (Figure 2.4).

- *The preparation required for aspiring ward sisters*

My own study reported the development needs of nurses aspiring to become ward sisters and described what methods of training and education they found to be most useful.

- *The development needs once in a ward sister role*

My own study reported the development needs of inexperienced and experienced ward sisters and described the methods of training and education they found to be most useful

- *Interventions that reduce the time period to reach the stabilisation phase in the ward sister role*

The regression analyses demonstrated that whilst preparing to become a ward sister studying for formal qualifications and external courses had a positive effect by reducing the time period to reach the stabilisation phase when in the ward sister role. Studying for formal qualifications, attending conferences and shadowing a more experienced ward sister were shown to have a similar positive effect once in the ward sister post.

- *The design of development programmes*

This was not the purpose of my own study, however information was gained to demonstrate what methods of training and education ward sisters found to be most useful in their development. The evaluations of ward sister development programmes in the literature review chapter (2) were based on programmes delivered in house whilst this study has shown that a multi method approach more reflects the needs of the ward sisters.

- *The qualifications required to be a ward sister*

A small number of studies that were reviewed in the literature review chapter (2) referred to the qualifications required to be a ward sister. My own study did not attempt to address this issue but did confirm that there was no national standard, and that indeed not all ward sisters were educated to degree level.

To conclude the original contribution that my own study has made to nursing knowledge was

- identifying the learning needs of nurses who aspire to be ward sisters (preparation)

- establishing the development needs of ward sisters (encounter and adjustment)

- ascertaining the interventions before and after becoming a ward sister that reduce the time period taken to reach the stabilisation phase in the transition to ward sister role (stabilisation)

- proposing a core curriculum for ward sister development (encounter and adjustment) and

- designing a framework for ward sister preparation and ongoing development (preparation, encounter, adjustment and stabilisation)

8.3   Recommendations

This study has implications for national policy makers, NHS provider and commissioner organisations, Higher Education Institutions and nurses themselves; the recommendations from my own study will be explained in this chapter and will relate to the categories above.

8.3.1   National policy makers

1. *Consider the need for a national initiative to help strengthen the role of the ward sister; this would include*

   i) Definition of the ward sister role, which is sensitive to different locations and sectors;

   ii) Developing a national person specification for ward sisters;

   iii) Designing a ward sister accreditation which should be linked to competence;

   iv) Formulating a core national standard for ward sister development and support; which should be reviewed periodically;

   v) Defining the parameters of the supervisory ward sister role which takes into account contemporary practice and delivery of health care.

The findings from my own study demonstrated that there was no consistent approach to how nurses were recruited to the ward sister role across the country and once in post their development and support was dependent on local arrangements; resulting in some receiving anything from a great deal to no development. The current national situation exists despite many national recommendations since 1966 that nurses in these posts should receive preparation and support. There is much literature to support how influential ward sisters are on the quality of patient care and therefore on the business of healthcare organisations. More than 10 years ago, Cook and Leathard (2004) stated that preparation to become ward sisters was poor because there was no commonly agreed definition of the role and that training was not obligatory. To do their challenging roles effectively ward sisters require adequate support and development and this is only likely to happen via national policy, as if it is left to local initiatives the status quo is likely to continue. This could be facilitated by a national task force commissioned by the Chief Nursing Officer for England or by the Department of Health with a membership comprising of

representation from national organisations (such as trades unions and regulatory bodies), Higher Education Institutions, Directors of Nursing and ward sisters.

2. *Consider commissioning a cost benefit analysis of providing a national standard for ward sister preparation and development.*

Having recommended that a national standard for the academic and experience requirements to become a ward sister should be agreed and standards to be implemented for their development, it is of course essential that this reaps benefits for the individual organisations and the NHS as a whole and therefore a cost benefit analysis should be commissioned by the Department of Health to support these recommendations.

8.3.2   NHS provider organisations

3. *To ensure ward sisters' managers (matrons and/or senior nurses) have effective meetings with ward sisters to provide coaching, guidance and feedback*

4. *To facilitate a local ward sisters' network forum to enable effective peer support*

5. *To facilitate a ward sisters' development programme, to enable ongoing professional and personal development*

6. *To facilitate a handover (actual or virtual) between the outgoing and the incoming ward sisters*

7. *To provide supervisory status for ward sisters*

8. *To offer shadowing and secondment experiences to band 6 (deputy ward sister) nurses to enable them to develop their skills and knowledge whilst preparing to be a ward sister*

9. *To ensure band 6 nurses (deputy ward sister) are given responsibility commensurate with their experience to prepare them for the ward sister role*

One of the themes that ran through the discussion chapter (6) was the employers' responsibility to develop ward sisters and whilst it is clear the nurses themselves have a responsibility for their own development, nevertheless in relation to building human capital within their organisations employers share that responsibility. The findings from the ward sisters' responses gave evidence as to what would help them prepare for the role of the ward sister and what would help them establish themselves in the role once recruited. In relation to preparing nurses employers should have a programme in place whereby nurses who aspire to become ward sisters can shadow experienced ward sisters to get an insight into the role. Employers should also offer secondments to aspiring ward sisters to enable them to have on the job development and gain experience

before actually being in the ward sister role. Nurses at deputy ward sister level should also be given more responsibility so that they have the opportunity to learn about the different aspects of the ward sister whilst in a supporting role.

A ward sister development programme should be offered to all ward sisters; this should be built around the four aspects of the ward sister development programme based on the evidence from this study and described in Table 6.1. The development programme and framework is unique as it is the first time that such a programme has been created using information from Directors of Nursing and ward sisters from across the country. The development programme should not only be offered to new but to all ward sisters, as the findings clearly demonstrated that the majority of experienced ward sisters recognised they required ongoing development, this also links well to the Nursing and Midwifery's proposals for nursing and midwifery revalidation (Nursing and Midwifery Council, 2014). The development programme should be supported by effective management by the ward sisters' line manager and an organisation wide ward sister network forum (see Figure 6.2). Where possible an actual or virtual handover from the outgoing ward sister to the new ward sister should be facilitated, this will help the incoming ward sister to have more insight into the ward culture.

8.3.3 NHS commissioner organisations

10. *If a national standard for ward sister development is introduced commissioners should assure themselves that NHS providers have implemented effective actions to develop and support ward sisters*.

Clinical Commissioning Groups are the local bodies in England that commission healthcare services from provider organisations; the NHS standard contract (NHS England, 2013) includes quality standards that have to be achieved, many of which are influenced by the effectiveness of the ward sisters and nursing teams. If a national standard for ward sister development was adopted NHS commissioning organisations should hold provider organisations to account to ensure this was implemented.

8.3.4 Higher Education Institutions

11. *To develop ward sister development programmes in conjunction with NHS provider colleagues.*

The ward sister development programme described in Table 6.1 gives higher education institutions guidance on what ward sisters currently require in terms of skills and knowledge development; these courses could be designed at Masters level which would also help increase the number of ward sisters who are graduates. Although development programmes can be managed in house by provider organisations some will want to work in partnership with their

local education providers to offer courses with academic credits and providing that these courses are based in the reality of managing a ward they could offer a valuable alternative.

8.3.5 Ward sisters

12. To take responsibility for their own development in collaboration with their employer.

Many of the ward sisters recognised that they themselves have a part to play in ensuring their ability to be a successful ward sister and this is supported in the Nursing and Midwifery Council's Code of Conduct (2008). However, there was also a view from the ward sisters that their employer should take responsibility for their development. In conclusion this has to be a joint venture and as such the ward sisters should participate fully in their own appraisals and objective setting; should ask for feedback on their performance from managers, colleagues, team members and patients; they should advise their managers if they require certain kinds of development and they should impart their knowledge to aspiring ward sisters to help develop the next generation of ward leaders.

8.4 Personal reflection

This study has not only offered the nursing community new knowledge about the transition journey nurses experience when promoted to a ward sister but it also gave me a huge opportunity to delve more deeply into a fascinating subject and to develop many skills along the way. Having achieved a Masters degree 15 years before I started my own study I had a limited knowledge of research skills and expertise; over the past five years my ability to lead and implement a research project has grown exponentially, resulting in being very confident to coach Masters degree students and critique other research studies and results. However it is not only that I have developed research skills on this journey but I have changed from someone who had little curiosity about cause and effect in general life, and have developed an inquisitiveness about why and how events happen and how events are experienced differently by different people.

Reflecting on the way in which this study was conducted, I believe that the methods used were appropriate to answer the research questions below

- What methods of preparation for new ward sisters are used in NHS acute hospitals in England?

- What preparation and support helps nurses manage the transition to the ward sister role?

However I also realise that a non-experimental, cross sectional study such as this gives a perspective in a point of time only and that had I been a more proficient researcher with additional time a longitudinal study may have offered further new knowledge as a consequence of following cohorts of new ward sisters through the transition.

I have realised that I already had many skills that were useful as a foundation for developing my aptitude for research; these included i) time management, ii) planning and iii) presentation skills. I have developed over a number of years, a very successful way of managing time and within that am able to prioritise and implement tasks; this is a skill that I have used every day throughout the past five years and has enabled me to deliver my own study to the agreed deadline. Planning has been essential in enabling me to plan study time; deliver course work, pass exams and plan the timetable to complete this study. Finally I have developed presentation skills as an essential part of my career, I have presented aspects of my own study at international conferences and at healthcare organisations, imparting knowledge to colleagues is very important to me and I will continue to do so through publications and presentations once the study is complete.

My final reflection is that although the study has been all consuming, the last five years have been incredible in many ways from the knowledge and skills I have learnt, the people I have met and the generosity of people who have given their time to help me.

8.5 Further research

This study offers new knowledge to the nursing and health care communities not only in the UK but also globally. As stated at the beginning of my own study there is a dearth of research about the ward sister in the UK and as such my own study has started to fill the knowledge gap but one study cannot do that completely and as with most research it has identified where further investigation would be beneficial.

The diverse range of methods used to prepare nurses to become ward sisters and to support them once in ward sister posts should be explored to identify which methods are the most successful to help ward sisters be effective in their role, as highlighted earlier this could be a longitudinal study. A potential design would be to study two cohorts of aspiring ward sisters in a randomised control trial. The ward sisters could be followed through their transition to their second year of being a ward sister, one cohort could be offered the current development package available in their organisation and the second cohort could be offered the development package created from the evidence in my own study. Both quantitative and qualitative data could be collected to measure their experience of the transition and their effectiveness in the new post.

The supervisory status of ward sisters was introduced in to the UK a number of years ago and an evaluation of the impact this has on quality of care, staff experience and organisational sustainability would be beneficial to the NHS currently.

At present nurse staffing is high on the NHS agenda with a focus on how nursing numbers impact on quality of patient care, however this is one aspect only that has an impact on patient outcomes one other being the nursing leadership in a clinical area. Investigating the impact of ward sister leadership on the quality of patient care would be a complex study but would impart much needed new knowledge to compliment what is already known about how nursing numbers affect patient care and to demonstrate whether effective transformational ward sister leadership can positively affect the patient and staff experience.

8.6   Closing remarks

The study originated because of the importance I attached to the ward sister role in terms of their influence over patient care and the staff experience. There was however, a dearth of literature in the UK about how ward sisters were supported in practice and whether nurses became effective ward sisters by accident or whether there was any system to which they could refer. The review of NHS policy in the literature review chapter (2) demonstrated that the current situation disregarded a number of historical and more recently published policy documents that drew attention to the requirement to prepare nurses for this role and support them once they are in the role.

My own study was unique in the UK as it was the largest study to investigate the role of the ward sister. Although there have been published evaluations of local ward sister development programmes, for example Enterkin et al (2013) my own study was the first study in the UK to gain information about the preparation and support required from a national sample of ward sisters themselves. There have been previous UK studies that have described the role of the ward sister, the RCN (2009) study being the most recent and the findings from my study have correlated with these earlier findings apart from that the ward sisters in my own study did not agree that being a researcher was part of their role.

The key findings from my own study have presented new knowledge about the transition to the ward sister role:

- *The preparation required for aspiring ward sisters*

My own study reported the development needs of nurses aspiring to become ward sisters and described what methods of training and education they found to be most useful.

- *The development needs once in a ward sister role*

My own study reported the development needs of inexperienced and experienced ward sisters and described the methods of training and education they found to be most useful

- *Interventions that reduce the time period to reach the stabilisation phase in the ward sister role*

- The regression analyses demonstrated that whilst preparing to become a ward sister studying for formal qualifications and external courses had a positive effect by reducing the time period to reach the stabilisation phase when in the ward sister role. Studying for formal qualifications, attending conferences and shadowing a more experienced ward sister were shown to have a similar positive effect once in the ward sister post.

- *The design of development programmes*

This was not the purpose of my own study, however information was gained to demonstrate what methods of training and education ward sisters found to be most useful in their development. The evaluations of ward sister development programmes in the literature review chapter (2) were based on programmes delivered in house whilst this study has shown that a multi method approach more reflects the needs of the ward sisters.

- *The qualifications required to be a ward sister*

A small number of studies that were reviewed in the literature review chapter (2) referred to the qualifications required to be a ward sister. My own study did not attempt to address this issue but did confirm that there was no national standard, and that indeed not all ward sisters were educated to degree level.

Whilst the original contribution my own study has made to nursing knowledge is:

- identifying the learning needs of nurses who aspire to be ward sisters (preparation)

- establishing the development needs of ward sisters (encounter and adjustment)

- ascertaining the interventions before and after becoming a ward sister that reduce the time period taken to reach the stabilisation phase in the transition to ward sister role (stabilisation)

- proposing a core curriculum for ward sister development (encounter and adjustment) and

- designing a framework for ward sister preparation and ongoing development (preparation, encounter, adjustment and stabilisation)

The responses from the Directors of Nursing confirmed that there was variance in the amount and type of preparation and support given to nurses in ward sister posts. There was also a lack of

consistency in what qualifications and experience employers expected nurses to have before they became ward sisters.

The ward sisters in my own study offered a great deal of information about what interventions would have helped them prepare for the ward sister role; the key approaches were shadowing an experienced ward sister, on the job development and coaching. When triangulated with the data from the regression analyses it was demonstrated that shadowing a more experienced ward sister had a statistically positive effect on the time taken to reach the stabilisation phase. These results demonstrated that the preparation of nurses aspiring to become ward sisters should start when they hold deputy ward sister positions so they acquire a level of understanding of what is expected in a ward sister role before they actually attain such a post.

The study also offered a current view of the challenges ward sisters face when moving into the role and what their development needs are; when this information was triangulated with the responses to the same questions from Directors of Nursing my own study formulated a framework for ward sisters' development. Interestingly the interventions and content within the development framework was not only supported by newly appointed ward sisters but also by the more experienced ward sisters; and would therefore support their continuous professional development.

Particular development needs in relation to the role transition to a ward sister have been found in previous studies in the USA, for example Conley et al (2007). My own study was the first to illustrate this need in relation to ward sister posts in the UK by using a national sample and gave detailed information about how ward sisters should be supported through the transition cycle with specific reference to identity and relationships with colleagues.

Quality of care has never been so important to the success of the NHS from both the perspective of the public and policy makers. Although Directors of Nursing have immense influence on systems and processes within an acute care setting it is the ward sister who will be implementing the corporate processes; they will have the most impact on quality of care because within their role they have 24 hour responsibility for their clinical area and are closer to the reality of providing patient care. This study gave a clear framework to Directors of Nursing to help them implement supportive measures for ward sisters; or to replicate the study in their organisation to obtain a more local review of what their ward sisters' development needs are and how they would like development to be delivered. A more local study was implemented in phase IV of my own study when a sample of ward sisters from the same organisation responded to the questionnaire; their results were remarkably similar to those in the national cohort.

As I said in the introduction to this thesis not only have I been a ward sister but I have held leadership posts where my performance has been influenced strongly by the effectiveness of the ward sisters I worked with. Ward sisters to me are the central role within an acute healthcare organisation and this is supported by the literature referred to within my own study (Bradshaw, 2012). The ward sister role is essential but is also very complex and challenging and as such, to be effective nurses should have more preparation when they are in junior ward sister roles, including studying for formal qualifications (preparation). When new in post, ward sisters should be set clear expectations by their key stakeholders and should have knowledge of and support to implement organisational policies to support good people and resource management, which will be helped significantly by shadowing more experienced ward sisters (encounter); ward sisters should be supported to manage how they are perceived by others in their new role (adjustment) and finally should receive ongoing support and development once established in their role (stabilisation).

The conclusion to this study is that nurses become ward sisters more often than not by accident rather than by design, however my own study offered a number of national and local recommendations that, if implemented could change the fortune of ward sisters, which can only benefit the patients in their care and the staff responsible to them.

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APPENDICES

Appendix 1 How the questions in phase I and phase III questionnaires relate to the conceptual framework and Nicholson and West's (1988) transition model

Conceptual framework

Conceptual framework	Question numbers in phase I questionnaire to Directors of Nursing	Question numbers in phase III questionnaire to ward sisters
Evidence of preparation before becoming a ward sister	10	6, 9
Evidence of development in ward sister posts	11	7, 25
Evidence of what development ward sisters require	11	7, 9-22
Evidence of required qualifications	9	28

Nicholson and West's (1988) transition cycle

Phase of Nicholson and West's (1988) transition model	Question numbers in phase I questionnaire to Directors of Nursing	Question numbers in phase III questionnaire to ward sisters
Preparation	10	6, 25
Encounter	11, 12	7, 8, 9-22, 25
Adjustment		9, 25
Stabilisation		9, 24, 25

Appendix 2 Director of Nursing (phase I) questionnaire

1. What is the name of your organisation?

2. Which SHA region is the trust in? (using pre October 2011 SHA boundaries)

- ⚪ East Midlands
- ⚪ East of England
- ⚪ London
- ⚪ North East
- ⚪ North West
- ⚪ South Central
- ⚪ South East Coast
- ⚪ South West
- ⚪ West Midlands
- ⚪ Yorkshire and the Humber

3. Is your organisation a Foundation Trust?

- ☐ Yes
- ☐ No

4. What is the total number of beds ? (include children's, maternity and critical care)

- ⚪ <400
- ⚪ 400-599
- ⚪ 600-799
- ⚪ >800

5. How many ward sisters* do you employ?

*for this study, ward sisters are defined as those who have 24 hour responsibility for a ward, they are usually band 7 and are primarily in charge of a ward. They may be called ward manager and includes both males and females. All ward sisters of adult medical, surgical and gynaecology wards only should be included. This study excludes paediatrics, critical care units (ICU, HDU), theatres and maternity areas.

6. On average how many ward sisters* do you recruit in 2011?

7. What methods do you use to recruit ward sisters*?

- ☐ Stakeholder sessions
- ☐ Presentation to stakeholders
- ☐ Presentation to interview panel
- ☐ Interview panel
- ☐ Psychometric tests
- ☐ Written tests
- ☐ Practical tests

Other (please specify)

8. What was the total nursing and midwifery turnover percentage rate in 2011/12?

9. Please identify which of the following criteria are essential for the role of a ward sister* in your trust

- ☐ Registered Nurse
- ☐ Degree level education
- ☐ Post registration nursing qualification
- ☐ Managerial qualification
- ☐ Experience as a band 6 nurse

Other (please specify)

10. Does your trust offer any of the following methods in a systematic way to help nurses prepare for the ward sister* role?

- ☐ Period of secondment into ward sister role
- ☐ In house leadership/managerial development course
- ☐ National leadership/managerial course
- ☐ In house sister development course
- ☐ National sister development course
- ☐ Band 6 in house development course
- ☐ Succession planning framework
- ☐ Nothing

Other (please specify)

11. Does your trust offer any of the following to all new ward sisters* in their first year?

- ☐ New sisters' in house development course
- ☐ Buddy system
- ☐ Action learning sets
- ☐ In house coaching
- ☐ External coaching
- ☐ In house sister development course
- ☐ Ward sister competency framework
- ☐ National sister development course
- ☐ Nothing

Other (please specify)

12. Approximately how much money do you invest in a Registered Nurse in their first year as a ward sister?

○ <£5000

○ £5001-£10000

○ £10001-£20000

○ >£20001

13. Do the ward sisters* in your organisation have supervisory status?

○ Yes, 100% of the time

○ Yes, 50-99% of the time

○ Yes but less than 50% of the time

○ No

14. In your opinion what are the top three challenges facing nurses in the first year as a ward sister?

1.
2.
3.

15. If you have any further comments about the transition to the role of the ward sister, please enter below.

16. I am recruiting ward sisters who have been in post for less than two years to participate in the part three of this research study. It will involve completing a survey about how they are managing being a ward sister and the development and support they had to help the transistion to the ward sister role, it should take less than 30 minutes and will be sent in Autumn 2012. If you would be willing for your ward sisters to participate please confirm in the box below.

○ Yes, I confirm I would like the trust to participate.

○ No thank you

17. If you have agreed to question 12 please add your name and the name of your organisation

Name

Organisation

Appendix 3 Becoming a Ward Sister – Accident or Design?

UNIVERSITY
of
GREENWICH

Mrs Jacqueline McKenna
Faculty of Education & Health
University of Greenwich
Mary Seacole Building
Southwood Site
Avery Hill Road
Eltham SE9 2UG

Direct Line 020 8331 8842
Direct Fax 020 8331 8824
Email research_ethics@gre.ac.uk
Our Ref UREC/1112.3.5.22
Date: 29th July 2014

Dear Jacqueline,

University Research Ethics Committee – Application ref. 1112.3.5.22

Title of Research: Becoming a Ward Sister: Accident or Design?

I am pleased to confirm that your application to amend your research proposal as follows:

- Undertaking surveys and a focus group to research the role and remit of ward sisters

was **approved** by Chair's Action on behalf of the Committee and that you have permission to proceed.

I am advised by the Committee to remind you of the following points:

- You must notify the Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Committee and/or which would raise questions about the safety and/or continued conduct of the research;

- You must comply with the Data Protection Act 1998;

- You must refer proposed amendments to the protocol to the Committee for further review and obtain the Committee's approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

- You are authorised to present this University of Greenwich Research Ethics Committee letter of approval to outside bodies in support of any application for further research clearance.

On behalf of the Committee may I wish you success in your project.

Yours sincerely

John Wallace
Secretary, University Research Ethics Committee

Cc: Professor Elizabeth West
Professor Pat Schofield

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Appendix 4 Director of Nursing (phase I) pilot questionnaire

Transition to ward sister role

1. What is the name of your organisation?

*2. Which SHA region is the trust in? (using pre October 2011 SHA boundaries)

○ East Midlands

○ East of England

○ London

○ North East

○ North West

○ South central

○ South East Coast

○ South West

○ West Midlands

○ Yorkshhire and the Humber

*3. Is your organisation a Foundation Trust?

☐ Yes

☐ No

4. What is the total number of beds ? (include children's, maternity and critical care)

○ <400

○ 400-599

○ 600-799

○ >800

Transition to ward sister role

* **5. How many ward sisters* do you employ?**
*include ward sisters who have 24 hour responsibility for acute adult wards only

* **6. On average how many ward sisters* do you recruit in a year?**

* **7. What was the nursing turnover percentage rate in 2010/11?**

Transition to ward sister role

8. Please identify which of the following criteria are essential for the role of a ward sister in your trust

☐ Registered Nurse

☐ Degree level education

☐ Post registration nursing qualification

☐ Managerial qualification

☐ Experience as a band 6 nurse

Other (please specify)

[   ]

9. What does your trust offer nurses in preparation for the ward sister role?

☐ Period of secondment into ward sister role

☐ In house leadershipmanagerial development course

☐ National leadership/managerial course

☐ In house sister development course

☐ National sister development course

☐ Band 6 in house development course

☐ Nothing

Other (please specify)

[   ]

Transition to ward sister role

10. What support does your trust offer ward sisters during the first year in the role?

- ☐ New sisters' in house development course
- ☐ Buddy system
- ☐ Action learning sets
- ☐ In house coaching
- ☐ External coaching
- ☐ In house sister development course
- ☐ National sister development course
- ☐ Nothing

Other (please specify)

[   ]

11. In your opinion what are the top three challenges facing nurses in the first year as a ward sister?

1.
2.
3.

*12. I am recruiting ward sisters who have been in post for less than two years to participate in the part three of this research study. It will involve completing the Maslach Burnout Inventory and a survey about the development and support they had to help the transistion to the ward sister role, it should take less than 30 minutes and will be sent in Autumn 2012. If you would be willing for your ward sisters to participate please confirm in the box below.

○ Yes, I confirm I would like the trust to participate.

○ No thank you

13. If you have agreed to question 12 please add your name and the name of your organisation

Name

Organisation

Appendix 5 Invitation to complete Director of Nursing questionnaire (phase I)

From:	"**[Email REDACTED]** via surveymonkey.com" <member@surveymonkey.com>
Subject:	Message from Jacqueline Mckenna, Director of Nursing
Body:	https://www.surveymonkey.com/optout.aspx Dear Colleague Here is a link to the survey https://www.surveymonkey.com/s.aspx This link is uniquely tied to your email address. Please do not forward this message. I am a Director of Nursing and am conducting a PhD study at Greenwich University into the transition to the ward sister role. The attached survey is the first phase and has been sent to all Directors of Nursing in England. I am sure the role of the ward sister is important to all of us and I would be very grateful if you would take 15 minutes to complete the attached survey. Should you want to discuss this with me or want further information about the research please email me at **[email REDACTED]**. Background information Whilst many of the policy documents since 1948 have proposed that nurses require preparation for this role, preparation is not mandatory. There is also very little British research on the subject, the most recent being the RCN's study 'Breaking down the barriers' (2009). This research is investigating whether a relationship exists between the way in which a nurse is prepared and supported for the role of ward sister and how ward sisters perceive they manage the transition to this role. The main aims of the research are: • To identify the methods of preparation and support for new ward sisters currently used in English hospitals • To identify what kinds of preparation and support seems to be most effective in helping nurses manage the transition to the ward sister role. The hypothesis of my research is that nurses who receive preparation for and support in the first year of being a ward sister will manage the transition more effectively. The research will be in three phases. The participants in phase I, will be Directors of Nursing in acute hospitals in England, this questionnaire is Phase I. Phase II, will use a focus group of ward sisters to elicit what the role of the ward sister is and what preparation and support they had to aid their transition to be ward sister. The focus group will use the RCN's Breaking the Barriers (2009) research as a basis for discussion with the aim of achieving a consensus of the role of the ward sister to be used in Phases III. The information from the focus group will help develop the survey which will be the main part of the design of the study in phase III. Phase III they will be Registered Nurses who have been ward sisters for less than two years in acute adult wards in acute hospitals, across England. The method of inquiry will be surveys administered via email to a sample of 300 ward sisters. My purpose in writing to you is twofold:

To request that you complete the attached questionnaire which should take less than 15 minutes.

To ask if you would support your ward sisters to participate in the main part of this study, which will involve completing a questionnaire about the preparation and support they have had during the first two years of being a sister.

All information collected about you during the course of this research will be kept strictly confidential. The results of the study will be used in my PhD thesis, in reports, published articles and presentations. Anonymity will be in place constantly.

Thanks for your participation.

Jacqueline McKenna
Director of Nursing
Medway NHS FT

Jacqueline McKenna
PhD student Greenwich University
Director of Nursing, Medway NHS Foundation Trust
Email **[REDACTED]**

Professor Elizabeth West
Director of Research
School of Health and Social Care
University of Greenwich

Email e.west@gre.ac.uk

Appendix 6 Thematic Framework for challenges for ward sisters

PRIMARY CODE	NAME	SECONDARY CODE	NAME
TRA	Transition	LEA	Leadership role
TRA		TRA	Transition
TRA		PRE	Preparation stage
TRA		ENC	Encounter stage
TRA		ADJ	Adjustment stage
TRA		STA	Stabilisation stage
ROL	Role	ACC	Accountability
ROL		UND	Understanding role
ROL		QUA	Quality
ROL		MAN	Management
ROL		AUD	Audit
ROL		EDN	Education
ROL		PER	Performance management
ROL		CUL	Culture
ROL		MDT	Multi disciplinary team
ROL		STA	Staff
ROL		LEA	Leadership
ROL		SUP	Supervisory
ROL		ADM	Administration
ROL		POL	Policies
ROL		BUI	Team building
ROL		TAR	Targets
ROL		SCR	Scrutiny
COM	Competencies	COM	Complaints
COM		BUD	Budgets/Finance
COM		CLI	Clinical
COM		RES	Resources
COM		STA	Staffing
COM		CON	Conflict
COM		PER	Performance management
COM		QUA	Quality
COM		BEH	Behaviour
COM		ORG	Organised

COM		LEA	Leadership
COM		DEL	Delegation
COM		CMN	Communication
COM		DEC	Decision making
COM		CHA	Change management
COM		MAN	management
STR	Stress	COM	Complexity
STR		ROL	Role
STR		PRI	Priorities
STR		CON	Conflict
STR		BUD	Budget
STR		TIM	Time
STR		STA	Staff/staffing
STR		DEP	Patient dependency
STR		ISO	Isolation
STR		COP	Coping with stress
STR		SEL	Self pressure
STR		MAN	Manager
LEA	Leadership	NET	Network
LEA		LAC	Lack of
LEA		MAN	Manager
LEA		STA	Staff
LEA		ALL	All/others
SUP	Support	LEA	Leadership
SUP		MAN	Management
SUP		PER	Performance management
SUP		LAC	Lack of
SUP		STA	Staff management
SUP		ROL	Develop the role
SUP		TIM	Time
SUP		SEL	Self development
SUP		BUD	Budget

Appendix 7 Focus Group Discussion Guide

<u>Focus Group Discussion Guide</u>

<u>Welcome</u>

Moderator will welcome everyone to the focus group session and thank them for taking time out of their day to contribute to the focus group.

<u>Explain the purpose of the focus group</u>

Moderator will explain the purpose of the focus group saying:

The focus group is part of a PhD study investigating what preparation and support is given to nurses when they move to the role of the ward sister to help them move successfully. For the purpose of the research and the focus group the ward sister will be defined as ward sisters who have 24 hour responsibility for acute adult wards only and can be male or female. The primary purpose of the focus group is to review the findings of the RCN's 2009 study 'Breaking down the barriers', with particular reference to the remit of the ward sister and the challenges faced by ward sisters. The participants will also be asked about the preparation and support they received when they first started their jobs as ward sisters. The information gained from the focus group which is phase II of the study will be used to develop the questionnaire to ward sisters in phase III and the main part of the study.

<u>Agree the ground rules</u>

Due to the time constraints the following ground rules will be written on flip charts and will be on the wall so that all participants will be able to see them. The moderator will explain the ground rules to the participants, they will be asked if they want to add any or delete any ground rules before agreeing to abide by them.

· Confidentiality

· The discussion will be recorded

· There are no right or wrong opinions

· One person to speak at a time

· Speak loudly enough so everyone can hear

· Stay focused

· Respect the views of others

· Participants free to stop participating and leave the group at any time

· Be open

<u>Introductions</u>

Having agreed the ground rules the moderator will start the introductions, she will introduce herself and explain the role of moderator and explain how long the session will take. The

observer will then introduce themselves. The moderator will then ask all the participants to introduce themselves, saying their name and how long they have been a ward sister.

Question 1

In its study 'Breaking down the barriers' the RCN highlight the huge breadth of the ward sister role. I would like to explore what you think are the key skills, competencies and capabilities of ward sisters?

At the end of the discussion the moderator will summarise the views and will see if they all link to the four main aspects of the sister role as defined by the RCN, these being: a leader, a manager, an educator, a nursing and clinical expert and a researcher.

Question 2

During the study the RCN found that there were certain pressures that the ward sisters experienced, what are the main pressures you face?

At the end of the discussion the moderator will summarise the views and highlight the pressures the RCN identified which were: lack of housekeeping and clerical support, being counted on the numbers on the shift, not feeling valued, lack of authority to change things and role conflict.

Question 3

Most ward sisters in the RCN study said they had little education and training to prepare them for the role. Please put your hand up if you had no training or education that prepared you for the ward sister role.

The moderator will make a note of how many this is.

For those of you who had education and training, please tell the group what it was and how it helped you. The moderator will ask whether this training was funded by the employer or by themselves.

At the end of the discussion the moderator will summarise the views.

Question 4

I would like to know when you look back to becoming a sister what do you think would have helped you manage the transition more effectively?

At the end of the discussion the moderator will summarise the views.

Closing comments

The moderator will thank all participants for joining the group and will offer to send them a summary of the focus group if they want it. The moderator will explain that the output of the focus group will be used to develop the questionnaire for phase III of this study, the content will also be used to write an article for publication and for presentation at nursing and research conferences.

Appendix 8 Participant Information Sheet

the
UNIVERSITY
of
GREENWICH

Participant Information Sheet

Project title: Becoming a ward sister, accident or design?

1. What is the purpose of the study?

I am a PhD student at the University of Greenwich, supervised by Professor Pat Schofield and Professor Elizabeth West.

This research is investigating whether a relationship exists between the way in which a nurse is prepared and supported for the role of ward sister and how ward sisters perceive they manage the transition to this role. The main aims of the research are:

· To identify the methods of preparation and support for new ward sisters currently used in English hospitals

· To identify what kinds of preparation and support seems to be most effective in helping nurses manage the transition to the ward sister role.

There are three phases to this research, these are:

Phase I, a survey will be sent electronically to all Directors of Nursing in England apart from those in the Kent (who will be used for the pilot of the questionnaire). This survey will be to ascertain what, if any preparation is used in NHS acute trusts to prepare nurses for the transition to the role of ward sister.

Phase II, will use a focus group of ward sisters to elicit what the role of the ward sister is and what preparation and support they had to aid their transition to be ward sister. The focus group will use the RCN's Breaking the Barriers (2009) research as a basis for discussion with the aim of achieving a consensus of the role of the ward sister to be used in Phases III. The information from the focus group will help develop the survey which will be the main part of the design of the study in phase III.

Phase III, a survey about the transition to the ward sister role will be sent to a stratified sample of 300 ward sisters in all parts of England. The survey will be piloted by ward sisters in two NHS

trusts in Kent. The survey is an effective method of gaining a large number of views, it is also time efficient and anonymity can be guaranteed (Muijs 2011).

2. Why have I been chosen?

I would like to speak to a group of ward sisters in a focus group. The primary purpose of the focus group is to use the findings of the RCN's 2009 study 'Breaking down the Barriers', to stimulate discussion, with particular reference to the remit of the ward sister and the challenges faced by ward sisters. The participants will also be asked about the preparation and support they received when they first started their jobs as ward sisters. The information gained from the focus group which is phase II of the study will be used to develop the questionnaire to ward sisters in phase III and the main part of the study. You have been chosen because you are attending RCN Congress and are a ward sister/charge nurse.

3. What will happen to me if I take part?

Your involvement in the research would be to take part in a focus group during the lunch break at Congress. We will discuss the key skills and main challenges for ward sisters, and the preparation and support you received when you became a ward sister. The focus group will last approximately 30 minutes. I will record the discussion with your permission. The information from the focus group will be written up and you will be offered a copy that will be emailed to you.

It is up to you to decide whether to take part or not. You will be asked to sign a consent form and will be provided with a copy of it. If you decide to take part you are free to withdraw from the focus group at any time without giving a reason.

4. If I want to take part, what will happen next?

If you decide to take part, please confirm your place in the focus group by emailing **[REDACTED]**. If you want to ask any questions before the focus group please email on the same email address.

5. Will my participation be kept confidential?

All information collected about you during the course of this research will be kept strictly confidential. The only contact information required is your email address if you want a copy of the findings of the focus group. The recording of the focus group will be destroyed at the end of the research. No names or identifiable data will be recorded in the summary of the focus group. I will be the only person with access to your consent form and your contact details.

It should be noted that if something is said during the focus group which has a consequence for patient safety and/or professional practice standards I will have to speak to you and agree what action should be taken.

6. What will happen to the results of the research?

The results of the study will be used in my PhD thesis, in reports, published articles and presentations. Anonymity will be in place constantly.

7. Contact for further information

Jacqueline McKenna

PhD student Greenwich University

Director of Nursing, Medway NHS Foundation Trust

Email **[REDACTED]**

Professor Elizabeth West
Director of Research
School of Health and Social Care
University of Greenwich

Email e.west@gre.ac.uk

The focus group may lead you to reflect on your role and initiate a feeling of anxiety, you are likely to have work based counselling services. The Royal College of Nursing Counselling service which provides free, confidential support and assistance to help you to deal with any challenging emotional issues that you may face, may be contacted on

Tel :0345 408 4391
Online referral: https://www.rcn.org.uk/support/services/referral
Email: mss@rcn.org.uk

Appendix 9 Consent form to participate in focus group

Project title: Becoming a Ward Sister; Accident or Design?

I consent to participate in this focus group.   Yes   /   No   (please circle)

I have had time to read the information about the study and ask questions and I am satisfied with the information provided to me   Yes   /   No   (please circle)

I am aware that I can ask any questions at any time before or during the focus group. I have been provided with a copy of the Participant Information Sheet and the consent form.

I have been informed that the confidentiality of the data will be maintained

I have not been coerced in any way to participate in this research and understand I can leave the focus group at any time.

I agree to the researcher processing my personal data connected to the research.

I agree to the focus group discussion being recorded.   Yes   /   No   (please circle)

Name of Participant_____

Signature_____

Date_____

Personal data (optional)

I have been a nurse for _____years

I have been a sister/charge nurse for _____years

I am male/female (please circle)

I am in age group <30, 30-39, 40-49, 50-59, >60 (please circle)

Name of Trust I work in _____

I would like a summary of the focus group, please email it to me on this email address

Appendix 10 Invitation to participate in focus group

Dear Colleague

RCN Congress 2012

I am seeking to recruit a number of ward sisters/managers working in acute Trusts to participate in a focus group to be held during RCN Congress. The focus group is part of a research study investigating what preparation and support helps nurses transition into the role of ward sister/manager and is part of my PhD at the University of Greenwich.

The attached information sheet gives you more details about the research study. If you would like more information or clarification please contact me at **[email REDACTED]** or my supervisor, Professor Elizabeth West at e.west@gre.ac.uk.

The focus group will not interfere with your participation in congress and has the full support of the congress organisers.

If you would like to participate in this focus group please attend (venue to be confirmed).

I look forward to seeing you.

Best wishes

Jacqueline McKenna MBE
M Phil Student, Greenwich University
Director of Nursing, Medway NHS Foundation Trust

Appendix 11 Notes from Focus Group held 14/5/2012

1. Breadth of role

Leader

Clinical role model

 Need to delegate

Need to be a confident person

Need to be able to ask for help and know when you need help

Meet together with sisters and do a blitz of action so can do it all together

The role is about the nursing staff- managing them

Manage financially- get the best for staff and for patients

Performance management

Sickness management

Demonstrate fairness – staff looking at how you manage different people

Need to understand workload and staffing

Need to know the HR policies overnight

Know staff

Deal with difficult people- relatives and staff

The way you manage situations will be reflected in the way the staff manage

Good at conflict management

Sister sets the ethos of the ward

Having less clinical time

Need good peer support (gave example of fortnightly sisters' meeting)

Be able to manage stressful situations

Have a sixth sense/ intuition – notice when someone struggling

Micro training on the ward

Know about training available in organisation

Coaching staff

Seek clinical supervision for self and then help the staff to have clinical supervision too

Subscribe to Nursing standard management journal and forums

Training all about mandatory subjects

Doing a ward away-day for mandatory training and doing a second one for clinical training necessary for the ward

Feel like sheep dipping for NHSLA requirements

Being consistent

(Moderator asked about research role)

No time

It is important, my background is in research

Opportunities but don't do it

Masters not research based dissertation

Use audit more-lots of audits (all agreed)

2. Pressures

Time

Not enough hours in the day

Not enough staff

Could spend every day in the office doing emails and meeting staff

Also could spend every day on the ward

Can't get into office if on the ward first, get caught up

Middle manager trying to please everyone

Incident forms- been told not to complete as things will go on the risk register

Try to meet demands of organisation and then have to explain to staff about the initiative

Need to filter out what's important

Too many heads on one body

Everyone has their own priorities- like CNSs they've only got one thing to think about, it needs to be policed more, about what comes to the wards

We're told to police the medics-so we have extra staff as well as ours

No control over them [doctors]

Consultant's won't obey rules and there's no consequence if doctors don't comply, no equality

(Moderator asked about physical support)

They've been talking for years about admin for ward sisters

'It's the organisations ward when things are going well and it's your ward when it's not'

We have HR support, sometimes have to wait for it.

HR aren't consistent-how are we expected to manage (gave example of HR telling band 6 at a training session different advice to what sister had been told) – the unions and staff come back to us if not following policy or not consistent

If you tell the boss about issues- you're the problem- they'll compare you with another ward with different issues- not equal

Waste of my clinical skills doing admin

We have a bit of admin support

I have admin support and she'll receive the sickness calls and sort out staffing

Told to be visible and want to be accessible, another thing to do

I worked on bank holiday Monday and a patient asked me why I was making beds- they don't think a sister should be doing this

Did daily walk rounds and had no complaints, I sorted everything out, public want to see the sister- no time to do it every day

Matron told staff not to complete incident form because they didn't say why they didn't have enough staff and other details (a number of the sisters in the group said 'that would be your investigation')

Electronic incident forms so they will have to be sent in

I still don't think they're counted

(Moderator asked about supervisory status)

All the sisters apart from the one working in mental health were counted in the numbers when they worked clinically

Have managerial/clinical day once/week

I have 30 emails a day

3. Preparation for the role

First year is a steep learning curve- sink or swim

Peer support essential

I've got a good mentor

Good role models needed

When I got the job there were three sisters- my role was to educate and then it changes and I was the only one and had to do everything and I didn't know about the other roles

Didn't get support after maternity leave- a lot had changed in that time-even the specialty of the ward

I got weekly supervision meeting, received feedback about performance. Had a mentor working with me for 8 weeks who was a senior manager

Have weekly meetings with matron

(Asked whether there was training in the organisation)

Leadership training in the trust, coaching, budgeting, finance but not specifically related to being a sister

Doing RCN leadership course now but I'm not a new sister

No one timetables training for you

No structured programme

I've done finance modules but it's coincidental

I've done leadership module on my degree

First line management courses available

4. What would have helped?

Some people are promoted by ability to blag at interview rather than ability to lead

People will be overlooked if they can't do interviews-minimise experience of better candidates

Should be promoted on wealth of clinical knowledge

There should be a personally defined course, well organised by trust, coached and mentored and agree which parts to do

Meet peers

Allocated someone to go to for support-don't leave it to the sister

Like having preceptorship for a sister

Important to have time with team, need credibility especially of new to ward

Need time to work clinically

Also difficult when they know you, you have to convince them, I was a Student Nurse on the ward and have had to change my relationship with the staff

First few months need someone to talk to, to reflect on behaviour, decisions – am I being rational

Also need help with priorities

Our mantra is 'not doing it'

(Asked about what they said earlier about delegating to band 6s)

There is a band 6 training programme

Doing more about developing bands 5 and 6

Band 6 acts up when I'm not there- they don't have same access to things as we do so can't do everything

Sickness bad when 'm off

When I started I used to hate being on leave

When I came back it was the most awful experience ever (after three weeks off), my friends and family don't understand it

I'd rather them [band 6s] on the wards

They do appraisals

I see them as clinical leaders nurturing the team

I want them with the staff not doing my job.

Appendix 12 Consent to use Ashridge middle manager questionnaire

Amy Armstrong

To Me
Oct 22, 2012 at 12:31 PM
Hi Jacquie

It was good to finally speak with you this morning. Your research sounds really interesting. I've attached the survey I developed which has been exported directly from Qualtrics. Hope that it is helpful for you. You'll see at the start of the survey (Q1-5) there are series of screen-out questions that we used to ensure the validity of the sample. Please let me know if I can help you in any way once you start working with it. As I said on the phone, I would be really interested in your findings and I think it would be great to work on a joint article with you at some point, comparing ward nurses to a general management population.

Good luck and stay in touch.

Best wishes.

Amy

Amy Armstrong
Research Fellow

Appendix 13 Adaptations made to Ashridge questionnaire

Mckenna question number	Reference to Ashridge question number or description if not an Ashridge question	How Ashridge questionnaire was adapted
1	Demographics	Original question
2	Demographics	Original question
3	Demographics	Original question
4	Demographics	Original question
5	Ashridge no 6	Same wording as Ashridge question but used likert scale rather than asking which was most helpful
6	Ashridge no 7	Same wording as Ashridge question apart from used 'BEFORE you were a ward sister' rather than 'FIRST PART of your career' and used likert scale rather than asking which was most helpful
7	Ashridge no 8	Same wording as Ashridge question apart from used 'since you've become a ward sister' rather than 'SECOND PART of your career' and used likert scale rather than asking which was most helpful
8	Ashridge no 9	Used the same wording but used likert scale to ask least-most significant barrier rather than asking for top three barriers
9	Ashridge no 13	Used same wording and added nursing/healthcare development needs – these were; patient safety, patient experience, clinical effectiveness, clinical skills, research in practice, regulatory compliance, communication skills, rostering, delegation, conflict resolution and recruitment & retention.
10	Ashridge no 14	Not adapted
11	Ashridge no 15a	Not adapted
12	Ashridge no 15b	Same wording but used four categories rather than likert scale
13	Ashridge no 15c	Not adapted
14	Ashridge no 16a	Not adapted
15	Ashridge no 16b	Same wording but used four categories rather than likert scale
16	Ashridge no 16c	Not adapted

17	Ashridge no 17a	Added word 'supervisor'
18	Asked why they did not have a coach	Original question
19	Ashridge no 17b	Added word 'supervisor'
20	Asked why they would not use a coach	Original question
21	Ashridge 17c	Added word 'supervisor'
22	Asked why they would not pay for a coach	Original question
23	Asked what the top three challenges for a ward sister are	Original question
24	Asked if they thought they had reached stabilisation phase yet	Original question
25	Asked what would have helped the transition to ward sister role	Original question
26	Demographics	Original question
27	Demographics	Original question
28	Demographics	Original question
29	Demographics	Original question
30	Demographics	Original question
31	Demographics	Original question

Appendix 14 Phase III questionnaire

1. How many beds in your organisation?

- ○ 0-400
- ○ 401-799
- ○ >800

2. How many years have you been a Registered Nurse?

3. How many people do you have reporting directly to you?

4. Many organisations find that learning is vital to career progression and organisational effectiveness. please indicate how strongly you agree or disagree with the following statements:

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
In my organisation sufficient time is allocated to MY learning and development	○	○	○	○	○
Career planning is mostly down to me	○	○	○	○	○
There is little support for career development in my organisation	○	○	○	○	○
I have my own personal development plan	○	○	○	○	○
My personal development plan is useful for me	○	○	○	○	○
In my organisation professional development is seen as a luxury	○	○	○	○	○
Within the past 12 months I have been involved in discussions about my own career development needs	○	○	○	○	○
Within the past 12 months I have had enough personal or professional development to help me to do my job effectively	○	○	○	○	○

5. Thinking about when you were in the role BEFORE you became a sister (band 6 post), of the
learning and development practices you engaged in, please indicate how helpful these
were to you

	Very helpful	Helpful	Not helpful	Not at all helpful	Not applicable
In house programmes	○	○	○	○	○
External short courses	○	○	○	○	○
On the job development	○	○	○	○	○
Coaching/being coached	○	○	○	○	○
Peer discussion/support	○	○	○	○	○
Supervision/Mentoring/buddying schemes	○	○	○	○	○
E-learning	○	○	○	○	○
Studying formal qualifications	○	○	○	○	○
Training/develpment by professional/industry bodies	○	○	○	○	○
Books/manuals	○	○	○	○	○
Conferences/seminars/workshops	○	○	○	○	○
Shadowing an experienced person	○	○	○	○	○

Other (please specify)

6. Now, thinking about your career since you've been a ward sister, of the learning and
development practices you engaged in, please indicate how helpful they have been.

	Very helpful	Helpful	Not helpful	Very unhelpful	Not applicable
In house programmes	○	○	○	○	○
External short courses	○	○	○	○	○
On the job development	○	○	○	○	○
Coaching/being coached	○	○	○	○	○
Peer discussion/support	○	○	○	○	○
Supervision/Mentoring/buddying schemes	○	○	○	○	○
E-learning	○	○	○	○	○
Studying formal qualifications	○	○	○	○	○
Training/development by professional/industry bodies	○	○	○	○	○
Books/manuals	○	○	○	○	○
Conferences/seminars/workshops	○	○	○	○	○
Shadowing an experienced person	○	○	○	○	○

Other (please specify)

7. Is there anything that stops you from engaging in more professional development? Please indicate the strength of these barriers in the table below.

	No barrier	Small barrier	Significant barrier	Most significant barrier
Family/personal commitments	○	○	○	○
Job pressures	○	○	○	○
Financial constraints	○	○	○	○
Lack of organisational support for learning and development	○	○	○	○
Low personal confidence	○	○	○	○
Lack of time	○	○	○	○
Not a priority	○	○	○	○
Lack of motivation/interest	○	○	○	○
Just finished course	○	○	○	○
Poor past experience of education	○	○	○	○

Other (please specify)

8. Please indicate below which management topics are most relevant to your CURRENT development needs.

	Yes	No
Leadership	○	○
Coaching	○	○
Innovation	○	○
Finance	○	○
Strategy	○	○
Marketing	○	○
Influencing	○	○
Change management	○	○
Personal impact and influence	○	○
People management	○	○
Sales management	○	○
Human resource management	○	○
Virtual working	○	○
Action learning	○	○
Patient safety	○	○
Patient experience	○	○
Clinical effectiveness	○	○
Clinical skills	○	○
Time Management	○	○
Computer skills	○	○
Research in practice	○	○
Regulatory compliance (eg CQC)	○	○
Communication skills	○	○
Rostering skills	○	○
Delegation	○	○
Conflict resolution	○	○
Recruitment and retention	○	○

Other (please specify)

_____

9. Are there any specific skills that you need to learn or develop further in order to do your CURRENT job better?

_____

10. Have you had any formal (ie classroom based) learning experiences since becoming a sister?

○ Yes

○ No

11. How effective have they been in your professional development as a ward sister?

- ○ Very helpul
- ○ Helpful
- ○ Not helpful
- ○ Very unhelpful

12. Please explain the reason for your answer to question 11

13. Have you had any informal 'on the job" development experiences (eg. mentors, challenging assignments, re-location to another area) in your career to date?

- ○ Yes
- ○ No

14. How effective have they been in your professional development in your sister role?

- ○ Very effective
- ○ Effective
- ○ Not effective
- ○ Not at all effective

15. Please explain your answer to question 14

16. Do you have a supervisor, mentor, career or life coach?

- ○ Yes
- ○ No

17. If you answered no to question 16, why not?

18. If you were offered a formalised supervisor, mentor, career or life coach, would you take up the opportunity to use one?

- ○ Yes
- ○ No

19. If you answered no to question 18, why not?

20. If you were offered a formalised supervisor, mentor, career or life coach, but you had to pay for the coach yourself (as opposed to your trust paying), would you take up the opportnity to use one?

- ○ Yes
- ○ No

21. If you answered no to question 20, why not?

22. In your opinion what are the top three challenges facing nurses in the first year as a ward sister*?

1.

2.

3.

23. In Nicholson and West's (1988) transition cycle they describe the final stage of transition as 'stabilisation', meaning that work of the new job becomes routine and established, how long after becoming a ward sister did it take you to enter the stabilisation phase? or say if you think you have not yet reached the stabilisation phase.

24. Looking back to becoming a ward sister what would have helped your transition to the role and becoming stabilised more effectively?

25. What is your gender?

○ Female

○ Male

26. Which category below includes your age?

○ 17 or younger

○ 18-20

○ 21-29

○ 30-39

○ 40-49

○ 50-59

○ 60 or older

27. What is the highest level of education you have completed?

○ Certificate of Higher Education

○ Diploma

○ Advanced Diploma

○ Bachelor degree

○ Masters degree

○ Doctorate degree

28. In which NHS region (using 2011 definitions) is your trust based

○ East Midlands

○ East of England

○ London

○ North East

○ North West

○ South Central

○ South East Coast

○ South West

○ West Midlands

○ Yorkshire and Humber

29. How long have you been in your current role

[   ]

30. What Agenda for Change band is your role?

○ 6

○ 7

○ 8A

○ 8B

○ East Midlands

○ East of England

Appendix 15 Invitation to participate in ward sister (phase III) questionnaire pilot

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Dear Colleague

I am seeking to recruit a sample of ward sisters/managers/charge nurses working in acute trusts to participate in the pilot study of my research by responding to a questionnaire about their preparation and support for the role of ward sister*. The questionnaire is the main part of a research study investigating what preparation and support helps nurses transition into the role of ward sister/manager and is part of my PhD at the University of Greenwich. Julie Pearce, Chief Nurse has kindly agreed that you may participate in the pilot but you are under no obligation to do so.

Having answered the questionnaire I would be grateful if you would give me your feedback regarding the following

1. How long did it take you to complete?

2. Did you understand all the questions? If not which ones needed clarification?

3. Are there any questions that do not need to be included in the questionnaire?

4. Is there an aspect of preparation and support to becoming a ward sister that you would like to be included that is in the questionnaire?

These questions will be at the bottom of the questionnaire.

Should you wish to participate please email me at **[email REDACTED]**, you will then receive the questionnaire to complete via email.

By participating in the pilot study you will help shape the questionnaire that will be sent to ward sisters across England. The questionnaire has been developed from a research study into middle managers' development led by Ashridge Business School, the focus group which was phase II of my study and by research findings from my literature review. I will be giving Julie Pearce a summary of the responses but it will be completely anonymous and presented as a group result, individuals will not be able to be identified.

The attached information sheet gives you more details about the research study, and is the information ward sisters who are in the research will receive. If you would like more information or clarification please contact me at **[email REDACTED]** or my supervisor, Professor Pat Schofield at p.a.schofield@greenwich.ac.uk.

Best wishes

Jacqueline McKenna MBE

M Phil Student, Greenwich University

Deputy Director of Nursing, NHS Trust Development Authority

*for the purposes of this research the title ward sister is being used to include charge nurses and ward managers, regardless of gender, the study includes ward sisters of acute adult wards with 24 hour responsibility only.

Appendix 16 Ward sister (phase III) pilot questionnaire

Appendix 4 - Phase III pilot questionnaire

1. How many beds in your organisation?

- ○ 0-400
- ○ 401-799
- ○ >800

2. How many years have you been a Registered Nurse?

_____

3. How many people do you have reporting directly to you?

_____

4. Many organisations find that learning is vital to career progression and organisational effectiveness. please indicate how strongly you agree or disagree with the following statements:

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
In my organisation sufficient time is allocated to MY learning and development	○	○	○	○	○
Career planning is mostly down to me	○	○	○	○	○
There is little support for career development in my organisation	○	○	○	○	○
I have my own personal development plan	○	○	○	○	○
My personal development plan is useful for me	○	○	○	○	○
In my organisation professional development is seen as a luxury	○	○	○	○	○
Within the past 12 months I have been involved in discussions about my own career development needs	○	○	○	○	○
Within the past 12 months I have had enough personal or professional development to help me to do my job effectively	○	○	○	○	○

5. Thinking about when you were in the role BEFORE you became a sister, of the learning and development practices you engaged in, please indicate how helpful these were to you

	Very helpful	Helpful	Not helpful	Not at all helpful	Not applicable
In house programmes	○	○	○	○	○
External short courses	○	○	○	○	○
On the job development	○	○	○	○	○
Coaching/being coached	○	○	○	○	○
Peer discussion/support	○	○	○	○	○
Mentoring/buddying schemes	○	○	○	○	○
E-learning	○	○	○	○	○
Studying formal qualifications	○	○	○	○	○
Training/development by professional/industry bodies	○	○	○	○	○
Books/manuals	○	○	○	○	○
Conferences/seminars/workshops	○	○	○	○	○
Shadowing an experienced person	○	○	○	○	○

Other (please specify)

6. Now, thinking about your career since you've been a ward sister, of the learning and development practices you engaged in, please indicate how helpful they have been.

	Very helpful	Helpful	Not helpful	Very unhelpful	Not applicable
In house programmes	○	○	○	○	○
External short courses	○	○	○	○	○
On the job development	○	○	○	○	○
Coaching/being coached	○	○	○	○	○
Peer discussion/support	○	○	○	○	○
Mentoring/buddying schemes	○	○	○	○	○
E-learning	○	○	○	○	○
Studying formal qualifications	○	○	○	○	○
Training/development by professional/industry bodies	○	○	○	○	○
Books/manuals	○	○	○	○	○
Conferences/seminars/workshops	○	○	○	○	○
Shadowing an experienced person	○	○	○	○	○

Other (please specify)

7. Is there anything that stops you from engaging in more professional development? Please indicate the strength of these barriers in the table below.

	No barrier	Small barrier	Significant barrier	Most significant barrier
Family/personal commitments	○	○	○	○
Job pressures	○	○	○	○
Financial constraints	○	○	○	○
Lack of organisational support for learning and development	○	○	○	○
Low personal confidence	○	○	○	○
Lack of time	○	○	○	○
Not a priority	○	○	○	○
Lack of motivation/interest	○	○	○	○
Just finished course	○	○	○	○
Poor past experience of education	○	○	○	○

Other (please specify)

8. Please indicate below which management topics are most relevant to your CURRENT development needs.

	Yes	No
Leadership	○	○
Coaching	○	○
Innovation	○	○
Finance	○	○
Strategy	○	○
Marketing	○	○
Influencing	○	○
Change management	○	○
Personal impact and Influence	○	○
People management	○	○
Sales management	○	○
Human resource management	○	○
Virtual working	○	○
Action learning	○	○
Patient safety	○	○
Patient experience	○	○
Clinical effectiveness	○	○
Clinical skills	○	○
Time Management	○	○
Computer skills	○	○
Research in practice	○	○
Regulatory compliance (eg CQC)	○	○
Communication skills	○	○
Rostering skills	○	○
Delegation	○	○
Conflict resolution	○	○
Recruitment and retention	○	○

Other (please specify)

_____

9. Are there any specific skills that you need to learn or develop further in order to do your CURRENT job better?

_____
_____

10. Have you had any formal (ie classroom based) learning experiences since becoming a sister?

○ Yes

○ No

11. How effective have they been in your professional development as a ward sister?

○ Very helpul

○ Helpful

○ Not helpful

○ Very unhelpful

12. Please explain the reason for your answer to question 11

13. Have you had any informal 'on the job" development experiences (eg. mentors, challenging assignments, re-location to another area) in your career to date?

○ Yes

○ No

14. How effective have they been in your professional development in your sister role?

○ Very effective

○ Effective

○ Not effective

○ Not at all effective

15. Please explain your answer to question 14

16. Do you have a mentor, career or life coach?

○ Yes

○ No

17. If you answered no to question 16, why not?

18. If you were offered a formalised mentor, career or life coach, would you take up the opportunity to use one?

○ Yes

○ No

19. If you answered no to question 18, why not?

20. If you were offered a formalised mentor, career or life coach, but you had to pay for the coach yourself (as opposed to your trust paying), would you take up the opportnity to use one?

○ Yes

○ No

21. If you answered no to question 20, why not?

22. In your opinion what are the top three challenges facing nurses in the first year as a ward sister*?

1.

2.

3.

23. In Nicholson and West's (1988) transition cycle they describe the final stage of transition as 'stabilisation', meaning that work of the new job becomes routine and established, how long after becoming a ward sister did it take you to enter the stabilisation phase?

	Years	Months
Time		

24. What is your gender?

- ○ Female
- ○ Male

25. Which category below includes your age?

- ○ 17 or younger
- ○ 18-20
- ○ 21-29
- ○ 30-39
- ○ 40-49
- ○ 50-59
- ○ 60 or older

26. What is the highest level of education you have completed?

- ○ Certificate of Higher Education
- ○ Bachelor degree
- ○ Masters degree
- ○ Doctorate degree

27. In which NHS region (using 2011 definitions) is your trust based

- ○ East Midlands
- ○ East of England
- ○ London
- ○ North East
- ○ North West
- ○ South Central
- ○ South East Coast
- ○ South West
- ○ West Midlands
- ○ Yorkshire and Humber

28. How long have you been in your current role

	Years	Months
Time	[▼]	[▼]

29. What Agenda for Change band is your role?

- ○ 6
- ○ 7
- ○ 8A
- ○ 8B

30. QUESTION ABOUT SURVEY How long did it take to complete the survey?

	Minutes
Time	[▼]

31. QUESTION ABOUT SURVEY Did you understand all the questions? If not which ones need to be re worded?

[text box]

32. QUESTION ABOUT SURVEY Are there any questions that do not need to be included?

[text box]

33. QUESTION ABOUT SURVEY Is there any aspect about preparation and support to be a ward sister that should be included that is not at the moment?

[text box]

34. QUESTION ABOUT SURVEY Is there any other feedback you would like to give me about the questionnaire?

Appendix 17 Invitation to participate in ward sister questionnaire

the
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July 2013

Dear Colleague

Becoming a ward sister, accident or design?

I am seeking to recruit a sample of ward sisters/ward managers/charge nurses working in acute Trusts to respond to a questionnaire about their preparation and support for the role of ward sister*. The questionnaire is the main part of my research study investigating what preparation and support helps nurses transition into the role of ward sister/manager and is part of my PhD at the University of Greenwich.

If you would like to participate I would be grateful if you would email me at **[email REDACTED].** I will then send you the questionnaire via email for you to complete, it should take between 15-20 minutes and has been piloted by a group of ward sisters in Kent.

Your Director of Nursing/Chief Nurse has given their permission for you to participate as they thought you may be interested in contributing, your individual responses will be confidential and not shared with your Director of Nursing, you are completely free not to participate your Director of Nursing will not be informed who participated or not.

The information below gives you more details about the research study. If you would like more information or clarification please contact me at **[email REDACTED]** or my supervisor, Professor Elizabeth West at e.west@gre.ac.uk.

Best wishes

Jacqueline McKenna MBE
M Phil Student, Greenwich University
Deputy Director of Nursing, NHS Trust Development Authority

*The job title 'ward sister' is used throughout this study reflecting the findings in the RCN's study 'Breaking down the barriers' (2009), for the purposes of this study ward sister refers to nurses who manage an adult ward, it is recognized they can be male or female and includes those who may work with a different job title including charge nurse and ward manager.

Participant Information

Project title: Becoming a ward sister, accident or design?

1. What is the purpose of the study?

I am a PhD student at the University of Greenwich, supervised by Professor Pat Schofield and Professor Elizabeth West.

This research is investigating whether a relationship exists between the way in which a nurse is prepared and supported for the role of ward sister* (ward manager/charge nurse) and how ward sisters perceive they manage the transition to this role. The main aims of the research are:

· To identify the methods of preparation and support for new ward sisters currently used in English hospitals

· To identify what kinds of preparation and support seems to be most effective in helping nurses manage the transition to the ward sister role.

There are three phases to this research, these are:

Phase I, a survey to all Directors of Nursing in England apart from those in the Kent (who will be used for the pilot of the questionnaire). This survey was to ascertain what, if any preparation is used in NHS acute trusts to prepare nurses for the transition to the role of ward sister.

Phase II, a focus group of ward sisters to elicit what the role of the ward sister is and what preparation and support they had to aid their transition to be ward sister. The focus group used the RCN's Breaking the Barriers (2009) research as a basis for discussion with the aim of achieving a consensus of the role of the ward sister to be used in Phases III. The information from the focus group helped develop the survey which is the main part of the design of the study in phase III.

Phase III, a survey about the transition to the ward sister role will be sent to a stratified sample of ward sisters in all parts of England. The survey has been piloted by ward sisters in an NHS Foundation Trust in Kent. The survey is an effective method of gaining a large number of views, it is also time efficient and anonymity can be guaranteed (Muijs 2011).

2. Why have I been chosen?

You have been identified as a ward sister in an adult acute ward who has the experience to answer the questionnaire in phase III of this study.

The information gained from the questionnaire which is the main part of the survey will be used to identify what preparation and support is given to nurses moving to the role of ward sister and what preparation and support would be most effective for these nurses.

The questionnaire has been developed from a questionnaire used by Ashridge Business School for middle manager development research, it has been altered in places to make it more health orientated. It has been approved by Greenwich University's ethics committee.

3. What will happen to me if I take part?

Your involvement in the research would be to respond to the questionnaire.

It is up to you to decide whether to take part or not.

4. If I want to take part, what will happen next?

If you decide to take part, please respond to me at **[email REDACTED]**, I will then email you a copy of the questionnaire. If you want to ask any questions before the responding please contact me on **[email REDACTED]**

5. Will my participation be kept confidential?

All information collected about you during the course of this research will be kept strictly confidential. The only contact information required is your email address if you want a copy of the findings of the focus group. No names or identifiable data will be used in the written thesis. I will be the only person with access to your email address

6. What will happen to the results of the research?

The results of the study will be used in my PhD thesis, in reports, published articles and presentations. Anonymity will be in place constantly.

7. Contact for further information

Jacqueline McKenna

PhD student Greenwich University

Deputy Director of Nursing, NHS Trust Development Authority

Email **[email REDACTED]**

Professor Pat Schofield
Professor of Nursing
School of Health and Social Care
University of Greenwich

Email p.a.schofield@greenwich.ac.uk

*The job title 'ward sister' is used throughout this study reflecting the findings in the RCN's study 'Breaking down the barriers' (2009), for the purposes of this study ward sister refers to nurses who manage an adult ward, it is recognized they can be male or female and includes those who may work with a different job title including charge nurse and ward manager.

The questionnaire may lead you to reflect on your role and initiate a feeling of anxiety; you are likely to have work based counselling services. The Royal College of Nursing Counselling service which provides free, confidential support and assistance to help you to deal with any challenging emotional issues that you may face, may be contacted on

Tel :0345 408 4391
Online referral: https://www.rcn.org.uk/support/services/referral
Email: mss@rcn.org.uk

Appendix 18 Notes from Focus Group held 13/8/14

1.Breadth of role

Knowledge

Communication

Expertise

Time management

Administration

Approachability

I think it's split into two Management side of it and specialty side of it. If in head and neck would expect her to have head and neck skills

As you know stroke was not my background but maybe that is a better way of it working

It is about succession planning

Sisters should be Imparting their knowledge so that whoever takes over has the knowledge and they carry on effectively

In neonatal have to do a certain amount even before you get a band 6. Had to have 2 years as a band 6 before became a sister.

Someone said administrative but I don't think this is what the role is could be done by a secretary or an administrator. Even if you share someone, at my old trust that's what the ward sisters did there. They found that a lot of the time they spent in the office could have been done by someone else. How else are future nurses going to learn unless there's someone there to guide them.

The reason I mentioned administration, it's just the volume of admin is huge so it's not the be all and end all. Just moving from band 6 to band 7 I've seen a big difference.

It's inevitable it's part of our job, we're not ward clerks.

Work very different in neonatal, we all have a management area each but we don't do all that you do

Maternity don't do Sis but in adult nursing you do

I'm actually going to take patients tomorrow and band 6 is going to run the ward. Nice break for me.

But for me that's all I am doing I haven't been in the office for a week, but at the end of the day my heart lies with the patient not the paperwork.

My time is best spent on the ward not typing a letter.

(What type of skills do you need to do Sis) Need to be a PI, investigate all those notes. Need to be computer literate, more so than when I started, learnt how to do spreadsheets and need to be confident to talk to different levels, your staff, board level and HR

Networking and finding out who you need to speak to

(Research) ...silence. Don't think there's a lot of time for that...there's no time for that.

I think we do an element of that but reading through policy for oral care and have just done assignment for that...I think there's an element that you do pick up and apply to work.

I have an idea that I'd like to implement about open visiting in a stroke unit...Need to get a small team together.

A good leader is someone who can nurture. What I've learnt is to ask staff what the problems are and let them sort it out, giving them licence to sort out. Give work to other members of staff because they appreciate it as well.

One of the biggest challenges for me was to let go. Even now when I have band 6s I still find it difficult to let go which may be because I'm new.

2. Pressures

Paperwork

Staffing

Time

Staff leaving –before you can get recruited, it takes a good three months

The current climate that we're in we have a lot of responsibility and not having power to change, huge pressure and very demoralising

Scary role, I think most of us feels that the buck stops with us. Ward sister has a certain amount of responsibility but certain things are out of our control, but we still get the blame if something happens.

I don't even think it's time, it's the other stuff, budgetary staff, staff morale.

People don't want to move to [different] wards and we have lost staff Morale – people leave it's not going to help the trust. That's never going to change because if a ward is short then we need to make it safe.

Is it the case that people in the job aren't in the right job. As a leader I want to know that someone has applied to come to my ward, I want to tell them what it's like on my ward and if they choose it we're ready to go.

Good point about morale, I had a nurse come to the ward and said everyone's leaving and I'm looking for a job, but that's not going to help because we all have a duty of care and if we all leave then it's going to be a spiral out of control. My healthcare threatened to leave and I said to her you can leave by all means but where are you going to get the support you need.

I think this is our job, if you have one person, she belongs with us and she's very very capable but everyday she comes in she can moan about the colour of magnolia. It's the 80:20. Instead of trying to encourage anyone else I've got to have her. I need to go back to her, I'm not afraid to have a frank conversation with her.

I've spent the last year trying to sort the disrupters out but now I'm going to concentrate on the people that are motivated and the ones that want to stay.

Need to develop the confidence to have those frank conversations.

This is about our job being a leader and manager have you got the skills and confidence needed. I think I have but it took a little bit to change my mind to do that.

We've tried to please staff that aren't ever going to stop moaning.

We've got it within our power to get it back, we don't have to wait for HR, we just have to do it.

Administration and not having support

3. Preparation for the role

You've got to train on the job

College isn't going to teach you how to do the paperwork

How much you learnt as a band 6 to prepare you for a band 7

I learnt a lot

Live experience in all the roles you've done prepares for you

2/6 had enough preparation

When we finished our training we had a management module to prepare for band 5, I learnt on the job but I did access courses myself, I did an NVQ course in management and a management module in my degree

We've all got a few people that we'd like to be like, I have and I think they were amazing and a few people who I thought was rubbish.

That's as useful if not more useful

But only more recently that I've had opportunity to look at courses

There's a limit to how many courses you can go on

It's all about the ward sister being visual so they can nurture and show

If you choose the right person then they will have the drive to learn and absorb

It's a bit of a competition in this job...it's not the be all and end all then if I see me going from red, amber then green. It's a healthy competition we are supportive in that.

4. What would have helped?

Show them anything and everything, throw it at them

I think they have their niche so I would ask them little by little

I think the other way they sink or swim.

There is an element for them to be experts – clinically spot on, so I know they can look after the patients safely

If you're going on holiday tell them they've got this, this and this to do

They should know they have a good support network, who to contact

They need education and skills around leadership and management, they need to have these conversations as well and to have your back

I was apprehensive about what I didn't know

I don't think anything can help you

A good mentor and good support network

I was asked what do you need – I said this, this and this...releasing time to care, ward was a mess and needed to look organised, 2 band 6s, little bit of decoration. That brought us together as a team, trying to raise the money for the decoration.

Clinical supervision or action learning, that we've started talking about.

Being able to pull on people informally, not necessarily nurses, want someone to empathise with you.

Peer support, this has started to happen here.

Appendix 19 Raw qualitative data from the questionnaire in phase I response to ward sister challenges

Theme	Director of Nursing response	Ward sister response
Transition – Preparation	No comments	• Lack of any formal training program-very much a 'here's you band 7-good luck' attitude • Not prepared in real time - I did not have any formal management training as an F grade • Inconsistency in training/induction. Too random and dependent on Band 7. Should be standardised and compulsory before person starts role
Transition – Encounter	• Stepping into their level of authority • Getting to know their teams strengths/weaknesses • Move from peer to manager • Step away from the clinical environment	• Transition from colleague to manager • Knowledge of the area and the systems in place • Management of change in role/position in team • The greater responsibilities and how to manage them • Getting to know your team • Transition from staff nurse
Transition – Adjustment	No comments	• Establishing your role • Establishing your place within the team • Finding your own level and deciding how the ward is to be managed • Establishing credibility • Asserting authority and establishing leadership
Transition – Stabilisation	No comments	• Gaining respect from your staff • Existing staff coming on board with new ideas and change. • Making a mark and earning respect of team • Accepting your own position • Making the ward 'your own