FACULTY OF SOCIAL WORK AND SOCIAL ADMINISTRATION

EVALUATION OF A PILOT HOSPITAL SISTER DEVELOPMENT SCHEME

by Marion Moody

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ABSTRACT

Master of Philosophy

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This study represents an evaluation, undertaken from 1985 to 1987 of a pilot scheme for the development of hospital sisters working in an Acute General Hospital. A total of ten sisters were involved in the innovation and studied in depth.

The research design combined action research with elements of formative and illuminative evaluation.

The first stage of the research was exploratory and concentrated on a literature search; the second involved data collection to assist in the accurate identification of the sisters' training needs and to provide an insight into the complexities of the participants present role and function. Stage three concentrated on the scheme and the scheme participants and sought to answer questions of relevancy, relatedness and accountability as they emerged. The fourth and final stage focussed on the effectiveness of the scheme as a method of sister development.

CHAPTER ONE

THE EVOLVING ROLE OF THE HOSPITAL SISTER AND THE NEED FOR PREPARATION AND DEVELOPMENT

1.1 INTRODUCTION

As long ago as 1943 there existed an awareness of the importance of the sister's role and the need for her to be properly prepared to fulfil this position. Yet very little attention was paid by employing Authorities to the lack of training for newly appointed sisters or provision for up-dating sisters established in posts. All that was provided by the majority of authorities was a basic training in management and that was not until the late 1960's. The exception to this was the King Edward Hospital Fund for London who provided training courses for sisters between 1949 and 1969. It is only in the last few years that interest and a commitment towards establishing a means of providing professional education and training for this key group of staff has emerged.

The work of the sister is highly complex and not always fully understood by those around her. The ward sister has in the past been referred to as 'The Hospital in Miniature . . . . responsible for the patients, staff and everything that happens in her area. This overall control involves nursing ability, teaching, administrative skills and a good deal of attention to minor house-keeping duties' (Department of Health for Scotland, Scottish

Health Services Council 1955). Equally, she must exhibit identifiable social processes that produce the respect that makes for effective leadership. The responsibilities of the sister as identified in the DHSS HSC (1955) report are probably just as relevant today. However, considerable change has occurred over the past three decades in the structure of health service management, philosophy of nurse education, health care technology and expertise. In addition, Society's expectations of health care provision, along with the expectations of professional carers, have all influenced the role of the sister to some lesser or greater extent.

1.2 An overview of the factors that have influenced the role of the sister and highlighted the need for preparation and development.

The demands upon staff and the demands made by staff are constantly changing in an endeavour to keep pace with the goals of the organisation. 'Adaptability and flexibility' (Georgopoulous and Mann 1972) are essential pre-requisites for the competent practitioner, 'for whatever competence means today, we can be sure its meaning will have changed by tomorrow (therefore) the foundation for future professional competence seems to be the capacity to learn how to learn', (Argyris and Schon 1984). The profession, however, continues to educate itself largely by a process of osmosis (Auld 1979) and both Hunter (1971) and Roper (1976) have drawn attention to the use of a medical model as a

foundation for professional education and development in nursing. Akinsanya and Hayward (1980) are amongst those who argue that the use of medical models inhibits or detracts from the development of skills and knowledge required as a basis for individual patient care.

The 'need' to extend the role of the nurse has been postulated by many nurse and medical practitioners. This extension of role has been frequently 'connected with a nurse undertaking a task which has hitherto been regarded as a prerogative of other professionals in the medical and paramedical field' (Royal College of Nursing 1979).

However, although medical staff appear to want intelligent observers and nurses capable of conducting highly technical procedures, they do not, as Chapman points out, want a colleague but rather a person who satisfies their demands. Their expectation of a sister is of one who primarily follows instructions (Anderson 1973) without question. Despite a gradual move away from a doctor orientated approach toward a patient orientated approach, many sisters still adopt a medical approach to their work (Fretwell 1979) which creates a certain type of environment that can be identified by the patient (Bendall 1975).

The importance of the sister in creating a ward atmosphere that provides a feeling of well-being, acceptance and security for both

patient and staff has been postulated by several researchers, including Stevens (1961), MacGuire (1969), Fretwell (1979), Orton (1979), but undoubtedly Revans (1964) has been a major influence in this field of enquiry. The personality and work of the sister were recognised and reported as important in creating an atmosphere conducive to happy nurses and patients by both the King's Fund (1949) and the Briggs Committee (1972). Perry (1978) attributes a friendly, happy atmosphere to good leadership by the ward sister. He further suggests that 'in such a ward the general standard of nursing care is good and maintained in sister's absence' (Perry (1978). Both Perry (1968) and McGhee (1961) have commented on the effects to patients and staff on wards where the sister openly makes time to teach and supervise nurses in training. They indicate that patients and staff appear more confident and motivated than in areas where there is little or no involvement by the sister in training. The sister has also been identified as 'the key person on the ward controlling all communication coming into and out of the ward, as well as within the ward itself' (Lelean 1973). The importance of the sister in creating an environment which facilitates the free exchange of information and encourages questions to be asked is, according to Revans (1964), an essential prerequisite for nurse learning and patient well being.

Despite the importance of these aspects of the sister's role, researchers have found little evidence to suggest that provision

is made to develop and promote interpersonal skills of trained nurses. The charge nurses in Stapleton's (1984) Study identified a need for clinical up-dating and for increased knowledge of interpersonal skills. The need for interpersonal skills training is supported in studies by Pepper (1977), Ogier (1979) and others.

Historically the response in meeting the identified training needs of sisters appears to have been stifled. The Working Party on the Recruitment and Training of Nurses (1947) acknowledged that in comparison with facilities provided in some other countries, the opportunities in Great Britain for 'Postgraduate' training were very restricted. As long ago as 1943 the report of the Nursing Reconstruction Committee stated that 'there should be short intensive courses especially designed for ward sister needs (Horder 1943). The Committee also considered that every ward sister should attend a course on the psychology of teaching. Reference to the preparation of ward sisters was also made by the Working Party on the Recruitment and Training of Nurses (Ministry of Health 1947) in which it was suggested that:

> 'the content of such a course might include principles and methods of teaching, administration and social psychology as well as special training in medical or surgical nursing or any one of the optional fields'.

During the early and mid 1940's concern at both local and national level was expressed by those responsible for providing and managing health care services, over the loss of trained nurses, from the health service.

Reasons given for this mass exodus included, long hours of work, poor pay, lack of suitable recruits, increased work load and inadequate preparation of nurses for sister positions. Hence in 1948, Ministry of Health officials approached The King Edward's Hospital Fund for London to ascertain if they would prepare young trained nurses for work as ward sisters, which they did from 1949 until 1969. The intervening years from 1950 gave rise to a plethora of reports and changes within the Health Service which further indicated the need for all sisters to receive some form of the preparation. In 1969 the General Nursing Council for England and Wales introduced new assessment criteria and skills to be taught during basic training which had implications for all trained nurses and especially ward sisters when they stated that:

> 'since nursing is essentially a practical art, the majority of the training period will be spent in the wards and departments of the hospital, learning and practising nursing skills under the guidance of registered nurses' (GNC 1969).

More recently, (1976) the General Nursing Council also referred to the need for role preparation of trained nurses when they stated that:

> 'Trained ward staff must be helped to develop and believe in their supervisory as well as their management role'. (The Relationship between Education and Service (GNC 1976).

The realities, however, of the ward as a learning environment were highlighted by MacGuire (1969) when she suggested that:

> 'little formal training takes place in the ward situation, training often falls short of expectations, life is fraught with major and minor disasters which leave some students feeling that the hospital lacks regard for them as individuals'.

An early reference by Goddard (1953) indicated that:

> 'there can be little opportunity for supervising the work done by student nurses and virtually none for giving practical instructions which would need to be planned in advance and free from interruptions'.

Previous research has highlighted that frequent interruptions occur in ward areas Davies (1972), Lelean (1973), Pembrey (1980). It would appear that the sister is expected to 'maximise' opportunities for learning at the same time as she manages the ward and ensures the highest possible standards of care are provided. The conflict between meeting the educational needs of learners and the needs of the service has long been acknowledged. The familiar pattern of the service demands of the hospital taking precedence over educational needs of the students remains the major obstacle in the pattern of progress (Platt 1964).

The broad based educational philosophy now being proposed to Ministers is that initial education and training should be on a supernumerary basis and attract a grant; and that,

> 'there should be a new single level of nurse and she/he will embrace much of the work of the present two levels of nurse (RGN and EN). The nurse of the future will be a 'knowledgeable doer' able to marshall information to make an assessment of need, devise a plan of care and implement, monitor and evalute it. The new nurse will be actively involved in the delivery of care not be simply someone who supervises it' (UKCC 1979).

The implications for existing trained staff, and in particular the sisters should these proposals become a statutory requirement, have yet to be fully explored. However, the latter part of the statement suggests a high level of clinical activity. Thus reinforcing the recommendation made previously that:

> 'the ward sister would need to be prepared for her teaching role, and assume responsibility and accountability in providing an environment conducive to good nursing practice' (Royal College of Nursing Committee on Nurse Education (1964).

The Ministry of Health report in 1966 on the Post Certificate Training and Education of Nurses stated that:

> 'the sister needs knowledge and skills additional to those acquired as a student in training which cannot be acquired exclusively from subsequent practice. The aim therefore, should be for all sisters to undertake some further formal training, preferably before taking up post. The aim of such formal courses would be ..... to give instruction in ward administration, in training methods and in the health and welfare and other social services available to patients'.

The fact that 'there may be too much for the ward sister to do' was formally recognized by the National Nursing Staff Committee (Salmon Committee 1966), with the result that the recommendations and

implementation of the Salmon Report had a direct influence on the role of the sister. The report recommended that 'non nursing duties' be undertaken by those other than nurses; the report favoured a 'mechanistic' model of management characterized by a hierarchial approach to authority where a single and clear system from top to bottom is operational with specialist knowledge located at the top. Such a system was thought to result in more economical and effective performance. However, a comparative study by Burns and Stalker (1961) of management systems in relation to their environments indicated that organizations such as hospitals with complex technologies and rapidly changing and unstable environments respond successfully to an 'organic' style of management, characterized by a non hierarchial approach, mutual respect for colleagues based on the 'contributive nature of special knowledge and experience' which could be located anywhere within the organization. Information is exchanged as opposed to the issuing of instructions. The controlling influence is the person who possesses the appropriate expertise for the task in hand. Likert (1967) expounded the importance of relationships which are supportive in 'that each member, in the light of his background, values, desires and expectations, will view his work experience as supportive and one which builds and maintains his sense of personal worth and importance'. The Salmon report did, however, recognise the need to prepare sisters for their evolving role. Unfortunately, the committee's awareness of the sister's role did

not extend to a close analysis of 'the nature of managerial work undertaken by ward sisters' (Pembrey 1980) and the type of decisions they were required to make.

The problems faced by many sisters following the implementation of the Salmon Report were compounded by the involvement of supervisors, nursing officers, clerks, receptionists and house-keepers to resolve service problems, creating an unsatisfactory situation where the sister:

> 'retained co-ordinating, monitoring and executive power at ward level for services, but could be divorced from involvement in planning and setting objectives for their change and improvement' (Runciman 1983).

In 1983 a Working Party, under the Chairmanship of Roy Griffiths, was established to examine current management practices in the National Health Service. The findings of the committee indicated 'a lack of identifiable individuals to accept personal responsibility for planning and implementing objectives' and of 'clearly defined general management functions'. The effects of the broad sweeping changes that followed implementation of a general management system within the health service are still to be fully evaluated.

Previous research on the relationships within large organizations has indicated that employees who are continuously exposed to numerous expectations from those around them become dissatisfied.

Rizzo et al (1970) and many other researchers consider hospitals to have multiple lines of authority with nurses caught between medical and administrative hierarchies, and 'accompanied by role conflict and dissatisfaction for the members and loss of organizational efficiency and effectiveness'.

Rizzo further expounds that the dysfunction which occurs appears to be a necessary concomitant and cost of providing professional control over the technical aspects of organizational activities. Role theorists like Kahn, Wolfe, Quinn, Snook and Rosenthal (1964) have suggested that an individual who experiences role conflict or ambiguity will respond by adopting some form of coping behaviour which 'may distort the reality of the situation or attempt to avoid the stress by trying to solve the problem'. I have found only one British study (Redfern 1979) that has attempted to measure levels of role stress in sisters.

The Ministry of Health (1966), DHSS (1972), (1974) and (1979) all recognised the need for sisters to have a clinical career structure which 'would give the sister the challenge she seeks' (DHSS 1972), at the same time as developing a 'strategy which holds a promise of lasting improvement is to seek to resolve the conflict between the ideal and the real' (Bendall 1975) and which includes rethinking the whole process of training for both trainees and trained staff.

The National Nursing Staff Committee (DHSS 1977) reported that:

> 'Experience gained from these (Management) courses and findings from research both inside and outside the NHS demonstrate that attendance at an off-the-job management course is not of itself sufficient to ensure learning and its own application to improved management at the place of work. A great deal depends too on 'climate' within the parent organisation, recognition of the value of training by top management, the quality of officer relationship and involvement of the student's senior officers, particularly in his preparation for the course and in follow-up on his return. Equally important is the personal motivation of the student and his capacity to see and develop the relationship between what he learns in the classroom and what he does in his job'.

The importance of situational factors on learning has gathered momentum over the last decade. Kerr et al (1974) attempted to demonstrate that the effectiveness of a leader is contingent upon particular situational factors:

i. consideration for one's subordinates;
ii. consideration towards one's superior;
iii. consideration of the tasks to be undertaken.

Members of a team under a good leader are interested in their work and want to do it well (Perry 1968). In such an environment learning can be 'evidenced by an increase in the ability to adapt effectively to the environment and more specifically to perform particular tasks more effectively' (Singleton 1974).

1.3 Recent proposals

The need for 'practitioners to be given formal preparation for their training and education role in practice settings' (UKCC 1987) has long been recognised. Many Schools of Nursing have now set up, under the auspices of the National Boards, training courses for Teaching and Assessing in Clinical Practice, ENB Course 998. However, not all Schools of Nursing provide this course, and places are limited thus it will be many years before all practitioners can be offered a place. In the past, some nurses have attended the City and Guilds Further Education Teachers Course No. 730 to gain more knowledge and expertise on teaching. Sisters working in nurse training areas attended local N.H.S. assessment courses which were of three to five days duration.

The commitment 'to achieving improvements in the education and training environment' is part of the underlying philosophy in the UKCC recommendations. However, greater effort is now required to produce a functional paradigm. In 1985, nurses lost their entitlement to practise if they had been absent from the profession for five years, unless they undertook a 're-orientation' programme. Furthermore, the Nurses, Midwives and Health Visitors Act (1979) gave power to the United Kingdom Central Council (UKCC) to instigate periodic relicensing and in 1990 entitlement to practise as a nurse will be dependent upon satisfying the UKCC, by a manner yet to be determined, that they have kept professionally up-to-date with developments.

1.4 Wessex Regional initiative for the development of sisters

In July 1983 the Wessex Regional and Chief Nursing Officers Group set up a Working Party under the chairmanship of the Director of Nursing Services for Basingstoke General Hospital to examine the present and future training needs of sisters and charge nurses as part of a broader strategy to develop a more systematic approach to career development within the region. Representatives were nominated from each district within the region.

The Working Party presented their findings and recommendations in November 1984 which offered a framework for each District to develop and pilot a detailed curriculum to meet local needs. The aims of a sister development programme were to:

> support sisters during their first year of appointment and prepare them to function effectively as sisters;
>
> assist the established sisters to examine their work and consider areas in which they might improve their performance.

Six main themes were recommended for the taught component of the programme:

- Management of patient care;
- Team management;
- Personnel management;
- Teaching;
- Research;
- Individual professional development.

Objectives were provided for each theme. On completion of the taught component, contract learning was to be undertaken to meet individual needs of sisters.

The group suggested that when sufficient sisters had been appointed to make a course viable, they attended a five day course designed to cover aspects particularly relevant to newly appointed sisters, who on completion of the course would then attend study days appropriate for both new and established sisters.

It is against this background of professional change and uncertainty that the proposals to plan, implement and evaluate a pilot scheme for the development of hospital sisters emerged at the hospital involved in the present study.

CHAPTER TWO

ELEMENTS OF THE EAST DORSET PILOT SCHEME FOR SISTER DEVELOPMENT AND ITS UNDERLYING EDUCATIONAL PHILOSOPHY

2.1 INTRODUCTION

Under the leadership of the Chief Nursing Officer and Senior Nurse Managers the notion of role preparation and development for sisters working within the East Dorset Health Care District gained momentum. In the absence of a national outline curriculum for sister training and development, the Senior Managers agreed to support the Wessex Regional Sister Development Working Group recommendation to develop and pilot a programme to meet local needs.

In January 1986 a small planning team was formed under the chairmanship of the Senior Tutor (Professional Development), Dorset School of Nursing, to assume responsibility for devising, implementing, monitoring and evaluating a pilot development scheme for sisters at one of the acute general hospitals within the District.

Membership of the planning team included:

- the Tutor for Professional Development Acute and Midwifery Unit.
- the Nursing Officer for the Surgical Units at the host hospital.
- a Clinical Teacher with a specific remit for sister development.
- a Ward Sister in charge of a Surgical Ward.

The terms of reference were to:

- devise a sister development scheme based on nursing research and sound educational principles.
- submit written proposals for a scheme to the Head of Nursing at the host hospital.
- implement, monitor and evaluate the effectiveness of the scheme.
- prepare a written evaluation of the scheme following an agreed pilot period.

The planning team were selected by the Senior Tutor, Professional Development and Director of Nursing Services of the hospital to be used for the pilot scheme, on the basis in individual expertise and potential contribution to the scheme.

2.2 Planning the scheme

The support and commitment of the Director of Nursing Services to the scheme enabled it to be evolved over a fairly short period of time.

The plan of action and progression of the scheme were based on two axiomatic assumptions:

> "that any such scheme should be cost effective and not detract from or duplicate existing professional development opportunities.
> and
> that such a scheme should take account of the now considerable body of research evidence on the role of the sister and on results of evaluated development schemes". (Dorset School of Nursing, 1985).

Information previously collected from sisters and charge nurses working in East Dorset during the previous two years on aspects of their role and perceived training needs. In conjunction with; the

report on the evaluation of the King's Fund Training Schemes for sisters, and, the findings and recommendations of the Wessex Regional Sister Development Working Party, provided the planning team with background information on ward sister development. This initial work identified the need to have a more precise understanding of what sisters actually do in their own environments and what their training needs were in relation to their present and expected performance.

In order to identify what the sisters do and how they do it, it became necessary to develop a tool to assess and measure performance. These aspects are discussed in detail in Chapters 3 and 4. Discussion also took place on the most appropriate methods for meeting identified training needs and facilitating the personal and professional development of the sisters. There was a concensus of agreement amongst the planning team of:

- the need for a realistic training scheme, predominately related to the individual needs of sisters.
- the need to minimise time away from the clinical areas for those undertaking the training.
- the advantage of having small groups of sisters with different levels of experience from a variety of specialist areas.

Discussion on how best to meet the training needs of sisters centred primarily on the debate between traditional and progressive methods of education.

2.3 Traditional versus progressive education

'Education has several important and well established functions. These include the presentation and transmission of knowledge (the teaching and learning function), the extension of knowledge (the research function) and the training in advanced skills needed by society' (Cox 1982).

The function of nurse education is to prepare and develop learners to act as competent professional practitioners. However, following the introduction of the Nurses, Midwives and Health Visitors Act (1979) there has been considerable debate within the profession about how best to educate and train nurses to meet the changing demands of society and goals of the National Health Service. This debate intensified from the Summer of 1984, when the statutory body for nurses, midwives and health visitors (United Kingdom Central Council), established a project 'to determine the education and training required for nursing ..... in relation to the projected health care needs in the 1990's and beyond'.

The project team stated in their final proposals that:

> 'to survive in a turbulent environment and at a time when cost saving and re-allocation of resources are on the agenda, as never before nurses must be prepared to accept challenges to their practice and to evaluate and review their performance' (UKCC - Paper 9, Feb. 1987)

However, the suggestion that education exists to assist and help individuals to grow and develop their potential as opposed to

helping to shape and mould people to suit the ideas and ideals of teachers is not an entirely new concept. Socrates made such claims during his lifetime. Debates about theories and models of learning and teaching in nurse education are currently taking place.

Traditionally nurse education has been teacher centred with extensive use of the medical model as its foundation. Many practising educationalists like Cox and Sheehan advocate the need for a high proportion of teaching to be initially based on traditional methods, mainly the lecture. In addition, many school of nursing classrooms have learners sitting for the greater proportion of time on chairs behind desks. Despite the increasing body of knowledge that indicates the fluctuating levels of attention and learning during lectures (Brown 1978, Hartley and Trueman 1978), this method is still widely used by many nurse teachers.

The self directed and motivational approach expounded by writers like Carl Rogers and Peter Jarvis has also been criticised, in so far as this approach may be to the disadvantage of some learners, who require a more traditional approach. A comparative study by Costin (1972) between the lecture method and the use of discussion indicated that there was no significant differences in outcomes. However, learners exposed to the discussion method demonstrated greater ability at problem solving. Other writers like Bloom et al (1974), Hollingworth (1979), Darwin (1980) question the

effectiveness of traditional teaching styles due to their inability to encourage creativity or critical and analytic thinking in the recipients. The main aims of progressive education and its strategies have been identified by Cooper (1981) and include:

> 'dealing with situations that are more realistic, discussing objective and subjective perspectives, encouragement of critical and analytic thinking, active learning, facilitation of transference of learning from one situation to another'.

2.4 Scheme philosophy and underlying assumptions

The development scheme in the present study subscribed to the underlying philosophy of progressive education and theory of adult learners, as exposed in the writings of Knowles (1984), Rogers (1969), Jarvis and Gibson (1985) to name but a few, as being the most suitable approach for the development of hospital sisters locally.

Written proposals for a pilot sister development scheme were submitted to the Director of Nursing Serivces at the host hospital and approved.

The philosophical ethos of the scheme was based on a humanistic perspective of 'personal growth and development, self direction and self and peer review'. The educational principles were drawn from the theory of andragogy. Knowles (1984) originally defined the term andragogy as 'the art and science of helping adults learn'. This term is perhaps best explained by examining four fundamental

assumptions of the adult learner postulated by Knowles .....

- Concept of the learner.
- Role of learner's experience.
- Readiness to learn.
- Orientation to learning.

Concept of the Learner

As part of the maturation process people move at different rates from dependency towards increasing self directedness. Mostly adults tend to 'have a deep psychological need to be generally self-directing' and, therefore, respond more effectively to teaching styles that facilitate this process.

Role of Learner's Experience

Each experience provides 'an increasingly rich source of learning which furthers personal growth and development'. Also a greater degree of meaning is attached to experiences gained through some activity as opposed to passive exposure. Therefore, the most appropriate educational techniques are experiential, problem solving, field experience, discussion, and such like.

Readiness to Learn

For a person to cope more effectively with real life problems or situations they experience a need and readiness to learn at certain times in their lives. The responsibility of the educationalist is to create the optimum conditions and resources for assisting learners to develop the readiness and 'need' to learn.

Orientation to Learning

Learners wish to apply the knowledge and skills gained today to living more effectively tomorrow. Thus they view education as the process of developing increased competence. Adults, therefore, tend to be performance centred in their approach to learning. The role of the adult educator is to organize and utilize experiences according to the development of competencies.

The dynamics of the learning process in adult education is reliant upon the learner's interaction with his environment. The role of the teacher is to facilitate and manage these two key variables, interaction and environment.

There is an increasing body of knowledge to suggest that certain conditions are more conducive to learning and to personal growth and development than others. Considerable energy was expended during the planning and implementation of the scheme to create these optimum conditions of learning which are thought to consist of:

- the learner's recognition and acceptance of the need to learn.
- fostering and environment characterized by mutual respect, trust and helpfulness, freedom of expression and acceptance of differences of opinion, and physical comfort.
- the goals of a learning experience being perceived by the learner as their goals.
- responsibility for planning, implementing and evaluating a learning experience being shared between educator and learner.
- learners actively participating in the learning process.

- relating the learning process to the learner's experience.
- learners having a sense of progress towards their goal.

The actual translation of the proposals into a functional time table was done by the clinical facilitator and scheme tutor. The development of the tool to assess and measure performance of sisters in their own environments was by joint discussion between facilitator and scheme tutor. The measures to evaluate the scheme, examine the complexity of the sister's role and, factors which appeared to influence what the sister does or does not do were produced by the scheme tutor, who used, wherever possible, existing scales known to be relatively valid and reliable. The measures are discussed in Chapter 4.

Members of the planning team assumed specific responsibilities for the scheme which included:

- co-ordinating planned periods of observation on the designated ward, and facilitating clinically based learning in the sister's own working environment through observation and critical comment on practice by the clinical teacher.

- ensuring the smooth operation of the scheme with particular reference to release of staff and liaison with management by the Nurse Manager.

- agreement by the ward sister to act as a 'role model' in so far as she would accept sisters on the scheme onto her ward to observe clinical organizational and educational practice, and participate in the debriefing discussions that would follow the period of observation.

- day to day management of the scheme and co-ordination of contributors by the tutor to the scheme, who also undertook responsibility for developing and implementing the evaluative strategy.

- overall management and educational rigour of the scheme was assumed by the Senior Tutor.

The planning meetings were short and concise, partially due to the cohesiveness of the group and the clear understanding of team members of their specific roles and responsibilities. A considerable amount of professional autonomy was exercised in the fulfilment of these commitments.

Help and preparation was provided for the 'role model sister' prior to the commencement of the scheme, which included a week at Guy's Hospital to observe and meet with staff involved in their Sister Training Scheme.

During this period, the sister spent time on a ward similar to her own which enabled her to compare and contrast leadership and management styles. The clinical teacher also spent time with the 'role model' sister on her ward observing activities of both sister and other members of the staff, and how they functioned as individuals and as a team.

The sister was not selected to act as role model because she was thought to possess attributes different or 'superior' to her colleagues. Her selection was based on her being a 'typical' sister at the host hospital and one who was willing to be observed and criticised by her colleagues.

The planning team decided that the Senior Nurse (Training) and the Clinical Teacher (Professional Development) should observe the sisters in their own environments immediately prior to commencement on the scheme, and again at approximately three and nine month intervals.

Detailed discussions between the 'observers' and the scheme tutor ensured a common understanding of the purpose of the observation, and how the performance index designed to record this information was to be used. The actual measurement tool is discussed in detail in Chapter 4.

Both observers tested the performance index on the 'role model sister' and obtained very similar findings.

The actions of the scheme tutor and facilitators reflected the belief that 'it is normal for individuals to reflect upon their own role performance, so that self-assessment may be regarded as part of the normal learning cycle.' However, the sisters need to be taught the art of self-assessment was not surprising because, while it is a natural process, individuals do need to develop a rigorous and relatively objective perception of their own role ability, and one of the functions of the teaching team was to assist in this development (Jarvis 1984).

The provision of 'feedback' to the sisters of their observed role behaviour formed part of this learning process.

An adaptation of Kolb and Fry's (1985) experiential learning cycle (see figure 1) demonstrates the conceptual framework of the scheme.

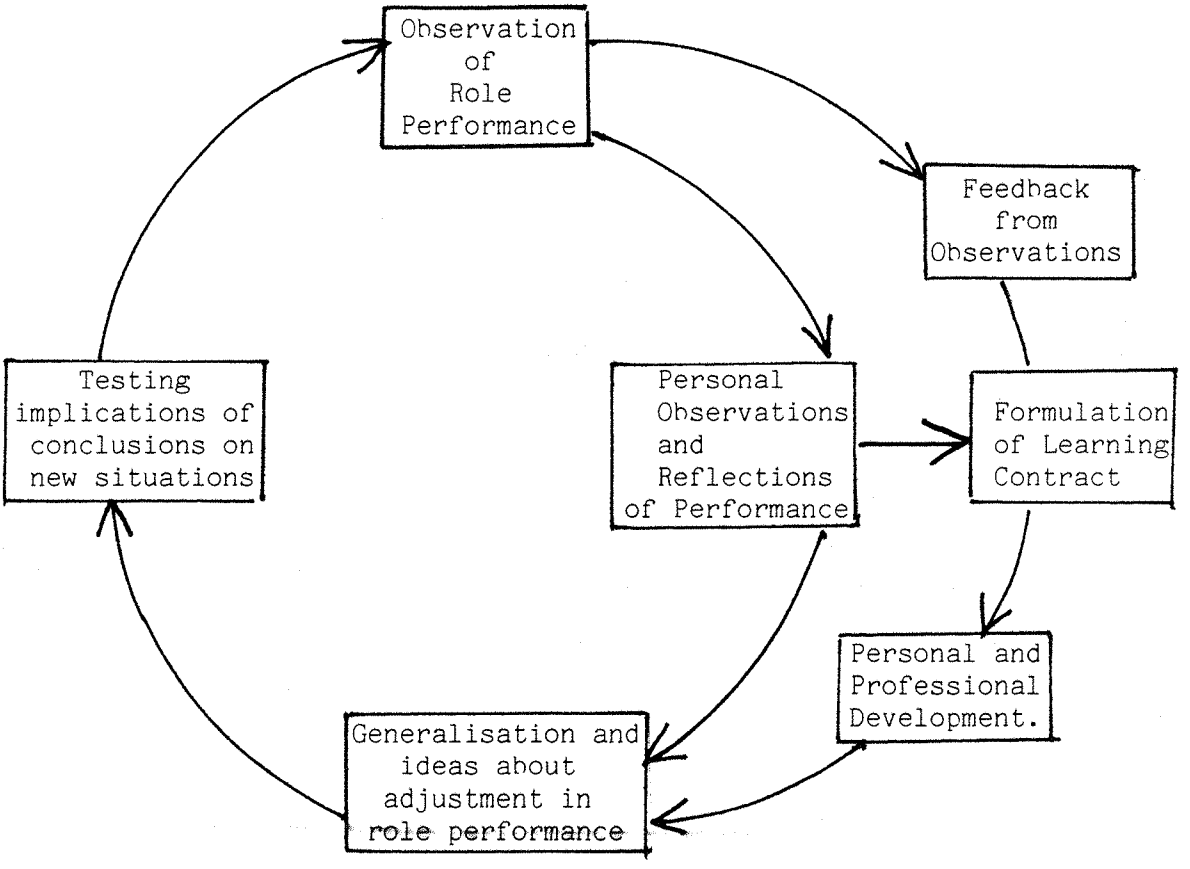


Figure 1 An experiential learning cycle as it relates to development.

2.5 Scheme structure

There were three distinct phases and two major components of the scheme.

Phase I

Extended over a four week period during which data were collected to assist sisters to clarify their own perceptions of their role and to provide a basis upon which to discuss improved role performance, and to help the scheme teachers to more accurately identify the sisters' training needs.

Observation like supervision may be defined as 'a method by which a person, through regular contact with a designated individual(s), is helped to develop an awareness of the situation in which she works and of her own role and behaviour within it' (Jarvis 1982, Task 1967).

Phase II

Phase two was designed to expose the sisters to new experiences and the possibility of greater role satisfaction and self-fulfilment. During this phase both teachers and sisters involved in the scheme shared experiences in a climate which encouraged mutual support and trust through small group, or one to one discussions, role play, independent study, reflection and constructive exposition of own and other's performance. Individual learning objectives were formulated and agreed between the sister and facilitator, which

encouraged the application of information acquired from exposure to new experiences.

The sisters were also encouraged during this phase of the scheme to develop mutually acceptable (between the tutor, facilitators and sister) criteria or methods for measuring progress towards their learning objectives. The sisters were absent from their wards for a total of twenty-one days over the twelve week period.

Phase III

Constitutes the evaluative phase of the scheme, both as a whole and of individual participant's progress, and was completed by week 46.

There are educators (Maslow 1954, Rogers 1969) who argue that the complexity of human learning does not lend itself to be described by terminal behaviours that are both measurable and observable. Knowles (1980), however, acknowledges that 'certain kinds of learning, particularly those that have to do with more or less routine operation' can probably be facilitated by a specification of the terminal behaviours. But, he is in general agreement with other humanistic theorists, that most learning is too 'complex to be reduced to mechanistic performances', especially if, like the development scheme, the components of learning involve judgement, creativity, confidence, analytic ability or sensitivity (Knowles 1980). The evaluative strategy took account of these views and combined elements of formative and illuminative evaluation, and

action research were used. (Evaluation strategies are discussed in detail in Chapter 3). An overview of the scheme structure is provided in Figure 2.

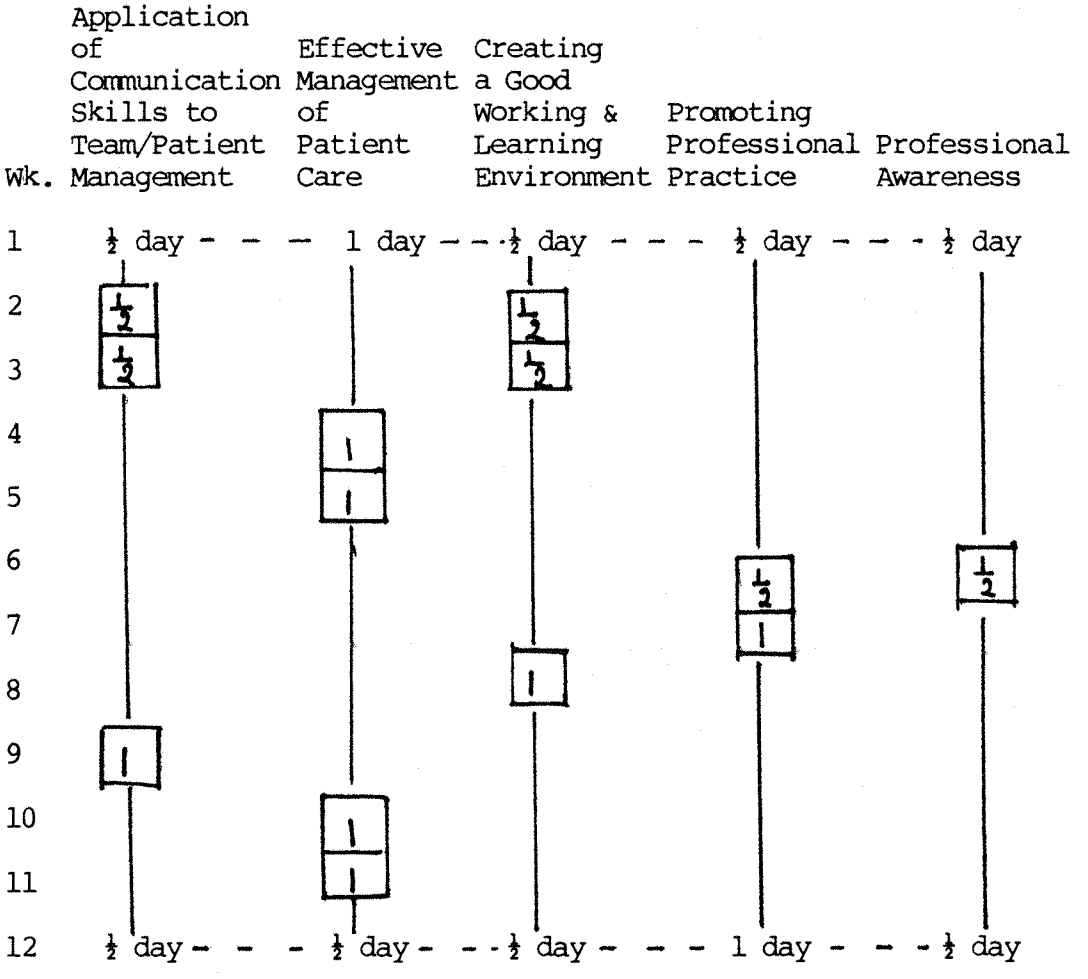
SCHEME STRUCTURE

Extends over 4 weeks	Extends over 12 weeks	Weeks 43-46
Phase I	Phase II	Phase III
Main Activities.	Main Activities.	Main Activities.
Data collection and analysis.	Data collection and analysis.	Data collection and analysis.
Development of individual profiles.	Feedback from clinical observation.	Clinical observations and feedback.
	Formulation of learning contracts.	Review of learning contracts.
	Contract learning.	Preparation for continued development.
	Implementation of taught component.	Evaluation.
	Clinical visits.	

Figure 2 Overview of the Scheme Structure.

2.6 Components of the scheme

A core component comprising of five major themes ran throughout this scheme and were taught/facilitated by designated people from various disciplines within the District, including members of the planning team. Each theme was specifically highlighted during the scheme to enable the taught aspect to be related to specific clinically based activities. (See figure 3).



* study day to undertake/complete Contract Work.

Figure 3 A Schematic representation of the major themes of the core component and their relative position in scheme one.

Some of the study days or part of the study days were spent undertaking specific activities within the clinical environment. The themes were similar to those identified by the Wessex Regional Sister Development Working Party in 1984.

Theme objectives

The objectives stated that on completion of the taught component and agreed contract study each sister who attended would be able to:

1. Apply communication skills to patient and team management

   Demonstrate basic communication skills with staff as individuals and in groups, using both verbal and written methods.
   Demonstrate skills in persuading and influencing others, in dealing with conflict and stress and maintaining one's position under pressure.
   Communicate information confidently and effectively to patients, relatives and members of the health care team.
   Maintain accurate records and reports in relation to patients and staff.
   Recognise signs of stress in herself and her staff and develop methods of stress management including the application of counselling skills to resolve conflict.
   Deal sensitively and effectively with complaints from patients or relatives.

2. Effectively manage patient care

   Implement and manage a system of individualised patient care in her ward.
   Identify leadership styles in relation to decision making delegation and assertiveness.
   Set nursing care standards and monitor nursing practice and care standards in her ward.
   Appreciate the significance of effective communication in ward and patient management.
   Be aware of legal responsibilities and accountability as a nurse and manager.
   Identify and implement operational policies and procedures, making suggestions for changes where appropriate.

3. Create a good working and learning climate

With reference to leadership styles, promote and maintain a high degree of morale amongst her staff.
Identify the role and responsibilities of the Sister as a teacher.
Identify the needs, expectations and appropriate levels of teaching for different groups of learners.
Adopt a systematic approach to clinically based teaching activities.
Identify methods of assessing learners' performance and to give constructive feedback both verbally and in written reports.
Act as a facilitator to the trained ward staff, by recognition of their individual needs and potential, promoting their self-development.

4. Promote professional practice

Discuss her role in relation to research relating to the ward sister.
Suggest ways of developing her role based on research findings and identified needs.
Identify aspects of clinical and ward management which could be improved by implementing research findings.
Discuss conflicting perspectives on patient care referring to relevant evidence to support or refute each perspective.
Produce a framework for introducing change in her ward.

5. Promote professional awareness

Discuss developments in basic and post basic nursing education.
Identify the role and functions of the Central Council and National Board.
Discuss developments in the organization of health care services.
Discuss issues relating to professional autonomy and accountability.
Identify and debate issues of contemporary medico-legal and ethical concern.
Accept responsibility for self-evaluation of professional practice and development.

The Taught Component

The taught component for the first scheme commenced with a three day introductory block, followed by weekly study days over ten weeks. In addition, a half day on alternative weeks was allocated to allow for private study and contract learning. The scheme concluded with a three day block to consolidate the main themes and discuss the continuation of participants' professional development and role satisfaction.

The scheme was located in the School of Nursing for the theoretical component and ward based for the clinical aspects. To encourage group participation and peer support, the scheme was designated the same room for each study day. The room had easy chairs which were usually arranged in a circle and facilities for making beverages were available. Attention to the layout of the room and comfort of the participants were seen by the tutor as essential to the schemes success. Particularly, as sensitive discussions on role performance, and attitudes towards changing existing behaviour or ward practices were involved.

The style of teaching used was predominantly informal and facilitative and designed to encourage participation and a climate conducive to adult learners.

An outline of the programme, which was sufficiently flexible to meet individual needs, is given on page 35.

Outline Programme for Introductory Block

Week 1

Day I — Analysis of present system of ward communication.
Leadership styles.

Day II — Managing a nursing team.
Management of an individualized care system.
Communication skills to persuade and influence others when dealing with conflict.
Maintaining one's position under pressure.

Day III — Management of people and their problems.
Strategies for avoiding potential conflict situations.
Promoting professional awareness.

Outline Programme for Study Days

Week 2
(i) Clinical visit to identify ward learning opportunities and observe nurse patient interaction.
(ii) Discussion of observational visit and comparison of findings with own clinical setting.
(iii) Methods to assess performance, provide constructive criticism and promote professional practice.

Week 3
(i) Clinical visit to observe handover report, post report activities of staff, written ward reports and patient activities.
(ii) Discussion of observational visit and comparison of findings with own clinical setting.
(iii) Review of basic skills for effective verbal and written communication.

Week 4
(i) Clinical visit, to examine existing framework for clinical practice and discussion of findings.
(ii) Current organizational structure and operational policies and procedures.
(iii) Developing a framework to promote clinical practice.

Week 5 Workshop and clinical visit to identify and set standards for measuring quality of care.

Week 6 Promoting professional practice through the utilization of research related knowledge.
Developing professional awareness.

Week 7 Continuation of professional practice theme.

Week 8 Designing a framework to create and maintain a good working and learning environment.

Week 9 Recognition of stress in self and others.
Techniques to alleviate or manage stress.
Counselling skills.
Designing a system to improve ward communication.

Week 10 (i) Clinical visit to observe delegation and decision making.
(ii) The art of effective delegation and decision making - discussion.

Week 11 Workshop on techniques to promote effective clinical management.

Week 12 Outline Programme for Consolidation Block

The detailed content of these days will be decided by the scheme participants and teacher.

Day I Review and discussion of contract learning experience.
Presentation by scheme sisters of individual action and future proposal to develop assertiveness, delegation and decision making skills.

Day II Discussion of improvements in patient documentation and implementation of an individualized patient care system.

Day III Preparation for continued professional development.

Contract Learning

The second component of the scheme related to the use of contract learning to meet the individual needs of the sister.

The theoretical foundation for contract learning is derived from Maslow's (1954) humanistic concept of man and hierarchy of needs. Evidence from research findings about adult learning suggests that 'when adults learn something naturally (in contrast to being taught) they are highly motivated and tend to learn more deeply and permanently' (Knowles 1984).

The purpose of introducing the sisters to this teaching strategy was two-fold. Firstly, as a means of promoting professional competency, as suggested by the findings of the Wessex Regional Sister Development Working Group, and secondly, as a method of self directed learning to facilitate the acquisition and application of new knowledge.

The learning contract became a vehicle for personal growth and development, enabling consideration to be given to the United Kingdom Central Council Code of Professional Conduct, the needs and expectations of the organization, patients and staff and, negotiation between these aspects and the sisters' own internal needs and interests. The sisters were encouraged to participate in the diagnosis of their learning needs, formulation of realistic objectives, identification of resources required to achieve the objectives (within the constraints of the organization), selection of appropriate learning strategies and deciding upon the criteria for evaluation. This gave the sisters a sense of responsibility and ownership of the learning contract.

A copy of the format used is shown in Figure 4.

Objectives for what I want/ need to know/ do.	Details of how I am going to do it, and the resources I need.	Date I shall have completed the contract.	Method by which I will demonstrate I have achieved the objectives.

Figure 4 : Format for contract learning.

Learning contracts were formulated and acted upon during the interblock periods. The equivalent of three working days were allocated for contract learning and taken at the convenience of the individual sisters.

Some of the study days or part of the study days were spent undertaking specific activities within the clinical environment. In addition participants spent one day during the twelve weeks working with the role model sister.

Support during the interblock periods was provided by peers and members of the teaching team.

A copy of the format used is shown in Figure 5

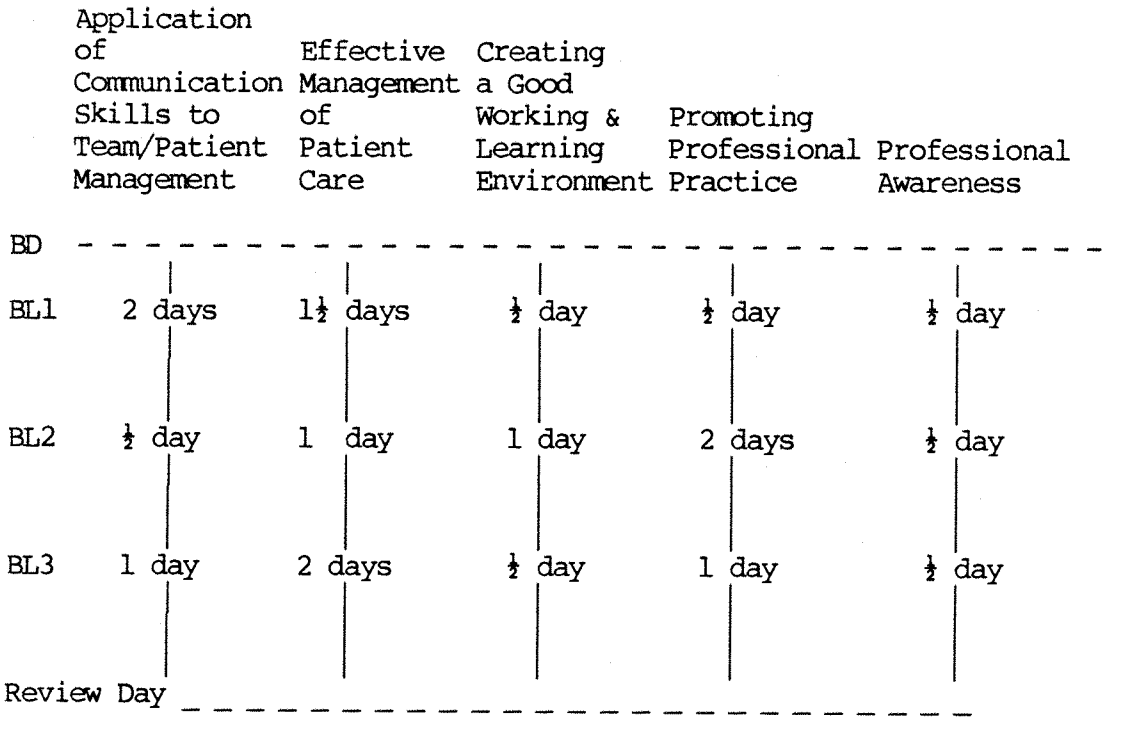


Figure 5 : A schematic representation of the major themes of the core component and their relative position in scheme two.

The theoretical content and format for developing learning contracts were the same for both schemes. Changes were, however, made in the scheme structure, from study days to three one week blocks in the light of evaluation findings.

A schematic representation of the themes and relative position in scheme two is provided in Figure 5.

2.7 Selection to the scheme

Four main issues relating to selection were addressed by the planning team:

- who the schemes should be for; experienced, newly appointed or potential sisters or a combination.
- whether the schemes should be mandatory or optional?
- the criteria for selection.
- nomination to the scheme.

The question of who the scheme should be designed for was discussed at length by the planning team. Some members thought it may be beneficial to have potential sisters (senior staff nurses) and newly appointed sisters together on the schemes, before they had had an opportunity to develop, largely by a process of trial and error, a 'role set'. However, the idea of potential sisters attending such a scheme raised other issues, for example: would the person completing the scheme have automatic right to the next available sister post and, as the first two schemes were a pilot study, would the potential sister be disadvantaged if applying for a sister's post during the scheme as her present role performance would have been closely scrutinized, as opposed to those not attending the scheme? Thirdly, as no arrangements presently existed for a potential sister to assume the role and responsibility of an appointed sister for the purpose of role development, what could one reasonably expect the person to achieve as a result of the scheme?

The planning team considered there was merit in having newly appointed sisters and experienced sisters together. Previous work by McFarlane (1977) suggested that the allocation of inexperienced and ineffectual sisters to one who had proven herself able to cope with the complexity of the role may enable them to learn from her wisdom. The planning team also felt that the number of newly appointed sisters to the hospital was quite small, therefore, to have a viable course of 4 - 6 sisters could mean that some were in post for at least twelve months before the minimum number of sisters were available. Some members also considered that there were experienced sisters who had become 'set' in their ways and were finding it difficult to understand and, therefore, implement the changes in nursing practice and patient management that were seen as desirable under the new management structure. It was, therefore, decided that the scheme was to be open to any sister within the host unit regardless of experience or speciality providing they met with the selection criteria.

The criteria for selection were drawn up by the planning team and agreed by the Head of Nursing for the host unit and included:

- full management support,
- the individual demonstrate the necessary interest and motivation,
- full study leave to ensured and feasible as outlined by the requirements of the scheme,
- the individual not undertaking or about to undertake any course which would run concurrently with the scheme,
- the individual be likely to remain in service for the immediate future.

CHAPTER THREE

EVALUATION STRATEGIES

3.1 INTRODUCTION

> 'The basic purpose of evaluation is to stimulate growth and improvement. Whatever other worthy puposes exist are only facets of the all inclusive effort to assess present conditions as a basis for achieving better ones'.
>
> (Kempfer 1955)

Over the years there has been increasing emphasis on the importance of evaluation in the health care service, including educational and training programmes. In 1979, the Joint Board of Clinical Nursing Studies defined evaluation as:

> 'A systematic examination of a whole course, or part of a course, in order to bring about improvements and development in the course programme' (JBCNS 1979).

Evaluation has become an essential and inescapable part of programme administration, as such the nature and function of evaluation has changed over the years to meet programme demands.

The evaluation strategy for the present study was determined by a number of factors, which primarily related to the purpose of the evaluation, the nature of the evaluation subject, and the role of the researcher. A framework based on an action research approach was chosen, combined with many of the features of illumination and formative evaluation.

Until recently, very little attention was paid to the use of action research in nursing or nursing research. Despite its extensive use in other organisations, however, where studies have used an action research approach to effect change in hopsitals, (Revans 1976, Cope 1981, Towell and Harries 1979, Towell and Darlington 1976) these have usually been aimed at improving hospital organization or the delivery of patient care. Cohen and Manion (1980) consider action research to be 'situational, collaborative and participatory and self-evaluation' and, therefore, "the method most appropriate for nurse research' in Greenwood's (1984) view. Towell (1979) has argued that where 'the intention is both to contribute to the resolution of practical problems and to increase understanding of the issues being studied' then greater attention should be paid to the use of action research.

Action research has been described as 'a process which does not pretend to be objective and which involves the objects of the research in the process itself' (Pedler 1974).

Unlike classical research, subjectivity is not an issue for criticism in action research and, therefore, requires the researcher to 'abandon any attempt at objectivity and declare a vested interest in the programme' (Powley 1976).

3.2 An overview of evaluation strategies

In order to indicate the thinking behind the evaluative strategy adopted in this study, a brief overview of the main evaluation strategies is provided. A search of the literature suggests that evaluation serves two purposes, accountability and decision making (Stufflebeam 1975), both of which must take account of the four elements of a programme; goals, design, process and product. According to Stufflebeam, accountability relates to justification of the value of the programme to the employers, participants and sponsors and this aspect of evaluation calls summative. Allen (1977) defines accountability as assuming responsibility for a programme's goals, methods and outcomes.

The second purpose of evaluation is decision making, and many writers have commented on the contribution evaluation makes to decision making, when information about a programme is fedback to programme planners and managers. Warr, Bird and Rackman (1970) saw evaluation as a means of helping the trainer to make decisions about a programme as it proceeds. This concept has been further developed by Burgoyne and Singh (1977) when they distinguished between the purpose of evaluation as feedback, and evaluation as adding to the body of knowledge and facts about training and education. They further suggest that evaluation can influence decisions at five levels. These levels are referred to as:

- intra method decisions,
- method decisions,

- programme decisions,
- strategy decisions,
- policy decisions.

Intra method decisions are concerned with how a particular teaching method is conducted, method decisions examines the appropriateness of a given method for a subject material. Programme decisions refer to the structure and conduct of the programme; strategy decisions relate to the use of resources and their appropriateness. Lastly, policy decisions are concerned about funding and availability of resources. Burgoyne and Singh consider that evaluation on this type of scale gives greater breadth and depth, thus avoiding concentration at one level with possible exclusion of other important variables. However, as Lathlean and Farnish (1984) point out, the link between the information collected and the nature of the decisions is not always made clear. The decision making component of evaluation is referred to by Stufflebeam as formative. The distinction between formative and summative evaluation is generally regarded as originating from the writings of Scriven (1967). In summative evaluation the researcher tends to focus on the outcome of the programme. Therefore, this usually takes place on completion of the programme and requires the researcher to seek to answer questions on whether the programme worked. In formative evaluation, the researcher concentrates on collecting information with the intention of improving the quality of the programme, usually through a system of information feedback. Evaluation that does not lead to improved practice is considered by

Kempfer to be sterile. One approach to programme evalution has been to concentrate on the programme's objectives. A paradigm for facilitating the evaluation of programme objectives has been suggested by Suchman (1967) when he questioned:

- the nature of content of the objectives,
- the target of the programme.
- when the desired change was to take place,
- if the objectives were unitary or multiple,
- the desired magnitude of effect,
- how the objectives were to be attained.

Smith (1975) suggests that one other question be added to Suchman's list; what are the unintentional effects of the programme's objectives? Over the years there has been a gradual move away from evaluation that seeks to concentrate on programme objectives and the relationship with programme achievements towards a more progressive approach which includes other elements such as the relationship between the programme and its organisational settings and the values that reflect the development of the programme. An overview of the trends in education research over the past fifteen years as illustrated by Nisbet (1980), is given in figure 6.

1. Experimental Method	2. Exploratory Survey	3. Curriculum Development	4. Action Research	5. Open Ended Inquiry
Empirical Educational Science.	Fact-finding as as a basis for decision making	New syllabus content and method. Field trials and Evaluation	Interventionist	Grounded theory Participant observation. Illuminative evaluation
The Agricultural Model.				**The Anthropological Model**
Experiments to improve your products by manipulating treatments.				Go and live there and see what it is like.

Figure 6. The Spectrum of Education Research (Nisbet 1980).

3.3 Values

Certain values or qualities are identified as worthwhile to the development of an educational programme. These values may then become the criteria against which all aspects of the programme are judged. Allen (1977) suggests that 'evaluation involves assessing these criteria in relation to the various aspects of the programme and to the programme as a whole'. She also states that criteria selected should be of assistance in answering the questions posed by evaluation. As society's views on what is valuable change, so do those deemed worthwhile to the evolving programme. Therefore, 'the criteria by which we judge anything reflect the prevailing values of the times, which in disciplines allied to science depend to some extent on the current state of knowledge'.

The values that reflect the development of the programme in the present study include:

> the relevance of the goals, activities, and outcomes of the programme to the participants and the organization;
> the relatedness of the different parts of the programme in seeking common goals and in discovering the means to achieve them;
> the accountability of the programme in assuming responsibility for its goals, methods and outcomes.

Davies (1972) in her evaluation of first line management courses for sisters highlights the importance of value systems within the organization and the effect this can have on the programme, when she concludes that management training is more likely to be effective if related to the organizational structure within which

the trainees work, and if the values are used to reinforce the training.

Alternatively, Hodgson and Reynolds (1980) have indicated that some of the value and belief systems of tutors or of the organization within which they work can if transmitted to the programme content and structure lead to conflict. These issues were particularly pertinent to the present study, as the sisters were coming from an environment which operated on a highly structured hierarchial basis into a situation that was designed to maximise group and individual involvement on a basis of equality which at times would be unstructured so as to meet individual needs of the participants.

Many writers, including Knowles (1980) and Smith (1975), acknowledge that there may be a conflict of values within the evaluation process, each arising from groups or individuals with a vested interest in the evaluation.

Conflicting values in evaluation of adult educational programmes may arise from differing educational philosophies. If, for example, education is defined 'as a process of educating a person, of taking responsibility for making changes in a human being', then an obligation is incurred to measure as precisely as possible what they are doing to that person. The evaluation will, therefore, be concerned with obtaining data to determine the efficiency of the programme and whether or not maximum change is being produced with

minimal time and costs. In other words, quantification becomes a dominant theme. If, however, education is defined as a process of facilitating, enabling and providing resources for self-directed inquiry and personal growth and development, an obligation is incurred to actively involve participants in data collection that will assist and enable them to assess the effectiveness of the programme in helping them to achieve their objectives. The dominant theme for the evaluator of an androgogical programme is, therefore, involvement.

The discussion at the beginning of this chapter suggested that evaluation serves two functions, accountability and decision making; it is perhaps self evident that evaluation has, in fact, numerous other functions, some negative, some positive. Brooks (1965) suggests two additional functions which he refers to as the dissemination function and the theory building function. The former provides a knowledge base for others to draw upon, the latter seeks to 'clarify, validate, disprove, modify or otherwise affect the body of theory from which the hypotheses underlying the programme were derived'. Some other functions of evaluation have been identified by researchers like Downs (1965), Caro (1971), Weiss (1972) and include support for the status quo, defence against not making decisions, boost morale, justify expansion of a programme.

3.4 Evaluation of the sister development scheme and action research.

In the present study, evaluation occurred at periodic times throughout the scheme, and provided data on how participants felt about the scheme. It was used by the planning team to make changes in design, facilities, method and the like, as required. Data about the knowledge, skills, attitudes and values acquired by the participants, were collected by pre and post scheme testing. Pre and post measures were also used for behaviour evaluation, which sought to identify changes that had been produced in the performance of participants. Data about the more tangible aspects of the scheme, like increased productivity, improved quality, reduced costs were more difficult to determine.

Despite criticism of traditional approaches to evaluation, little had been done 'to develop alternative models' until Parlett and Hamilton (1972) described an approach termed 'illuminative evaluation'. This approach has much in common with the 'goal-free' evaluation subscribed to by Scriven (1972) and Deutscher (1976) in which the evaluator is seen as a person processing the judgements as opposed to making judgements himself. Illumination evaluation is concerned with description and interpretation rather than measurement and prediction and seeks to examine and explore the innovation in its own setting by addressing and illuminating a complex array of questions.

The adoption of elements of this adaptable and eclectic approach enabled evaluation of the present scheme to commence with an extensive data base, therefore, potentially important variables were not precluded. The breadth of the enquiry was systematically reduced in the light of emerging issues, which then become the subject of further enquiry. This method, referred to as 'progressive focussing' permitted 'important factors to be studied in depth, whilst at the same time reducing data overload by permitting less important factors to be quickly considered. The third stage of the evaluative process sought to explain by illumination why the things observed were happening. The merit of this approach relates to its ability to help the evaluator 'sharpen discussion, disentangle complexities, isolate the significant from the trivial and raise the level of sophistication of the debate' (Parlett and Hamilton 1972) in his report.

The use of illumination evaluation made it possible to move away from the constraints of traditional methods, which tend to encourage the researcher 'to focus on the few things that are measurable, with the results that there are a host of alternative explanations for their findings' (Easterby-Smith 1981).

Concern may be expressed at the subjective nature of the illuminative approach, and of the emphasis placed on information gathering rather than the decision making component of evaluation and value of a particular programme.

It is possible to defend the interpretative nature of this approach by arguing that behind the question 'can personal interpretations be scientific?' there 'lies a basic but erroneous assumption:

> that forms of research exist which are immune to prejudice, experimentor bias and human error. . . . . Even in evaluation studies that handle automatically processed numerical data, judgement is necessary at every stage . . . . . particularly in the selection and presentation of findings in reports' (Parlett and Hamilton 1972).

Concern may be expressed about the validity and reliability of qualitative data. However, validity is about truth, and as 'there is no such thing as absolute truth, all the most objective researcher can report is his version of the actions of others and how they see their world' (Wiseman 1978).

'An individual may enter a system in order to seek truth through explanation, or alternatively, he may enter it to seek truth through the portrayal of reality' (Walker 1980). The action researcher tends to do the latter. However, 'most positivists would admit to the validity of some qualitative material, and many participant observers employ a modicum of quantitative evidence' (Bryman 1984). Reliability refers to the degree of matching between different sets of data generated by the same source, or, alternatively, about the relationship between several representations of the one event (Lathlean and Farnish 1984). The most common method is to correlate observations made by more than one observer of the same phenomena. Even so, the method is still

subject to several errors such as, inadequate sample content due to the complexity of the situation or different observers sampling different aspects; chance response tendencies due to imprecise categories or observers not adequately understanding the definitions used. Thirdly, subtle changes to the environment or those being observed can lead to unreliable data. Bold (1934) argues that observers should worry more about validity than reliability, as 'the relationship between the representation of events, and the events themselves is not so critical because the researcher makes more modest claims', (Lathlean and Farnish 1984) furthermore the interpretations of the readers are also significant.

3.5 Summary

The purpose of the evaluation was to assess the effectiveness of the Sister Development Scheme in achieving its aims, and provide information to assist in the modification and development of the scheme. Therefore, a strategy which allowed action and evaluation to take place concurrently was required. The model adopted contained many features common to other projects, in particular, Lathlean and Farnish (1984) and included:

> an exploratory phase to identify issues that were likely to be important to the study.
>
> a cyclic stage when recommendation for changes were made and implemented, the results evaluated and further recommendations made. The criteria of relevance, relatedness and accountability provided the structure for data analysis.

ongoing evaluation in order that each stage of the development scheme be fully evaluated.

the fostering of a collaborative relationship between members of the planning team and scheme participants, provided support for those involved directly with the scheme, and permitted changes to be negotiated.

the provision of feedback to scheme participants, planners and nurse administrators/managers.

involvement of the researcher in discussion about the scheme, so acknowledging the research as an integral part of the decision making process about the scheme.

The use of this approach is discussed in greater detail in Chapter Four, entitled Research Design and Method.

CHAPTER FOUR

RESEARCH DESIGN AND METHODS

4.1 Aims of the Research Project

The original outline of the project described the purpose of the research as to identify and measure changes in the behaviour of sisters or potential sisters as a result of undertaking a sister development programme.

The intention of the author was to gather information about specific interactions from a given situation as opposed to testing an already formulated theory. Emphasis was, therefore, placed on the processes involved in the innovation. The writings of Glaser and Strauss (1967) on grounded theory provided a useful frame of reference. The design of the study was influenced by the assumption that principles which govern a process are intrinsic to that process, and can not be discovered other than by studying the process and observing how it operates and seeing the connection between the parts (Taylor 1970).

4.2 Design Implications

The design for evaluating the pilot sister development scheme had to be amenable and flexible to accommodate the collection of

information over a period of time and be appropriate to the programme setting, as well as to a level of modification and change.

In formulating the design strategy a variety of questions were posed, which were similar to those asked by other researchers, in particular, Allen (1977), and included:

- What criteria is used to adopt the programme's relevance, relatedness and accountability to the role of the sister?
- What information needs to be sought in order to answer these questions?
- How is that information to be collected?
- What safeguards must be introduced to ensure validity, reliability and representativeness?
- How should the information be analysed to enable evaluation of the whole programme?
- What are the existing behaviours of the sisters?

For the purposes of the present study the operational definitions for the terms relevance, relatedness and accountability were stated as:

'Relevance'	-	the extent to which the development - *scheme objectives are a resposne to - identified needs of the participants and service.
'Relatedness'	-	the extent to which the different parts of the scheme, curriculum content, teaching strategies, philosophy of nursing, administration and research influenced its development.
'Accountability'	-	the extent to which the scheme has been evident in evoking a change in the behaviour or performance of participants.

* Scheme - the term development scheme was decided upon by the planning team as opposed to development programme, the former being considered a more suitable noun and defined as 'a combination of things adjusted by design rather than a plan of proceedings (the latter being a definition of the ward 'programme'). (Concise English Dictionary).

The development scheme had two main components; a core component applicable to all scheme participants comprising of five major themes. Each theme had objectives expressed mainly in behavioural terms. The second component of the scheme was the formulation of contract work based on individual needs and had no specific objectives, although members of the planning team considered that some participants would achieve a number of theme objectives by contract work. One might, therefore, assume to evaluate the scheme by comparing the scheme objectives with the behaviour demonstrated by the sisters before and after attendance. Such a design, however, would not answer the majority of research questions previously stated and would create immense difficulty due to the complexity of the variables to be measured.

The research design had also to take into account that the research setting and sample population were not selected because of their representativeness. The design emphasis was, therefore, on the study of the processes involved in the innovation and on producing a descriptive account of the issues as they emerged which would include answering questions on the level of success of the development scheme. Furthermore, the design selected had also to assist in the modification of the scheme to maintain its practicability.

The design chosen combined action research with elements of formative and illuminative evaluation and had the advantage that it

facilitated concentration on the processes within the innovatory milieu, rather than concentrating on specific outcomes derived from predetermined objectives. By concentrating on information gathering and detailed description, it was possible to provide a comprehensive understanding of the complex realities which surrounded the development scheme, and to comment on the visible outcomes, whilst permitting others to judge the value of the information and make decisions in accordance with their own priorities.

4.3 Stages of the research

The first stage of the research was exploratory and involved a search of literature on evaluation and action research, the need for role preparation of sisters and theories of adult education.

Stage two of the research involved data collection to assist in the accurate identification of training needs for individual sisters nominated and accepted on the schemes, and to provide an insight into the complexities of the sample populations present role and function as well as biographical information. A summary of the measures used are provided in Appendix 1a.

Stage three concentrated on the scheme and scheme participants and sought to answer questions of relevancy, relatedness and accountability as they emerged, for example, how does the administration ensure the relevancy of the scheme curriculum and

the facilitation of the sister's needs? Is the ratio of sisters to teachers congruent with the scheme's objectives and teaching strategy? Are the resources appropriate? What factors appear to support the scheme and how are they fostered? What are the constraints and problems and how are they dealt with?

The fourth and final stage of the research focussed on evaluation of the scheme as a whole and includes follow up observations and assessment of the work problems.

4.4 Methods

The initial methods of enquiry in the exploratory stage of the research consisted of literature search, interviews, observation and attendance at two meetings of the Regional Sister Development Working Group. On completion of this stage, four variables appeared to be important to the development of sisters and, therefore, presumably to measuring the effectiveness of any scheme designed to aid their developments; present level of insight of role performance, level of performance, level of role stress and perceived problems.

It was, therefore, decided to use a variety of methods to collect information on the study sample prior, during, at the end and approximately six months following attendance at the scheme. Questionnaires, interviews, discussions, personal records and observations were the instruments selected, and, where possible,

existing scales known to be relatively valid and reliable were used. The researcher's involvement in the planning and implementation of the scheme enabled feedback of research results to be used in decision making. Attendance at meetings and access to documents pertaining to the scheme provided a useful source of data.

4.5 Role performance index

The purpose of the role performance index was to provide, as near as possible, an objective account of the behaviours demonstrated by the sister in her clinical environment to enable:

- a more accurate description of the sister's performance to be identified,
- a comparison to be made between the entry and terminal behaviour of the sisters,
- a set of behaviours to emerge which could be identified as 'typical' of these sisters, and a comparison made with findings from previous research.
- the development of learning contracts to be based on descriptive information.

The exploratory work previously undertaken had identified five components of the sister's role that were amenable to observation:

- management of patient care
- teaching,
- ward management,
- personnel management,
- utilization of research based knowledge.

(A copy of the index is found in Appendix 2a)

The observations were undertaken on two occasions by different observers immediately prior to the sisters commencement on the scheme, repeat observations occurred at approximately three and

nine month intervals. Each sister was observed between four and six hours on each occasion. The day was selected at random by the observer, and no generalisations were to be made. It was, however, possible to state what activities took place and the behaviour of the sister on the given day. The problems and effects of observer bias needed to be considered. Normally the first day of observational data was discarded as the subject would probably be unused to being observed. However, the constraints of time did not permit first observations to be discarded in the present study. Therefore, it can be argued that the sisters may have behaved differently whilst being observed. The high level of correlation between the observations and verbal confirmation by the sisters that the observed behaviour was typical, led the researcher to conclude that no major changes in behaviour occurred during periods of observation. In addition, data were collected on each clinical visit on the number and dependency categories of patients (with the exception of paediatric areas) and the number and grade of staff on duty.

4.6 Self assessment profile

The self assessment profile consisted of eleven items and a possibility of five responses from which the sister was asked to indicate the response that most accurately described the item stated. (A copy of the profile used is shown in Appendix 2b). The completion of the profile was optional and designed to be used by

the sister on the days she was observed, to provide her with an opportunity to reflect on her feelings about her performance that day. The items were similar to those in the categories being assessed by the observers, and in addition opportunities were provided for the sister to make any other comments about her feelings on being observed, and if she considered the ward environment and her actions fairly typical. The profile was sent directly by the sister to the researcher. The data was also hand analysed.

4.7 Semi-structured interview

The purpose of the interview was to obtain the sister's own description and impression of job performance.

The interview was conducted in a quiet and comfortable room in the school of nursing. The seating arrangement was of a circular design and the chairs comfortable and of the same height. Encouragement for the sisters to speak out and say what they actually did think and feel was given in an opening statement by the scheme tutor about the purpose of the 'interview'. The interview with the individual sisters was conducted in the presence of the two observers and was combined with feedback by the observers of their impressions about the sister's job performance. The sisters were told that the purpose of the feedback and interview was to help them (the sister) identify and discuss aspects of their practice which could be developed; and that the

feedback and interview were an integral part of this identification process. It was emphasised the observations were based on peoples' perception of what had been seen, therefore, it was important that she (the sister) ensure all the facts pertaining to the discussion on role performance were identified. (The interview schedule is given in Appendix 2c). The sisters varied in the degree to which they conceptualised their role performance and some appeared to find it difficult to explain why they did things in a particular way.

The interview schedule was hand analysed.

4.8 Perceived role characteristics

The role opinion questionnaire consisted of twenty-three objective pairs of characteristics attributed to the sister. The characteristics were identified as a result of exploratory work by the researcher with approximately fifty sisters/charge nurses within East Dorset during 1984/85. The purpose of the questionnaire was to help the scheme tutor and facilitators to formulate a picture of how the sister perceived herself at a given moment, and provide insight into self judgement of covert role characteristics.

Each sister completed the questionnaire on commencement of the scheme, none of the sisters appeared to have difficulty with this activity and all were completed within fifteen minutes.

The questionnaires were hand analysed, and the results recorded and compared with findings from the clinical observations, self assessment profile and interview. (A copy of the questionnaire is given in Appendix 2d).

4.9 Checklist of work problems

A check list is useful in seeking information, and can provide nominal or ordinal data, it is, however, highly structured and therefore limited in its application. The purpose of the checklist used in the present study was to facilitate the identification of work problems, identify commonality of work problems and form a basis for problem solving exercises and contract work.

Twenty-four items were included in the checklist, which was developed and piloted during 1984/85, using respondents of similar status to those in the present study to ascertain that all the significant elements had been included.

Initially, forty-five items were identified and categorised under four headings:

Category 1 - problems that can affect ward organization,
Category 2 - problems with resources,
Category 3 - problems of communication,
Category 4 - personnel problems.

Subsequent testing and re-testing and analysis resulted in twenty-one items being discarded. Each item was analysed for the number of times it occurred as a problem. During the testing, and

in the main study, the respondents were asked to record any additional problems not included on the checklist. (A copy of the checklist and format are found in Appendix 2e).

The sisters found the checklist useful and easy to complete, the approximate amount of time taken was ten minutes. For the purpose of identification, a work problem was defined as 'something which interferes or prevents you from doing what you would like to do'.

Fleishman Leadership Opinion Questionnaire

The Leadership Opinion Questionnaire provides measures of two important dimensions of supervisory leadership, Consideration and Structure, both of which are applicable to ward sisters. Originally identified in the Ohio State University Leadership Studies, these two broad patterns have been shown to be meaningful in a wide variety of supervisory - subordinate situations. The need to consider the style of leadership in the context in which it occurs has been highlighted by numerous researchers; Forehand and Gilmer (1964), Payne et al (1976), Kerr, Schriescheim, Murphy and Stogdill (1974), all sought to highlight how the effectiveness of leadership is contingent upon certain situational factors.

The purpose of using the LOQ in the present study was to provide the sisters with an objective measure of their own leadership attitudes. The two scores provided by this questionnaire are defined as:

> Consideration 'reflects the extent to which an individual is likely to have job relationships with his subordinates characterised by mutual trust, respect for their ideas, consideration for their feelings and a certain warmth between himself and them.
>
> Structure reflects the extent to which an individual is likely to define his own role and those of his subordinates toward goal attainment' (Fleishman 1960).

A high score on the consideration dimension is indicative of a climate of good rapport and two-way communication. A low score indicates the individual is likely to be more impersonal in relations with group members. A high score on the structure dimension characterises individuals who play a very active role in directing group activities through planning, communicating information, scheduling, criticising, trying out new ideas and the like. A low score characterises individuals who are relatively inactive in giving direction in these ways.

Research findings indicate that these two dimensions are independent, hence it is possible to score high or low on both dimensions or a combination of a high and a low score. As the questionnaire has been well tested by previous researchers, no pilot study was undertaken prior to its use in the present study.

The LOQ is self-administering, and was completed by the sisters on commencement of the scheme and measures the individuals respond in terms of how frequently they feel they should engage in the behaviour described in each item. Instructions on how to use the

questionnaire were given on the front page, none of the sisters appeared to have any difficulty in following the instructions, and all had finished within fifteen minutes. Scoring was done automatically by the self scoring format of the answer sheet; alternatives to each of the items are scored 0, 1, 2, 3, 4 and complete scoring instructions given inside the answer sheet. As there are twenty items on each scale, the maximum score possible is 80 on each scale. The scores according to Fleishman generally range from 30-70. Percentile norms based on more than three thousand supervisory and managerial personnel from a variety of organizations are given in Appendix 2f.

4.11 Role stress measures

Four role stress measures were used in the present study and are similar to those used by Redfern (1981) in her study on ward sisters. Lyons' (1971) modification of the Job-Related Tension index developed by Kahn, Wolfe, Quinn and Snoek (1964), Lyons' Role Clarity Index, and the Role Conflict and Ambiguity Scales compiled by Rizzo, House and Lirtzman (1970).

The need to identify and measure the levels of stress present in sister on commencement of the scheme arose from the exploratory work, when sisters expressed that they were feeling more 'pressurised and stressed' at work than previously and that their staff also felt under pressure. This situation appeared to be 'affecting morale and job satisfaction'. Reasons given by the

sisters for these feelings were related to 'changes in the management structure', lack of staff, too heavy work-load and the like. The Job Related Tension Index (JRT) consists of nine items which are designed to indicate how much the respondent is bothered by the items, which could be perceived as evoking ambiguity or conflict in their work role. (A copy of the scale can be found in Appendix 2g, items 1 - 9).

Items 1 to 5 refer to:

- the scope of responsibilities of the job,
- opportunities for advancement,
- feedback from immediate superior,
- information needed to carry out the job,
- knowing co-workers' expections.

Items 6 to 9 refer to:

- heaviness of workload,
- having to do things against one's better judgement
- satisfying conflicting demands of senior personnel.

4.12 Role clarity index

Four items make up the role clarity index, and refer to the perceived clarity by the sister on:

- her limits of authority,
- the policies, rules and regulations of the hospital.
- how and what to do on the job.

(see items 10 to 13, Appendix 2g for further details).

4.13 Role conflict scale

The Role Conflict Scale consists of eight items (see Appendix 2h) which refer to:

- insufficient manpower and resources,
- incompatible requests,
- unnecessary assignments,
- having to bend the rules.

Two other items not included in the Conflict Scale were added, which concerned the sisters' perceived influence with co-workers and nursing management.

4.14 Role ambiguity scale

This scale consists of six items (see Appendix 2h) which are concerned with lack of clarity about:

- job objectives,
- responsibilities,
- authority,
- expectations of others.

The reasons for including the job related tension index and the role clarity index as well as the role conflict and ambiguity scales were two fold. Firstly, the four measures had been used with British Sisters (Redfern 1981) and found to be reliable and appropriate; secondly, the JRT index contained items not included in the conflict and ambiguity scales, and which the exploratory work had indicated were important to sisters and their potential development, i.e. feedback from manager and workload. It is

necessary to retain all the items in the scales despite at times their similarity and redundance, as all the items were summed in each scale to provide a total. Exclusion of items could, therefore, have led to doubts about the validity of the scales.

4.15 Propensity to leave index

The index contained four items and referred to the respondents intention to stay in or to leave the organization (see Appendix 2g, items 16-19) and is based on the three item index developed by Lyons (1971) and used by Redfern (1981).

The questionnaires were completed on commencement of the scheme and completion took approximately forty-five minutes. Information was given to indicate that there were no right or wrong answers to the questions and specific instructions on how to fill in the questionnaires were given in each situation.

4.16 Biographical information

A variety of methods were used to obtain biographical data; questionnaires, (see items 21 to 26, Appendix 2g and Appendix 1b), interview and personal records. Two items included (items 14 and 15, Appendix 2g) referred to the sisters' perceptions of the hospital as a place of work and how well she liked her job. Other items refer to professional and educational qualifications held, previous job held prior to nursing, marital status, occupation of spouse, number and ages of children, breaks in nursing service, age

of sister, distance between home and hospital, hours and shift pattern worked, professional journals read, courses attended in relation to work.

4.17 Scheme evaluation

The methods used to evaluate the scheme sought to assess the progress of the scheme participants, and appropriateness of the scheme content to their (participants) continued development on a systematic and continuous basis. As such, regular feedback from course participants and facilitators was encouraged on a group and individual basis by the researcher.

At the end of the twelve weeks 'taught component' of the scheme, participants were asked to complete two questionnaires; the first related to the overall planning, general organization and format of the scheme. (See Appendix 2i); the second contained items about the scheme content. (See Appendix 2j). Respondents were also given the opportunity of making any other comments about the scheme.

The sisters were also asked to indicate whether or not they had achieved each of the theme objectives and to state the extent to which they felt they were relevant to their role, i.e. very relevant, relevant, not relevant. The sisters were observed again in their work situation on two occasions, using the role performance index and a comparison made with the behaviour observed

prior to commencement on the scheme. Feedback from the observations were given to the sister, and she (the sister) also had the opportunity to discuss her views on the days the observations occurred. This enabled the sister's progress to be discussed with her and new contracts formulated to facilitate her development. The progress of the sisters continued to be monitored during the next six months by the two scheme facilitators.

The end of scheme evaluation also included group interviews, which appeared successful in their encouragement of participants to be constructively critical. The information obtained related to the immediate reactions of participants to the scheme, and were considered by the planning team when discussion took place about changes in course content and format.

4.18 Post scheme evaluation

Post scheme evaluation occured approximately six months after the end of the scheme and the design was similar to that used for end of scheme evaluation. The sisters were again observed in their work situation. In addition, their work problems, leadership styles and stress levels were re-examined. Where there appeared to be a difference between the pre-scheme and post-scheme findings, questions were then asked and answers sought about the relationship of the scheme to the post scheme findings.

The respondents were also asked:

- how they felt the scheme had helped them in their role as a sister,
- how they felt about being observed,
- how they felt the ward staff reacted to them being observed,
- what they most disliked about the scheme,
- what they hoped to do next.

It is acknowledged that this study has the limitations of confining itself to an evaluation of this one approach to the development of sisters.

4.19 Sample characteristics of those nominated to attend the schemes

Biographical information on the ten sisters who participated in the schemes enabled a profile to emerge which described their background and personal characteristics.

The sisters' ages on commencement of the schemes ranged from 25 years to 53 years; the difference in age between the oldest and youngest sister was 28 years. Three of the sisters were aged between 25 and 27 years, three were aged 33 years, two were 39 years and two of the sisters were aged between 50 and 53 years, the median value of the age characteristic was 33 years. Table 1 gives a summary of the age of the sisters at commencement of the schemes.

SISTER:	A	B	C	D	E	F	G	H	I	J
AGE IN YEARS:	33	25	53	27	39	50	39	33	33	28

TABLE 1. Summary of the Sisters' Ages

The educational qualifications of the sample ranged from no formal academic qualifications to 11 'O' levels and 3 'A' levels. Two of the sample had taken between 4 and 5 'O' levels or CSE grade 1; three had 6 'O' levels each one of whom also had 3 'A' levels; another sister had 7 'O' levels and three had 9, 10 or 11 'O' levels respectively, the latter also had 3 'A' levels. One of the sample had been awarded the Diploma in Professional Nursing Studies and one sister held an OND in Business Studies. A summary of the educational qualifications is given in Table 2.

Sister A	:	1 'O' level	3 CSE (1)
Sister B	:	10 'O' levels	3 CSE (1)
Sister C	:	0 'O' levels	
Sister D	:	11 'O' levels	3 'A' levels
Sister E	:	6 'O' levels	
Sister F	:	6 'O' levels	
Sister G	:	5 'O' levels	
Sister H	:	6 'O' levels	3 'A' levels
Sister I	:	7 'O' levels	730 City & Guilds Teaching Certificate. Diploma in Professional Studies in Nursing.
Sister J	:	9 'O' levels	OND Business Studies.

Table 2. Educational qualifications of the sisters participating in the development scheme.

All but three of the sisters had more than one professional qualification. A summary of the professional qualifications and dates obtained is given in Table 3.

SISTER	A	B	C	D	E	F	G	H	I	J
Date qualified as RGN.	1974	1982	1979	1980	1969	1977	1968	1976	1976	1981
Other qualifications			EN	ONC	ONC		RM		RM	RM
E.N.B. Courses										930 & 100
Other Courses							CC		ID	

Table 3. Professional qualification obtained by scheme sisters.

RGN - Registered General Nurse. RM - Registered Midwife.
ID - Infectious Diseases Certificate. CC - Coronary Care.
ONC - Orthopaedic Nursing Certificate.
English National Board Course 930 : Care of the Dying Patient.
English National Board Course 100 : Intensive Care Nursing.

Only five out of the ten sisters had attended a basic management course and a list of those attending is given in Table 4. Of those who had not received management training, sister B had only been in post for 6 months whereas sisters D, H and I had been in post between one and two years and sister E for eight years, mostly on night duty. Six of the sisters were also on the panel of assessors, which entitled them to assess in the clinical situation practical skills of learner nurses, which is part of their formal assessment for the purposes of gaining registration or enrolment as nurses. Of the four sisters not recognised as assessors (Sisters B and D), two were awaiting confirmation of a place on the new English National Board Course 998, Teaching and Assessing, on completion of the development scheme. The two remaining sisters either did not have learners allocated to their area or those

allocated were not required to undertake an assessment during their period on the ward/department. A list of the sisters eligible to be assessors is also given in Table 4.

Only three of the sisters (E, F, and G) stated that they regularly read the more advanced nursing journals and two (B and H) said they read the Nursing Times. Two of the sisters (D and J) stated that they occasionally read articles relevant to their speciality.

The length of time spent working as a sister on commencement of the development scheme varied from six months to fourteen and a half years. A summary of length of time as a sister is given in Table 4.

Of the sisters attending the scheme two worked in paediatrics, two in medical specialities, three in wards specialising in caring for the elderly, one worked in the orthopaedic unit and two were from mixed specialities. (One ward was a high dependency medical and surgical ward, the other had a mixture of trauma, medical and surgical patients).

SISTER	A	B	C	D	E	F	G	H	I	J
LENGTH OF TIME AS A SISTER	6yrs 6mth		4yrs	1½yr	8yrs	5yrs	14½yr	2yrs	1yr	1½yrs
DATE OF ATTENDANCE AT MANAGEMENT COURSE.	1980	-	1982	-	-	1978	1971	-	-	1986
DATE OF ATTENDANCE AT ASSESSORS COURSE-	1980	-	1984	-	1980	1982	1973	1985	-	-

Table 4. Length of time as a sister, and dates of attendance at Management and Assessors Course.

The distance the sisters travelled to work, and their family commitments, varied quite considerably. Six of them lived between one and four miles from the hospital; two lived between five and nine miles and one lived over ten miles away. Only one sister considered travelling to work difficult, due to traffic problems, she lived between one and four miles from the hospital. Five of the sisters were married or co-habiting and had indicated their intention to stay for the forseeable future at the hospital. Of the five that were single, two stated they had family commitments; three sisters in the younger age category were uncertain as to whether or not they would leave the hospital within the next year, their reasons for comtemplating terminating their employment included wanting to travel, and boyfriend changing his job.

Sickness and absent rates recorded on the sisters between 1st November, 1984 until 31st October, 1986 for sisters attending the first scheme, and between 1st November, 1984 until 31st December, 1986 for sisters attending scheme two are given below.

SISTER:	A	B	C	D	E	F	G	H	I*	J
DAYS:	11	3	18	7	12	11	15	2	2	0

*Sister I was only appointed to the hospital on 1st July, 1985.

Table 5. Sickness and absence

All the periods longer than 3 days were certificated. When comparing sickness levels with the age of the respondent it may be seen that the sisters in the higher age bracket have longer spells of sickness than those who are younger. Such a suggestion, however, is purely speculative and no attempt has been made to examine sickness rates with age, propensity to leave, or perceived levels of role stress. The majority of recorded sickness occurred before the schemes commenced, only one sister appears to have had a day's illness during the scheme.

The mean number of days sick per sister per year, based on the above information, is 4.75 for Scheme one and 3.5 for Scheme two. The combined mean number of days sick per sister per year was 4.1. Some of the previous research into sickness and absence has been reported by Redfern (1981) and indicated that the frequency of absence spells for sisters was lower than for other grades of 'ward based' nurses, although the duration of spells were longer. Redfern also concluded from her study that there was evidence to suggest that for nurses who had reached the seniority of sister, their levels of absence and turnover are totally unrelated and whether they choose to stay or leave 'will depend on perceived opportunity for alternative employment and the attractiveness of those jobs relative to the ones held' (Redfern 1981).

In summary the exploratory work in the present study was concerned with developing a profile of the individuals on the pilot sister development scheme.

CHAPTER FIVE

RESEARCH FINDINGS

This chapter describes the main findings, from the evaluative study and is divided in two sections. The first is concerned with pre scheme findings, the second with scheme outcomes.

5. Section 1 Pre scheme findings

5.1 Observation

Findings from analysis of the pre scheme observations of sisters in their work situations (see Appendix 3a for summaries) indicated that the method of nursing used to provide patient care resembled at times a task or medically orientated approach as opposed to the reported use of the nursing process, which is based upon an individualised approach. On further investigation the sisters implied that a combination of high patient turnover and inadequate skill mix made it impractical to use an individualized patient care system for the majority of the time. These views were largely supported by the observers and scheme tutor, based on the patient dependency categories and, numbers and skill mix of staff on the wards when the observations were conducted. (see Appendix 3a). Furthermore, not all the sisters appeared aware of the care nurses had provided for the patients or the quality of the delivery.

Many of the nursing documents pertaining to care were found to lack the required basic information, and on some occasions when relevant documentation was available, it was not well used by nurses in the provision of their care or when reporting about the patients to other staff.

The atmosphere on most of the wards seemed happy and relaxed with the sister visibly supportive to staff and patients, with the exception of one ward where the sister appeared to be 'distanced' from the staff and providing little support. This person was also considered by the observers to be rather disorganised and there was a feeling of 'tension' on the ward between sister and the staff. Slight tension was also noted in the staff and sister on one other ward but was thought by the sister and observer to be a result of a prolonged period of low staffing and a rather unstable workforce. (The staff turnover was high due to use of agency and bank nurses and loss of permanent ward staff). The sister was, however, seen to be very supportive to the staff and patients.

A considerable number of complex and inter-related activities were reported to have been simultaneously occurring on most wards, but of which some sisters appeared to be unaware of and not 'in control'. Responsibilities were seen on many occasions to be delegated, with no attempt made to monitor or obtain feedback on the nursing actions.

Findings from the observations on the sisters were compared with the sister's self assessment profiles and the responses from the role opinion questionnaire; some discrepancies existing between perceived characteristics and performance and observed characteristics and performance. For example, Sister A, considered that she was always willing to talk to relatives and to try out new ideas, but was observed on more than one occasion to 'block' suggestions and not to utilise the available opportunities to talk to relatives. Sister I felt she was a good manager; organised, supportive of her staff and a good decisions maker, whereas the observer's findings indicated these were all areas in which sister performed rather badly. A summary of the findings from the role opinion questionnaire are given in Table 6. Individual profiles on each sister based upon their responses to the questionnaire and verbal confirmation are given as Appendix 3b.

	Always	Mostly	Sometimes	Rarely	Never	
I am:						
Organised	1	9	-	-	-	Disorganised
A Poor Communicator	-	-	8	1	1	A Good Communicator
Consistent	-	10	-	-	-	Inconsistent
Lacking knowledge of my speciality	-	1	4	5	1	Knowledgeable of their speciality.
Tolerant of others views	4	6	-	-	-	Intolerant of others views.
A Good Ward Manager	-	9	1	-	-	A Poor Ward Manager
Working with subordinates	2	2	6	-	-	Not working with subordinates.
Not supported by the manager	-	3	4	3	-	Well supported by the managaer
Approachable	7	3	-	-	-	Unapproachable
Respected by medical staff for my opinion	1	8	1	-	-	Rejected by medical staff for the opinions held.
Spending too much time doing paperwork	1	4	4	1	-	Not spending enough time doing paper-work.

Number in Sample - 10

Table 6. Summary of the findings from the role opinion questionnaire

5.2 Work problems

For the purpose of identification, a work problem in the present study was defined for the sisters as 'something which interferes or prevents you from doing what you would like to do'.

Findings from analysis of the work problem checklist are discussed under their category heading in the next section. Table 7 indicates the category and frequency of the items perceived as a problem by sisters.

C.	I.		F.
1	6	Interruptions from telephone	10
3	19	Not enough time to explain things to patients	8
2	22	Nurses going off sick	8
2	2	Insufficient trained nurses	7
1	4	Patients being admitted before their beds are ready	7
1	16	Number of intravenous injections to be given	7
3	18	Insufficient time to talk to relatives	7
3	8	Conflicting medical advice	6
1	17	Doing off duty rotas	6
4	23	Lack of support from senior colleagues	6
1	1	Rapid patient turnover	5
2	5	Insufficient clerical help	5
2	9	Inadequate equipment	5
2	10	Lack of linen	5
1	21	Getting regular maintenance done	5
1	7	Doctors rounds at inappropriate time	4
3	11	Badly written prescription sheets	4
2	12	Too many bank/agency nurses	4
1	13	Too many doctors' rounds	2
1	14	Early discharge of patients	2
1	20	Patients inappropriately sent to your ward	2
1	24	Preparing for doctors' rounds	2
2	3	Too many junior nurses	1

Number of sample - 10 F = frequency of yes response.

Table 7. Category and frequency of items perceived as a problem by sisters.

Cateogry 1. Problems that can affect ward organization

Of the eleven items in this category, sister C identified eight as interfering or preventing her from doing what she wanted to do, sister G identified seven and sisters A, E. H and I six items each. The number of items perceived as being a problem does not appear to be related to the age or length of experience as a sister. (See Table 8).

SISTER	A	B	C	D	E	F	G	H	I	J
Number of items	6	4	8	4	6	3	7	6	6	2
*Length of time as a Sister	6yrs	6mth	4yrs	1½yr	8yrs	5yrs	14½yr	2yrs	1yr	1½yrs

* on commencement of scheme.

Table 8. Number of items perceived as a problem and length of experience as a sister.

A list of the items that could affect ward organization and of the sisters who perceived them as a problem is given in Table 9.

Item		Scheme One Sisters				Scheme Two Sisters					
1	Interruptions from telephone.	A	B	C	D	E	F	G	H	I	J
4	Patients admitted before their beds are ready.	A	B	C		E		G	H	I	
16	Number of intravenous injections.	A		C		E	F	G		I	J
17	Doing off duty rotas.	A	B	C		E		G	H		
1	Rapid patient turnover.	A		C	D	E		G			
21	Getting regular maintenance done.	A			D		F	G	H		
7	Doctors rounds at inappropriate times.			C	D				H	I	
13	Too many doctor's rounds.			C						I	
14	Early discharge of patients.							G		I	
20	Patients inappropriately sent to your ward.		B	C							
24	Preparing for doctors' rounds.					E			H		

Table 9. Problems that can affect ward organization.

All ten sisters identified interruptions from the telephone as a problem. One sister, for example, was observed to have been interrupted no less than nine times whilst giving a ward report. However, this and other findings from analysis of the checklist cannot be generalised due to the small study sample, although, on searching the literature it was found that a study by Pembrey (1980) reported 86% of a sample of 50 sisters had identified interruptions by telephone as problematic. Other researchers, notably Davies (1972), Lelean (1973) and Runciman (1983), have all concluded that interruptions pose a considerable problem for sisters.

Despite the disruptive nature of the telephone interruptions, most of the sisters appreared to accept the situation as an inevitable part of the job;some actually saw it as a 'necessary evil' and the only means of ensuring control of information into and out of the ward. Runciman (1983) suggested that the interruption factor was related to a feeling of being 'in control'. A comment made by sister C supported this view in that she stated 'it is important to answer the telephone myself otherwise I might not know what is going on if I leave it to others'. There appeared to be a strong element of agreement amongst the sisters that interruptions usually required the sisters' involvement and were seldom unnecessary.

However, there is some evidence to suggest that the interruptive aspect of the sister role warrants further investigation, which was not within the scope of this research project to undertake.

Item 4, patients admitted before their beds were ready and item 16, the number of intravenous injections to be given, were perceived by seven out of ten sisters as a problem. During discussions with the sisters about work problems, it became apparent that these items and others that involved medical staff in rapid patient turnover, conflicting medical advice (item 3, category 1) were viewed by the sisters as beyond their control and had, therefore, to be 'put up with'. Some of the sisters also indicated their reluctance to

discuss these issues with senior medical staff (Consultant grade) for 'fear' of 'rocking the boat'. The relationship between medical and nursing staff was not examined in detail in the present study, but the 'existence of tension between medical and nursing staff' has been documented in the British Medical Journal (1981).

Six of the sisters indicated that doing off duty rotas was a problem. The reasons they gave included too many requests from nurses for special off duty, making it difficult to have a good balance of staff on duty; poor skill mix; insufficient staff. However, all but two of the sisters rejected the suggestion that the off duty could be done by other members or grades of staff or that people should be given 'set' off duties.

Category 2. Problems with resources

There were eight items in this second category, a list of which can be found in Table 10 together with the number of sisters who perceived them as a problem.

Item 22, 'nurses going off sick' was identified by eight out of ten sisters as causing most problems, and item 2, 'insufficient trained staff' was the next most frequently identified problem with seven sisters indicating this as a problem. Comments made by the observers during their clinical observations support the views of the sisters and examples are found in the qualitative data collected.

SISTERS WHO PERCEIVED ITEM AS A PROBLEM

Item		Scheme One Sisters				Scheme Two Sisters				
22	Nurses going off sick.	A	B		D	E	F	H	I	J
2	Insufficient trained staff.	A	B	C	D	E	F			J
5	Insufficient clerical help.					E	F	H	I	J
9	Inadequate equipment.	A	B		D			H		J
10	Lack of linen.	A	B		D	E	G			
12	Too many bank/agency nurses.		B		D		F			J
3	Too many junior nurses				D					

Table 10. Problems of resources

One item, not enough CSSD' meaning Central Supplies Sterilizing Department items, however, was not identified by any of the respondents as a problem, although it ranked quite high on the list of problems identified by sisters during the exploratory and testing stages of the research tools.

The two sisters who identified the most problems in category 1, sister C with eight problems and sister G with seven, had least problems in Category 2 (one each); for sister C it was 'Insufficient trained staff', a problem identified by all four of the sisters in scheme 1, whereas, for sister G, it was 'A lack of Linen'. Sister I also had less problems in this category. 'Insufficient clerical help' was identified by five other sisters on the second scheme, whereas none of the sisters on the first

scheme perceived this as a problem. However, one of the sisters on the first scheme did identify clerical help as a major problem, a view supported by the observations made during the pre, end and post scheme assessments. The problem related to an almost total lack of understanding by the clerical help of what she was supposed to do, and an inability to perform the basic activities of a ward clerk, despite a thorough explanation and demonstration by the sister and other members of the team.

The intensity of sister J's problems on discussion appeared to fluctuate according to how busy the clinical area was, whereas sister D's clinical situation did not fluctuate greatly, so the problems were more constant. Only sister D identified 'Too many junior nurses' as a problem, which she associated with the lack of trained staff to supervise and teach them. She also expressed concern about the disapproval from the School of Nursing that learners were not adequately supervised. Not all the sisters on the development scheme had learners allocated to their ward, (this was to enable learners to be concentrated on fewer wards so that peer group support was available); of those that did some had only senior student nurses allocated to them.

Problems of Communication

Of the four communication items, sisters B and D considered each one to be a problem (see Table 11). Sisters A, G. and J identified the same three items, Item 8 'Conflicting medical advice', Item 18

'Insufficient time to talk to relatives', Item 19 'Insufficient time to talk to patients', as problematic, whereas sisters C, H and I indicated two of the four to be problems. Item 19 was given by all three sisters. The second item for sisters H and I was 18, whereas for sister C it was indicated as 'Conflicting medical advice'. Sisters E and F only, identified one item, item 11, 'Badly written prescription sheets' as being a problem.

		Scheme One					Scheme Two				
Item		Sisters					Sisters				
19	Insufficient time to talk to patients.		B	C	D			G	H	I	J
18	Insufficient time to talk to relatives.	A	B		D			G	H	I	J
8	Conflicting medical advice.	A	B	C	D			G			J
11	Badly written prescription sheets.		B		D	E	F				

Table 11. Problems of communication

The feeling of eight of the sisters in the study that they had not enough time to explain things to patients has also been identified as a problem by sisters in Runciman's study. Although the sisters on the scheme saw their patients daily, they expressed concern about their ability to find time to talk and explain things in detail as they were being constantly interrupted. One sister was observed on two occasions to get halfway round the ward talking to the patients, then get called away and not complete this activity.

What, however, was not identified was whether sister commenced her round of patients at the same end of the ward on each occasion, which could possibly leave some patients without regular sister contact. One sister was observed not to utilize the time she had available to talk to the patients; although on questioning she did not perceive the time as available. Findings from the clinical observations suggests that some of the sisters have a workload and staffing level that allows little time to undertake this activity. Some sisters who did find time on occasions to talk to patients indicated that they felt guilty because they were thinking about other jobs they had to do whilst talking to the patients. They also expressed concern that the patient may be aware of their lack of time. The time required for a sister with a 30 bedded ward who spent merely three minutes with each patient would be one and a half hours, excluding walking time to the patients. Considering the average working day for a sister should be 7.5 hours, or 450 minutes, and that research has indicated that a sister could on average have 72 interruptions per day. A sister may find herself being interrupted on average once in every 6.25 minutes, or once every two patients. All the sisters attached great importance to this aspect of their role, yet considered that little could be done to improve the situation. Redfern (1979) suggest s that this type of activity is within the scope of the sister to control, but not without support and confidence to

reassess present priorities and existing work practices.

Personnel problems

The fourth category had only one item (Item 23) and related to lack of support from senior colleagues. Six out of the ten sisters (B, D, E, G, I. J.) considered this item a problem. Sisters B, E and I had the same service manager. This finding will be discussed later under the section on role stress. A summary of the work problems perceived by individual sisters can be found on pages 115 to 126.

5.3 Leadership

The leadership opinion questionnaire provided information on two dimensions of the sisters' leadership style, consideration and structure.

> Consideration 'reflects the extent to which an individual is likely to have job relationships with his subordinates characterised by mutual trust, respect for their ideas, consideration for their feelings and a certain warmth between himself and them'.
>
> Structure 'reflects the extent to which an individual is likely to define his own role and those of his subordinates towards goal attainment' (Fleishman 1960).
>
> 'A high score on the consideration dimension is indicative of a good rapport and two way communication, emphasized by a deeper concern for group members needs and includes such behaviour as allowing subordinates more participation in decision making. A low score indicates that the individual is likely to be more personal in his relations with group members'.
>
> 'A high score on the structure dimension is characterized by an individual who plays an active role in directing

> group activities through planning, communicating, information, scheduling, criticising, trying out new ideas, he defines the role he expects each member to assume, assigns tasks . . . ., and established ways for getting things done. This dimension, according to Fleishman and Harris appears to emphasise overt attempts to achieve organizational goals'.

These two dimensions are considered to be independent of each other, hence it is possible to score high on both dimensions, low on both, or high on one and low on the other.

In the present study sister H had the highest pre scheme score on the Consideration dimension (62), sister I had the lowest (44). On the Structure dimension sister H also had the highest score (54), sister J the lowest (33).

PRE SCHEME

	A	B	C	D	E	F	G	H	I	J
Consideration	58	56	54	55	49	58	58	62	44	54
Structure	48	45	35	47	42	47	46	54	45	33

Maximum Score : 80.

Table 12. Sisters' scores from leadership opinion questionnaire.

Data collected by observation of the sisters in their clinical environments to identify how they 'managed' their wards included information about the 'style' of leadership demonstrated. This enabled a comparison between the scores obtained from the LOQ and the data collected by observation to be compared.

As previously stated, the LOQ has a variety of uses in any organization. Its purpose in the present study was to provide insight to the sisters' own leadership attitudes.

The need to consider the style of leadership in the context in which it occurs has been highlighted by numerous researchers. Forehand and Gilmer (1964), Payne et al (1976), Kerr Schriescheim, Murphy and Stogdill (1974) all sought to highlight how the effectiveness of the leadership is contingent upon certain situational factors. For example, where a situation is perceived as ambiguous or stressful, the subordinates appear to tolerate a greater degree of 'structure' from their supervisors. Ogier (1982) concluded that not only do sisters have different leadership styles, the styles exhibited may according to the evidence be associated with the type of ward of which the sister is in charge. Her findings suggest that the medical wards allow for more internal ward planning by the sister and that less constraints are imposed upon the ward from without, so that the sister can exhibit a style of leadership that is more open to consideration of other's opinions and needs and a leadership style that is more 'consideration' based can be utilised. Whereas the work of the surgical ward was seen as controlled to a large extent by events outside the sister's control, such controlling events include operating theatre times and admission days. Where much of the care is provided by nurse learners it is thought that sisters exhibit a

more 'structured' approach.

The author of the present study had originally intended to also measure the learners' perception of the ward climate and to place sisters in order of perceived favourability. This, however, was not to be the case as most of the sisters nominated to attend the development scheme were not allocated learners or had insufficient number on their wards at any one period of time for the proposed LPWC measure to have been worthwhile.

The sample in the present study is made up of sisters working in paediatrics (2), orthopaedics (1), medicine (2), high dependency (1), short stay trauma and private patients (1), and care of the elderly (3), in comparison with sisters working in medical and surgical wards as in Ogier's study.

The range of scores for consideration in the present study, irrespective of speciality, was between 44 and 62, and from 33 to 54 for levels of structure. On comparison with the norms table for supervisory and head nurses (see Appendix 2f) was between low to very low at the bottom of the scale and the lower section the high scale.

An undesirable pattern emerged in the present study on two sisters (I and E) who scored low on both Consideration and Structure levels. Previous research has suggested that in some situations individuals with low scores on both dimensions, are more likely to

be bypassed by subordinates and may not even be seen as the functional manager (Fleishman, Harris, Burtt, 1955).

Sister E had a low score on both dimensions C49 and S42. She was, however, observed to be seen by the ward staff as 'being in charge' of the ward, even though sister was observed not to be present at 'handover' report times and lacked awareness of what care had been given.

Information obtained at the ward round and which was important for continuation of patient care was not passed on by sister to the staff on duty. The observer intervened later (and gave the information) when it became apparent that this information was required but was not forthcoming from sister. Learners on the ward were not well supervised but those spoken to said they enjoyed the ward and were not afraid to ask questions but 'felt they didn't always learn a lot'. Sister I, however, was not seen by the staff as the natural leader and the observers identified a number of problems associated with this situation. For example, the ward atmosphere appeared tense, and sister was seen and heard to make a rather 'offhand' remark to a nurse during a 'handover' report. She later stated to an observer that she had been waiting to 'put her (the nurse) in her place for a long time'. The staff appeared to bicker and showed little signs of support or rapport with the sister. The relationship between consultant and sister was not

good, and neither showed very much understanding for the other. previous research studies have also indicated that high structure and low considertion levels in a supervisor is likely to reflect a higher rate of staff turnover, grievance and stress amongst subordinates. Fleishman and Harris (1962) stated that there is also evidence to suggest that managers high in consideration can be higher in structure without adverse effects. However, no studies have yet found low consideration levels associated with good performance. Furthermore, low consideration scores are often indicative of an undesirable situation, whereas structure is more dependent upon the situation.

5.4 Role stress

(i) Role conflict scale

The total scores for role conflict pre scheme indicated that over half the sisters on the development scheme appeared to be experiencing a high level of role conflict. Nine of the sisters, for example, gave a score of 5-7 (high conflict) for 'I receive an assignment without the manpower to complete it'. A further four of the eight items on the role conflict scale were scored high (5-7) by six or more of the sisters. (The scale and summary of the findings are given in Table 13.

Two additional role conflict items were included in the study which asked sisters how much influence they had with co-workers (item 15) and higher management (Service Managers) (Item 16).

The sisters considered they were very influential with their co-workers. Nine rated their influence as very high, the remaining one considered she had moderate influence.

The sisters' perceived level of influence with higher management was quite diverse. Five thought they were influential, 5 considered they had little say or influence.

		Number of sisters who responded to:		
		OF	MY	JOB
		Definitely Not True	Uncertain	Extremely True
4	I receive an assignment without the manpower to complete it.	1		9
6	I have to bend a rule or policy in order to carry out an assignment.	2		8
12	I receive an assignment without adequate resources and materials to execute it.	3		7
14	I work on unnecessary things.	1	3	6
2	I have to do things that should be done differently.	2	3	6
11	I do things that are apt to be accepted by one person and not by others.	3	2	5
7	I work with two or more groups who operate quite differently.	5	1	4
9	I receive incompatible requests from two or more people.	4	2	4

Number of respondents - 10.

Table 13. Role conflict scale and summary of findings pre scheme.

(ii) Role ambiguity scale

The sisters total pre scheme scale scores for role ambiguity indicated that the majority experienced low ambiguity (high clarity). The scale and a summary of the findings can be found in Table 14.

The role ambiguity scale scores were reversed, thus a high score indicated a low level of role clarity. Four of the six items on the ambiguity scale were given low scores (1-3) by the majority of sisters (see Table 17). Two items which produced moderate ambiguity in four of the sisters were 'clear planned goals and objectives for the job' and 'properly dividing time'.

		Number of sisters who responded to:		
		OF	MY	JOB
		Definitely Not True	Uncertain	Extremely True
5	I know what my responsibilities are.	2	1	7
8	I know exactly what is expected of me.	3	-	7
10	I feel certain about how much authority I have.	3	1	6
13	Explanation is clear of what has to be done.	2	2	6
3	I know that I have divided my time properly.	2	4	4
1	Clear, planned goals and objectives for my job.	3	4	3

Number of respondents - 10.

Table 14. Role ambiguity scale and summary of findings pre scheme.

(iii) Job related tension index

The findings from analysis of the job related tension index indicated that all the sisters attending the development scheme were bothered to some extent by aspects of their role and most experienced moderate to high levels of tension in their job.

Two items which apparently gave the greatest concern to the sisters from the job related tension index relate to workload. 'Too heavy workload . . . can't possibly finish'. Seven sisters were bothered rather often or all the time by this and two sometimes bothered. 'The amount of work you have to do may interfere with how well it gets done' concerned six of the sisters rather often or all the time, and three sometimes. Seven of the ten sisters indicated that they experienced moderate conflict of Item 8, 'feeling they had to do things on the job against their better judgement'. Six of the sisters were bothered rather often and two sometimes, at not knowing what their 'Service Manager' thought of them or how he evaluated their performance. The same number (six) were also bothered by 'not knowing what the people they worked with expect'. One sister indicated she was bothered rather more often. Five felt unclear at times about the scope and responsibility of their job and three were more often concerned. The fact of being unable to 'get information needed to carry out the job' provoked tension rather often in two of the sisters and at times in six of the sisters.

Eight of the sisters experienced tension 'thinking they would not be able to satisfy the conflicting demands of people'. Four indicated that this situation arose sometimes, the remaining four suggested it was rather more often (two) or nearly all the time (two).

(iv) Role clarity

The four items that made up the role clarity scale, relate to how clear the sisters were about the limits of their authority, what they were supposed to do and how to do it, and how clearly defined the hospital rules and policies were. The scores for each of these items tended to be skewed towards the clear end of the response scale. Six of the respondents felt fairly clear about what to do in their job; only one respondent was unclear on the hospital policies and limits of authority.

The findings from the clarity index suggests that over half the sisters were very clear on these aspects of their job.

The summary of the role stress scale scores is found in Table 15, and indicates the proportion of low, medium and high scores for each of the four scales used in the present study.

Role Stress Scales	Role Stress Scores %		
	Low	Medium	High*
Role Conflict	26	14	60
Role Ambiguity	55	20	25
Job-related Tension	24	36	40
Role Clarity	7.5	37.5	55

* A high score represents high values of the variable and vice-versa.

Total sample number - 10.

Table 15. Proportion of low, medium and high scores on the role stress scales.

The scores for over half the sisters indicate that they experienced a high level of role conflict. Although the low ambiguity and high clarity scores, suggests that the sisters consider their roles to be fairly clear and unambiguous. However, some of the ambiguity items on the job related tension index did as previously stated, bother the sisters to some extent:

- not know what the service manager thinks of their performance, or how he evaluates it.
- unclear of others' expectations.
- unavailability of information to do the job.
- uncertain of scope and responsibilities of the job.

At present very little data is available on British nurses to enable comparisons to be made. One previous British study (Redfern 1979) has used role conflict and ambiguity

scales, although a number of studies in America have used a variety of role stress scales on various occupational groups.

The author used the scales and scores as a means of providing background data on the sisters attending the development scheme. Thus comparison of findings with other studies were limited to one British (Redfern 1980) and one American (Arndt and Laegar 1970) study. Table 16 gives a summary of the job related tension items and index scores for the present and previous research.

		PRESENT STUDY	BRITISH HOSPITALS			AMERICAN HOSPITALS	
	JOB-RELATED TENSION ITEM		A	B	A+B	Arndt and Laeger	
			Redfern				
1.	Unclear about scope and responsibilities	3.2	2.5	2.3	2.4	1.9	2.0
2.	Not knowing advancement opportunities.	2.8	1.9	2.0	1.9	1.4	1.5
3.	Unclear how superior evaluates performance.	3.4	2.5	2.2	2.3	1.9	2.1
4.	Unable to get information for job.	3.0	2.9	2.3	2.5	2.3	2.6
5.	Uncertain of colleagues' expectations.	2.8	2.5	2.3	2.4	2.1	2.4
6.	Too heavy a workload	3.9	2.6	2.3	2.4	3.2	3.2
7.	Workload interferes with quality of work.	3.8	3.0	2.7	2.8	3.1	3.3
8.	Have to do things against better jedgement.	2.7	2.4	2.4	2.4	2.0	2.1
9.	Unable to satisfy others' conflicting demands.	3.4	2.5	2.2	2.3	2.6	2.6
	Job-related Tension Index (mean)	3.2	2.5	2.3	2.4	2.3	2.4

Note: Possible score range = 1 to 5

Table 16. Items and index scores from present and two previous studies

Six of the sisters on both the JRT and Rizzo Ambiguity scales indicated they felt clear about how much authority they had, yet eight admitted to being bothered sometimes, or more often, by being unclear of the scope and responsibilities of their job. Redfern (1979) and Miles and Petty (1975) also found a variance between these items. It may appear initially that these responses are contradictory but this, however, may not be so to the sisters. Discussion with the sisters and data from previous studies suggest that it is possible for the sisters to feel clear about the limits of their responsibilities in general, but be bothered sometimes, or more frequently by uncertainty on 'specific responsibilities'.

Role Ambiguity Index (Mean)	Role Conflict Index (Mean)	
3.5	4.5	Present Study - Sisters
1.5	3.7	Redfern, S.J. (1979) Sisters, Combined Hospitals.
3.0	3.7	Szilagyi, et al (1976) American Study. 'Professionals'.
2.9	3.7	Technicians including Licensed Practical Nurses.
3.5	3.9	Administrators (non nurses).

High scores indicate high conflict and ambiguity (ambiguity score reversed).

Possible range of score 1 - 7.

Table 17. Role conflict and ambiguity scores from present and previous studies.

Nine of the sisters felt they received assignments without adequate resources and materials to complete it, and eight indicated on the JRT index that they were bothered sometimes or rather more often when unable to get information needed to carry out their jobs. The scores on both these items are higher than those reported by Redfern which were 40% and 46% respectively.

Several items on both the JRT index and Role Conflict and Ambiguity produced a high score value. Nine of the sisters indicated they received an assignment without the manpower to complete it, and were bothered by feeling the workload was too heavy; the amount of work to be done could interfere with how well it gets done. In comparison, Redfern's study which indicated scores of 47% and 64%.

Seven of the sisters were bothered that they sometimes had to do things against their better judgement. To the item of the Role Conflict and Ambiguity Scale 'I have to do things that should be done differently', 5 said this was extremely true of their job, 3 of the respondents placed themselves midway on the 1 - 7 scale. Eight of the sisters scored high on Item 6 on the conflict scale 'having to bend a policy or rule in order to carry out an assignment'.

A summary of the comparison between the proportion of low, medium and high scorers of the present study and that conducted by Redfern (1979) are contained in Table 18.

ROLE STRESS SCALE	ROLE STRESS SCORES %					
	LOW		MEDIUM		HIGH*	
	Present	Redfern's	Present	Redfern's	Present	Redfern's
Role Conflict	26	27	14	58	60	15
Role Ambiguity	55	68	20	29	25	3
Job-related tension	24	28	36	67	40	5
Role Clarity	7.5	6	37.5	48	55	46

* A high score represents high values of the variable and vice-versa.

Table 18. Comparison of proportion of low, medium and high scores for role stress scales between present study and that conducted by Redfern.

The low stress score between the studies are similar for role conflict, job tension and role clarity. The most noticeable differences are to be found between the medium and high role conflict scores, where the two scores are almost reversed and high role ambiguity scores. The variance between the medium and high job related tension index is also quite considerable, the present study indicated higher levels of stress amongst the sisters.

SECTION 2

5.5 INTRODUCTION

This section will consider the identifiable effects of the scheme on the sisters who participated.

Despite the difficulties encountered in assessing and measuring change, there is evidence to indicate that all the participants have enhanced their role performance in significant key areas. During the post scheme evaluation phase (week 43-46) the participants were asked to state how the scheme had helped them. The responses were in two broad categories; the first related to help with the clinical aspects of their role, the second to their personal and professional development. The most frequent responses in relation to clinical practice were:

- a clearer understanding of the nursing process philosophy,
- clarification of areas of management,
- the opportunity to critically examine ward practices,
- support to implement change, and ideas to overcome work problems.

The most commonly expressed feelings in relation to personal and professional development were:

- increased confidence,
- greater insight of own performance,
- clear understanding of others expectation

Information from other sources, most notably, the end and post scheme observations, anecdotal evidence from sister s and their managers, ad hoc ward visits and discussions, attainment of learning contract objectives and post scheme interview supported the perception of the sisters of changes in their behaviour.

5.6 Work Problems

The post scheme findings indicated that the number of sisters who had perceived an item to be a problem on commencement of the scheme had slightly reduced, or was considered by them to be a less frequent problem in many cases. Where there had been management intervention to improve staffing levels or skill mix, the sisters stated they felt this enabled them to concentrate on other aspects of their role and made cover for the ward easier to achieve. Nurses going off sick had also ceased to be a problem for three of the previous eight sisters. The sisters and facilitators felt that certain items, such as interruption by the telephone, number of intravenous injections to be given, would require discussion and negotiation with other disciplines if they were to be resolved, as well as possible changes to the pattern of the sister's work, which at the present moment was not practicable. Details of individual sister's work problems are given later in this section. The sisters attributed the improved skill mix and staff number to attendance on the scheme, and the support provided by the scheme teachers in reaffirming the effects of inadequate staff numbers and skill mix.

5.7 Scores for consideration and structure

The purpose of using the Fleishman Opinion Questionnaire was to provide sisters with an objective score on these two dimensions of leadership, consideration and structure and compare them with observed findings.

As previously stated (page 95) the need to consider the sister's style of leadership in the context in which it occurs is of paramount importance. The post scheme scores had a variance of between minus 4 to plus 5 on the consideration dimension and minus 12 to plus 11 on the structure dimension (see Tables 19 and 20).

Sister	A	B	C	D	E	F	G	H	I	J
Pre Scheme	58	56	54	55	49	58	58	62	44	54
Post Scheme	55	52	59	56	45	57	55	59	48	57
Variance	-3	-4	+5	+1	-4	-1	-3	-3	+4	+3

Maximum Score - 80.

Table 19. Leadership opinion questionnaire : consideration scores

Sister	A	B	C	D	E	F	G	H	I	J
Pre Scheme	48	45	35	47	42	47	46	54	45	33
Post Scheme	45	52	46	51	41	48	50	42	44	38
Variance	-3	+7	+11	+4	-1	-1	+4	-12	-1	+5

Maximum Score - 80.

Table 20. Leadership opinion questionnaire : structure scores.

Both the post scheme scores and findings from the clinical observations indicated that the sisters in the present study continued to exhibit different leadership styles. These findings concur with those of Ogier (1982) and may according to the evidence be associated with the type of ward the sister is in charge. Hence changes in an individual score is unlikely unless the situation changes, or an individual deliberately undertakes to alter their style of leadership. The purpose of providing the sisters with objective feedback of their observed clinical performance and the scores following completion of the Fleishman Leadership Opinion Questionnaire was to enable them to reflect on the appropriateness and effectiveness of their leadership style, and to consider what, if any, changes were required.

Sister C had the largest increase in scores on both dimensions. Her consideration score had increased by 5 (to 59) and her structure by 11 (to 46). Observation and interview indicated that in the clinical situation sister now involved other members of staff on doctors' rounds, and was more active in directing activities in the ward and on trying out new ideas to improve aspects of patient and ward management.

Sister H's score had decreased on both dimensions. Her consideration score was now 59 (-3) and her structure score 42 (-12). Observation and interview suggested that sister was beginning to assign more responsibility to her staff, and feeling

more confident in her role. The nature of the ward permits a degree of internal planning which reduces the need for a highly structured approach, but requires the sister to delegate certain responsibilities. Sister H, is continuing to work on this aspect of her role under the supervision of her facilitator.

The scores for sisters E and I (both of whom work in the same specialist field) indicated that both still had low scores on the consideration dimension, (45 for sister E and 48 for sister I). Sister E's level of 'morale' which she stated was low at times, and her perceived level of role stress may have been a contributory factor. Sister I's slight increase in score was reflected by her observed behaviour which showed her to be more supportive and considerate to her staff. Both sisters also had a low level of structure, and was reflected by their difficulty to plan, assign and achieve tasks and the like. The persistence of this undesirable pattern in the study necessitated the involvement of the nurse manager and is discussed in more detail in Chapter 6.

Sister B had a slightly lower post scheme score of 52 as opposed to 56, but her structure score had increased by 7 to 52, which was reflected in her improved ability to structure her own and the work of others and to effectively communicate with her staff, peers and colleagues from other disciplines.

5.8 Role Stress

The interval between the pre and post scheme administration of the Role Stress measures was forty-six weeks. The findings indicate a reduction in the high level of perceived role conflict and tension. A table showing the proportion of pre and post scheme low, medium and high stress scores is given below:

	Role Stress Scores %					
	Low		Medium		High*	
Role Stress Scale	Pre	Post	Pre	Post	Pre	Post
Job-related Tension	24	41	36	31	40	28
Role Clarity	7.5	12.5	37.5	22.5	55	65
Role Conflict	26	40	14	21.25	60	38.75
Role Ambiguity	55	65	20	18	25	17

*High score represents high values of the variable and vice-versa.

Table 21. Comparison of proportion of low, medium and high stress scores.

Despite the increase in low scores on the job-related tension and role conflict index, the high scores on both indexes remains greater than that found in other studies, Redfern (1980) and suggested that some sisters are still bothered by aspects of their role and feel a high level of conflict. The items which appeared to still be causing conflict and tension for some sisters were mostly related to:

- heavy workload and its affect on quality of care;
- having to do things against their better judgement;
- the inability to satisfy conflicting demands.

However, the post scheme scores for the majority of sisters (B, D, E, F, G and I) were lower for item 12; J 'received an assignment without adequate resources and materials to execute it'. Sister I's score on the role conflict scale showed a lower score on seven of the eight items; sister E lower on 6 items; sister H lower on 5 items; sisters B, D and G lower on 4 items; sister C lower on 3 items; sister A lower on 2 items and sisters F and J lower on 1 item. Sister C had a higher score on 5 items; Sisters A, B and G had a higher score on 4 items; Sisters D, E and I had higher scores on one item each, the remaining items for the sisters were unchanged.

The scores on the Role Ambiguity Scale showed an increase on some items by a few of the sisters. Item 1, 'clear planned goals and objectives for my job' had a higher post scheme score for sisters B, D and G; sister A had a higher score on Item 8. 'I know exactly what is expected of me' was perceived by sisters A, B and E as more ambiguous; sister G's score also remained high. Item 10, 'I feel certain about how much authority I have' had a higher score for Sisters B, G and J; sisters B and G also gave a higher score for Item 13, 'explanation is clear on what is to be done'. Sister A had a higher score on Item 3, 'I know I divide my time properly'.

Discussion with the sisters individually, and in small groups suggested that the increased role ambiguity experienced by some sisters was from their use of self evaluation and personal

reflection of issues not previously considered. Sister B still felt unclear about the limits of her authority. This may be due to the fact that she had only been in post for six months on commencement of the scheme and had spent that time trying to emulate the previous sister's practices and had thus not really addressed issues which relate to role clarity until attending the scheme. Sister D indicated that she was less clear about what she was supposed to do in her job (Item 11); this she concluded was due to the fact that 'up until coming on the scheme she hadn't really thought a lot about what she was supposed to do, probably because nobody told her so she just did what she thought was right. As nobody told her otherwise, (until she came on the course), she just got on and did her job or the job as she saw it. Sister C stated that 'there had been a lot of talk from various senior people that our role would change, but no one actually said how or why. When the 'boss' spoke to us, she didn't really tell us what we should be doing'.

5.9 Individual sisters

Sister A was thought to have made least progress during the scheme, partly because she was disadvantaged through staff sickness, the late replacement of leavers and fluctuating work patterns. This required her contract work dates to be renegotiated and extended. However, she had made considerable progress towards implementing a more individualized system of patient care, and improving the standard of record keeping. Sister was perceived by the observers as being less authoritarian with her staff and beginning to involve

them in patient care decisions. A review of sister's perceived work problems indicated a status quo with the exception of two items that were improving. Sister is seeking to obtain a place on a specialist course, not run within the host authority, to update her clinical knowledge.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
1	Rapid patient turnover.	No change
4	Patients admitted before their beds are prepared (occasionally).	Improving
6	Interruptions from telephone.	No change
16	Number of intravenous injections required to be given (occasionally).	No change
17	Doing off duty.	No change
21	Getting regular maintenance done.	No change
Resources		
2	Insufficient trained nurses.	Improving
22	Nurse going off sick (occasionally).	No change
9	Inadequate equipment.	No change
10	Lack of linen (occasionally).	No change
Communication		
8	Conflicting medical advice.	Occasionally
18	Insufficient time to talk to relatives.	No change
19	Not enough time to explain things to patients.	No change

Sister B had only been in post six months when she came on the scheme. She appeared, in her clinical environment and in discussions with her peers, to be very quiet, apprehensive, lacking in confidence and assertiveness. She was observed to gradually become more confident and assertive which was reflected in her performance on the scheme and in her clinical area. Sister had also experienced severe staffing problems during the scheme, and this had delayed the implementation of new ideas.

The post scheme evaluation and subsequent informal discussion indicated that sister's morale had been quite low at times and she stated that initially she felt 'demoralised' and 'disorientated', having only been in post a few months and just finding her feet when 'everything was turned upside down around her ears'. Despite this, she showed signs of improvement in all key areas of her role; patients, ward and personnel management, teaching and in the use of research related findings in the provision of care. Sister has since attended a course to update her specialist knowledge and has indicated a reduction in the number of perceived work problems. Five items were no longer a problem, and four only occasionally a problem. She has been nominated to attend the English National Board 'Teaching and Assessing in Clinical Practice' (ENB 998) Course.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
4	Patients being admitted before their beds are prepared (occasionally).	Not a problem.
20	Patient inappropriately sent to the ward.	Occasionally
6	Interruptions from telephone.	No change
17	Doing off duty.	No change
Resources		
2	Insufficient trained nurses.	Not a problem
12	Too many bank/agency nurses.	Not a problem
22	Nurses going off sick.	Not a problem
9	Inadequate equipment.	Not a problem
10	Lack of linen.	Occasionally.
Communication		
8	Conflicting medical advice.	Not a problem
11	Badly written prescription sheets.	No change
18	Insufficient time to talk to relatives.	Occasionally.
19	Not enough time to explain things to patients.	Occasionally.
Personnel		
23	Lack of support from senior colleagues.	No change.

Sister C was initially very anxious about participating in the scheme but found it a very rewarding experience.

The end and post scheme findings demonstrated that sister had replaced her 'laissez-faire' style of leadership with a democratic approach and reflected her increased leadership structure score. She was also considered to be less medically orientated than on previous occasions. The method of patient care was still task orientated at times, but this was considered to be due to poor skill mix. The 'work book' previously in use was no longer evident, and sister confirmed it had been 'done away with', although she and some of her staff said they 'missed it'. A review of sister's perceived work problems indicated a status quo.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
1	Rapid patient turnover.	No change.
4	Patients being admitted before their beds are prepared.	No change.
7	Doctors' rounds at inappropriate times (occasionally).	No change.
20	Patients inappropriately sent to the ward.	No change.
16	Number of intravenous injections to be given (occasionally).	No change.
17	Doing off duty.	No change.
6	Interruptions from telephone.	No change.
13	Too many doctors' rounds.	No change.
Resources		
2	Insufficient trained staff.	No change.
Communication		
8	Conflicting medical advice (occasionally)	Improving.
19	No enough time to explain things to patient.	No change.

Sister D was keen to participate in the development scheme and was felt to have gained considerably from attending. The post scheme findings indicated that sister planned and co-ordinated her own work and that of others far more effectively than was previously recorded. Her level of interaction with learners had improved, and a planned teaching programme and mentor scheme was operational. Sister had also developed her assertiveness skills and was thought no longer to be overshadowed by members of her team. There was a slight increase in her structure score from 47 to 51. Sister scored lower on four role stress items on which she previously scored high.

It was felt that sister could have achieved more had her staffing levels been better. However, seven of the fourteen items she perceived as a problem on commencement of the scheme were resolved or no longer considered a problem.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
1	Rapid patient turnover (sometimes).	No change
7	Doctor's rounds at inappropriate times.	Not a problem
21	Getting regular maintenance done.	Not a problem
6	Interruptions from telephone.	No change
Resources		
2	Insufficient trained nurses	Not a problem
3	Too many junior learner nurses (sometimes).	Not a problem
12	Too many bank/agency nurses (sometimes).	Not a problem
22	Nurses going off sick.	No change
9	Inadequate equipment.	No change
10	Lack of linen.	No change
Communication		
8	Conflicting medical advice (sometimes).	No change
11	Badly written prescription sheets.	No change
18	Insufficient time to talk to relatives.	Not a problem
19	Not enough time to explain things to patients.	Not a problem

Sister E was already an experienced sister, but her recent change of speciality made her an appropriate, although initially reluctant, candidate to attend the scheme. Sister's lack of specialist knowledge made her feel initially vulnerable and she relied heavily on the ward staff to the extent they were not always as well supervised as the situation required. Sister had improved the morale of the ward and appeared to have a good relationship with her staff. A post scheme review of the work problem check list indicated sister now perceived herself as 'having less problems'. A summary of her pre and post scheme problems are given below.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
1	Rapid patient turnover.	No change
4	Patients being admitted before their beds are prepared.	Not a problem
16	Number of intravenous injections required to be given (only sister eligible at present to do them).	Improving
17	Doing off duty.	Not a problem
24	Preparing for doctors' rounds.	Not a problem
6	Interruptions from telephone.	No change
Resources		
2	Insufficient trained nurses.	Improving
22	Nurses going off sick.	Not a problem
5	Insufficient clerical help.	No change
10	Lack of linen.	Improving
Communication		
11	Badly written prescription sheets.	Occasionally
Personnel		
23	Lack of support from senior colleagues.	New Manager in post.

Helping sister to identify areas for development, also initially undermined her confidence. However, post scheme findings indicated that sister was becoming more decisive and assertive in her actions She felt her confidence had been restored and, in fact, enhanced. Some improvement was evident in record keeping, reporting systems and level and quality of supervision.

However, sister's leadership scores for levels of consideration and structure remained low. Since completing the post scheme interview sister has been given additional support and has attended a specialist course to update her clinical knowledge. She has also been allocated a place on the English National Board (ENB 998) Teaching and Assessing in Clinical Practice Course in 1988.

Sister F was very positive about the development scheme and used the scheme to try out and implement new ideas, which were primarily related to evolving a format for a realistic plan of care. She benefited from the observations and group discussions which she felt gave her more confidence to try out new ideas. Her perceived work problems and leadership scores post scheme remained similar to pre scheme scores.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
6	Interruptions from telephone.	No change
16	Number of intravenous injections to be given.	No change
21	Getting regular maintenance done.	No change
Resources		
2	Insufficient trained nurses (at times).	No change
12	Too many bank/agency nurses (at times).	No change
22	Nurses going off sick (not frequent).	Occasionally
5	Insufficient clerical help.	No change
Communication		
11	Badly written prescription sheets.	No change

Sister G was an experienced sister and, initially, felt the scheme would be of little value to her. However, the post scheme findings indicated that sister was more willing and able to be self-critical and to receive constructive criticism from others. She also had a greater insight into herself and how she was perceived by others. Her dislike of the 'nursing process' and the unnecessary' paperwork she felt it generated reflected her lack of commitment to developing this approach evident by findings from the clinical observations. This situation had shown little signs of improvement during the scheme.

At the post scheme interview, sister acknowledged that she needed to have a greater commitment towards improving the present state of patient documentation and agreed that progress would be reviewed by the on site Clinical Nurse (Training) at a later date. Review of sister's perceived work problems post scheme showed a reduction in number.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
1	Rapid patient turnover.	No change
4	Patients being admitted before their beds are prepared.	Occasionally
14	Early discharge of patients (sometimes).	No change
16	Number of intravenous injections to be given.	No change
17	Doing off duty.	Not a problem
21	Getting regular maintenance done.	Occasionally
6	Interruptions from telephone.	No change
Resources		
10	Lack of Linen.	Not a problem
Communication		
8	Conflicting medical advice.	Not a problem
18	Insufficient time to talk to relatives.	No change
19	Not enough time to explain things to patients.	No change
Personnel		
23	Lack of support from senior colleagues.	Not a problem

Sister H's confidence was felt to have been enhanced by her attendance on the scheme, and she appeared to her service manager and to the scheme facilitators and tutor to be more positive towards meeting the demands of her role. Following observation and interview she was thought to require further support to continue to develop delegation skills. Sister agreed that delegation was difficult for her to do, believing it quicker to do it herself. Her attitude was fostered, to some extent, by the presence of a ward clerk who required constant supervision and instruction, even with repetitive tasks. However, changes in sister's structure score from 54 to 42 (-12) combined with observation and interview, indicated a positive improvement in other aspects of her management role. A summary of sister's perceived work problems showed a reduced number.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
4	Patients admitted before their beds are prepared.	Occasionally
7	Doctor's rounds at inappropriate times.	Not a problem
17	Doing off duty.	Not a problem
21	Getting regular maintenance done.	Not a problem
6	Interruptions from telephone.	No change
Resources		
22	Nurses going off sick (occasionally).	No change
5	Insufficient clerical help.	No change
9	Inadequate equipment.	No change
Communication		
18	Insufficient time to talk to relatives.	Occasionally
19	Not enough time to explain things to patient.	Occasionally
Personnel		
23	Lack of support from senior colleagues.	Mainly over short notice sickness

Sister I's observed post scheme role performance indicated she had changed significantly over the duration of the scheme. She was better organised and had less difficulty in deciding priorities. There was a greater involvement of staff in decision making, and sister was seen to be more supportive and caring in attitude towards the staff. The ward atmosphere was more relaxed and the facilitator expressed the view that 'a team spirit' was beginning to emerge. Improvement was also noted in ward communication, most notably the system of reporting on patients. The number of items identified as a problem pre scheme by the sister was also reduced.

Sister's confidence and insight into her role had increased during the post scheme period and she has become more assertive, being clearly seen by the ward staff as the leader. She scored lower on seven of the eight role conflict scale items.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
4	Patients admitted before their beds are prepared.	No change
14	Early discharge of patients.	Not a problem
7	Doctor's rounds at inappropriate times.	No change
16	Number of intravenous injections to be given.	No change
6	Interruptions from telephone.	Not a problem
13	Too many doctors' rounds.	No change
Resources		
22	Nurses going off sick.	Not a problem
5	Insufficient clerical help	Not a problem
Communication		
18	Insufficient time to talk to relatives.	Not a problem
19	Not enough time to explain things to patient.	Not a problem
Personnel		
23	Lack of support from senior colleagues.	New manager in post

Sister J The type of environment sister worked in enabled her to use a limited range of management skills, which she did very effectively. The scheme provided sister with the opportunity to gain a greater insight into the range and complexity of management skills used in other clinical areas. She used the scheme to reflect on her existing levels of knowledge and expertise and the potential to develop these to a higher level. Sister was one of the several working within the same specialist area, hence she shared the management and other component parts of the sister's role with colleagues. The nature of sister's work did not lend itself to a high degree of structure, hence sister's low scores on the Leadership Opinion Questionnaire of 38 for structure, is a reflection of her work situation.

A review of sister's perceived work problems indicated a small reduction in number. Sister was uncertain as to her future in nursing, and resigned immediately after the post scheme interview to go on an adventure holiday round the world with her friend. She considered the opportunity "too good to miss". Sister resumed her nursing career at the hospital after an absence of one year.

Pre Scheme	Perceived work problems	Post Scheme
Organization		
6	Interruptions from telephone.	No change
16	Number of intravenous injections to be given.	Not a problem
Resources		
2	Insufficient trained nurses.	No change
12	Too many bank/agency nurses.	Not a problem
22	Nurses going off sick.	No change
5	Insufficient clerical help.	No change
9	Inadequate equipment.	No change
Communication		
8	Conflicting medical advice.	No change
18	Insufficient time to talk to relatives.	Occasionally
19	Not enough time to explain things to patients.	Not a problem
Personnel		
23	Lack of support from senior colleagues.	No change

CHAPTER SIX

CONCLUSIONS AND IMPLICATIONS

6.0 INTRODUCTION

The main aim of the study was to identify and measure changes in the behaviour of sisters or potential sisters as a result of undertaking a sister development scheme

Emphasis has, therefore, been on the:

> gathering of information to assess the effectiveness of the scheme in achieving its aims.

An action research approach combined with elements of formative and illuminative evaluation was used and enabled investigation of the issues as they emerged.

6.1 Main Issues

A number of important issues have emerged from the study, some of which have already been highlighted. This section provides a summary of the main issues and their implications for future sister development schemes.

6.2 The Role of Management

The importance of the organizational context of an innovation and the role played by management have been highlighted by several writers, for example Lathlean and Farnish (1984) and Davies (1972).

The planning and implementation of the development scheme took place during a period of major change in the management structure of the hospital and National Health Service in general and, whilst the planning team were informed that the termination of Nursing Officer posts and the subsequent appointment of 'Service' managers would affect the role of the sister, they were not, however, told how the sister's role was to change. The sister's own perception of her role under the 'Griffiths' Structure was vague and varied considerably. The current job description for the sisters reflected a previous management structure and did not help clarify this situation.

The introduction of service managers resulted in an unclear relationship between the managers (most of whom were previous nurse managers) and the sisters within their units. The sisters attending the scheme indicated that they felt considerable additional responsibilities had been given to them (covering unit absence of service manager, obtaining bank staff) without adequate consultation or support.

The involvement of managers in planning, implementing and supporting the scheme was very limited, partially due to changes in the management structure. The manager selected to join the planning team had, in fact, changed roles under the new management structure to become Senior Nurse (Training) and as such had no management function and did not attend managers' meetings. The newly appointed service managers did, however,

ensure the release of the sisters to attend the scheme but most did not appear according to comments made by the sisters and facilitators, to offer any other form of support. However, several sisters stated that they did not bother to ask their managers for help as they felt the manager was not in a position to help them with issues relating to clinical management or their development.

Despite the initial lack of clarity and increased ambiguity between managers and sisters as to perceived roles, responsibilities, channels of communication and professional accountability, many of the sisters, on completion of the scheme, expressed greater clarity and less ambiguity on most of these issues.

6.3 Status of the Scheme

Another important issue identified early in the implementation of the scheme was its status within the host hospital, and the attitudes of staff towards the scheme. Initially, the information staff received about the scheme varied considerably. The sisters were formally told of the proposed development scheme at a routine sisters' meeting. The Head of Nursing explained the purpose of the scheme as a means of offering a comprehensive programme for the professional development of sisters. In addition, informal discussions took place between staff and members of the planning team, in particular, the on site Senior

Nurse, Training and scheme facilitators. Those nominated to attend the scheme were seen by the Senior Nurse, Training.

However, some staff remained sceptical of the value of such a scheme to the development of sisters. This was particularly noticeable by comments from some medical staff and sisters, in areas where the relationship between sister and consultant were well established or the sister quite experienced. A few of the sisters were given a copy of the scheme proposals by their service manager but without the opportunity to discuss the document. It became apparent from the commments that certain sisters felt they were being sent by their managers because they were doing a 'poor job' and much work was required by the scheme tutor and colleagues to present a positive perspective of the scheme.

Eight of the ten sisters at the end of the scheme indicated on the questionnaire that they would have preferred more information before commencing.

The provision of resources to meet the needs of patients is the responsibility of the managers and it became necessary at times during the scheme to inform the managers and Head of Nursing of findings from the research when there was evidence to suggest that inadequate resources, in particular, skill mix and staffing levels, were felt to be an inhibitory factor to the success of

the sister on the scheme. The conflicts that may arise between the needs of the service and the needs of training are well documented in the literature. However, in the project under study the conflicts were minimised due to the joint collaborative approach of service and educational staff.

6.4 Effects of the scheme on other ward staff

As the scheme progressed, discussions with the sisters revealed two main concerns about the effects of the scheme on other ward staff. Sisters on the first scheme were mainly concerned with the lack of continuity of ward management and the additional strain their absence from the ward was causing the staff, especially in wards where there already existed a high work load and low staffing levels or poor skill mix. The change from weekly study days to three one week blocks appeared to eliminate this concern to some extent. Sisters on the first scheme also indicated that there were some problems with staff who had to accept a greater responsibility for managing the ward in their frequent absences, and who demonstrated some reluctance on the re-emergence of the sister to hand over control of the ward. However, the sisters themselves said they felt they were losing control of the ward because they were unable in the few days on their ward to become fully conversant with all the current situations and implications, and were often placed in the position of being unable to answer consultant's questions on patient responses to treatments.

Feedback from the ward staff on a number of occasions suggested that the concerns of the sisters about the effect of their presence on the scheme and the undermining of authority or position as sister's were unfounded. Indeed, there is evidence to suggest that in most cases the staff had considerable respect and loyalty for the sister. Some staff expressed feelings of anger and resentment on occasion when questioned by the observers about ward activities and stated they felt it was disloyal to the sister to talk behind her back. The observers also reported that some staff appeared initially anxious by their presence on the ward. A post scheme questionnaire completed by the sisters indicated that the majority of staff present during the observations felt initially anxious, believing that they too were being assessed. These feelings were reported to diminish with each subsequent period of observation, as did the sister's own level of reported anxiety.

6.5 The training ward

The selection of a ward within the host hospital to accommodate sisters for specific periods of observation on the ward sister and her approach to various aspects of her role function was based on the premise that the development scheme should be related to the practical art of sistering in a constantly changing environment.

The ward chosen specialised in general surgery and was selected because of its geographical similarity to many other wards within the hospital. No additional staff resources were allocated during the presence of the scheme sisters. The clinical teacher introduced herself to the ward staff and helped them to understand and apply the philosophy of the nursing process with greater effectiveness prior to the first cohort of sisters visiting the ward. In addition, the clinical teacher worked closely with the ward sister to help prepare her for the role as a 'model' during the scheme.

The selection was also influenced by the nurse manager representative who was from the Surgical Unit and, therefore, felt in a position to offer a greater level of support and understanding of the potential stressfulness of being observed by one's peers.

Analysis of the data collected by end of course questionnaire and discussion indicated that all ten participants found the visits to the 'training ward' useful. A sample of the reasons given is listed below:

- 'provided an opportunity to stand back and observe ward activities'.
- 'seeing how another sister functions enabled me to pick up a number of helpful points'.
- 'helped me to look at my own ward in a new light'.
- 'the opportunity to exchange ideas and discuss problems was extremely valuable'.

The initial concerns of the planning team that the use of only one type of ward would not meet the needs of the sisters working in other specialities appeared to be unfounded in practice.

Despite their preparation, some of the staff on the 'training ward' were reported by the ward sister to be initially a little anxious over the presence of between four and six sisters plus two facilitators during their periods of observation. Their anxiety was reported by the training ward sister and staff themselves to have been reduced after the first couple of visits and they began to enjoy the presence of the visiting sisters.

The Role Model sister attended and participated in the post observation discussions on most occasions. On occasions when sister was unable to attend due to her high level of involvement in patient and ward management, points which were raised and required sister to clarify and/or elaborate on, were dealt with at an alternative time more convenient to the sister). The scheme sisters stated that their initial reaction to the presence of their 'training ward' colleague at the discussion was one of 'embarrassment' as they considered sister may interpret the comments made as a personal criticism, and they had no wish to 'hurt her feelings'. Reassurance was given by the facilitators that the 'host' sister had been prepared to accept and expect constructive comments about the observation findings.

Despite reassurance the group was initially very slow to initiate discussion and dealt only with very superficial findings, until prompted by the host sister and facilitators to highlight 'more sensitive' areas. The host sister responded in a 'non threatening' manner to criticism and gradually the group began to spontaneously question and raise issues on a fairly constructive basis. However, despite the preparation to be a 'role model', sister said there were occasions when she felt rather sensitive to some of the comments being made, but had stifled this so as to encourage further points to be raised. Sister was observed to always present a logical argument for why she did things. Furthermore, she involved members of her staff in the innovation and kept them informed about the discussions following the observational visits. One of the facilitators was always available to provide support and encouragement to the host sister and ward staff throughout the duration of the scheme. The stimulus and opportunity for self reflection by the 'model sister' encouraged both sister and staff to analyse various aspects of ward work including patient nurse interaction, methods of ward management and communication, the identification and use of learning opportunities, support mechanism for staff and patients/relatives.

6.6 Scheme facilitators

The facilitators for the first scheme were the Senior Clinical Nurse (Training) and the Clinical Teacher for the Elderly Service wards and Professional Development. Both facilitators had demands made upon their time which were unrelated to the demands made by the development scheme, and at times caused a conflict of interest to arise. This was usually due to insufficient time being available to meet what was seen by the facilitators as an important priority. The Senior Clinical Nurse (Training) had not been able to completely relinquish all her previous management responsibilities and was having to be in charge of the hospital on numerous occasions in the evenings; this often meant it was difficult to arrange meetings at which both facilitators and tutor could be present. Secondly, the demands of her new role frequently included her presence at meetings and interviews which were unrelated to the development scheme demands. The clinical teacher had enormous demands made upon her by both the elderly service wards and development scheme which also produced competing and conflicting priorities.

The relationship between facilitators and those creating the demand were such that it enabled the problems to be clearly identified and discussed, although not all were immediately resolved.

The second scheme produced different facilitation problems. The Senior Clinical Nurse (Training) had by this time relinquished all management responsibilities and had been able to adapt her new role to adequately meet the demands of the scheme. The Clinical Teacher was leaving due to the opportunity of career development, and her post was not going to be filled. The role of second facilitator was shared between an experienced sister who had shown an interest in teaching and the Training Officer for the host hospital. The sister was one of a number who worked together in a specialist unit, and expected to spend the remaining two days per week in her own clinical area. The Training Officer was expected to continue with her usual role commitments.

The implications of having two people from quite diverse backgrounds were discussed at length by the planning team and various concerns highlighted. However, the over-riding priority was the implementation of the second scheme. It was agreed that both people act as facilitators as and when required by the demands of the scheme and its participants.

Although both facilitators underwent a period of inservice training under the guidance of the clinical teacher, which included instruction on observing and recording the behaviour of sisters in their own environment, how to act as facilitator during clinical visits to the training ward, and to individual

sisters. Some problems did arise during the feedback sessions from the training ward observations and discussions on various aspects and problems of the sister's role.

One of the problems primarily stemmed from the close relationship between the 'sister' facilitator and scheme sisters to the extent that she quickly began to lead and control the group as opposed to encouraging the group to adopt a self directed approach and to seek to find answers from within their own peer group. The facilitator was popular with her peers who appeared to be quite happy for her to answer questions on their behalf and make the decisions. This often made it difficult for the tutor and other facilitators to get the sisters to take more responsibility for directing and controlling the events surrounding them and, for developing a critical approach to their work and that of others. The second problem related to the expectations of the facilitator about her role and the discrepancy that existed between expectation and reality. On discussion with the facilitator this was partially due to the structure of the scheme and its underlying philosophy. Input by the facilitators was required during the study blocks to oversee the clinical visits and listen to feedback. In addition, those with a specialist knowledge also had an input to the taught component. The weeks between the blocks had a less well defined facilitator input and was related to the needs and requests of the individual sisters. This resulted in some redundancy of the sister facilitator's allotted scheme time as full use of the three days per week would

have meant that contact with the sisters would be at times unrelated to their needs and requests. The relationship, however, between the facilitator and tutor were such that it permitted amicable discussion and resolution of the problems.

6.7 Scheme tutor

The tutor to the scheme, who was also the author of this study had additional competing demands on her time which arose from:

being course tutor to three English National Board courses,

the need to fulfil other continuing educational commitments at the host and one other acute general hospital within the Authority,

teach on other post basic and basic courses.

Although this situation could have proved quite problematic and untenable, apart from minor problems related to time constraints, there appeared to be no major disadvantages to the scheme, its participants or tutor.

However, the use of teaching strategies designed to promote and encourage critical analysis, self direction and evaluation with a group of people who had been previously and predominantly exposed to a didactic teacher centred approach appeared to cause resentment in some sisters, who expected to be 'taught' the things they need to know in a formal and didactic manner. The teaching methods most frequently used were discussion, seminars, contract work, demonstration and observation. Role play and

private tutorial were rarely used, and although opportunity was available, these were least favoured by the participants.

6.8 Selection

The importance of 'choice' on the part of the potential participants in attending the scheme had been initially identified and agreed between the relevant parties. However, it was clear from listening to the sisters that the majority felt obliged to attend or told they had to. Following discussion with the Head of Nursing on completion of the pilot scheme, it was decided that attendance would be mandatory for all sisters.

6.9 Expectations and motivations of participants

At the commencement of each scheme the participants were asked what they felt the purpose of the scheme was and what they hoped to get from attending. A variety of responses were given, the majority were positive; 'identify key areas for professional development; 'help me develop my role as a sister; 'to become a better organiser; 'observe other methods of ward management. Most participants could see the potential of coming on the scheme, although some showed visible signs of nervousness and uncertainty at the beginning of the scheme. Some participants on the second scheme appeared to lack motivation in the early stage of the taught component. Discussion of these negative attitudes being portrayed highlighted that those concerned were worried about the ward being left at a difficult time or were anxious about being on the scheme.

The post scheme questionnaire and discussion highlighted that even sisters E and G who had initially negative attitudes had, by their own admission, gained from the scheme. Others, like sisters B and H, stated that it was several months after completing the scheme that they became aware of additional benefit. This pattern is supported by findings from a study by Lathlean and Farnish (1984) which showed that whilst motivation and the relationship between expectation and experience are important, attitudes expressed at the time of the course and immediately after are not necessarily indicative of the full extent of learning.

6.10 Assessment

The progress of the sisters was assessed mainly by observation, questionnaire, interview and discussion. Few problems were encountered by either the observers or the participants when using the evaluation tools.

Two problems that were identified related to the use of the role performance index; the first related to continuity, four facilitators had been involved with observing performance instead of the proposed two and only one of these had been present throughout the pilot scheme. However, observations during the post scheme phase were undertaken by the same observers as for the pre scheme phase, although no two observers saw all the sisters. The second problem was concerned with objectivity and rating of performance numerically, as no explanation of the

values had been given on which to judge and rate the performance. In practice, analysis of data was not as problematic as thought due to its illuminative properties, the information was descriptive and enabled comparison to be made between the performances. These problems do, however, highlight the need for those using field work techniques to be confident and competent in their usage.

The amount of time devoted to ongoing evaluation during the scheme was considered to be sufficient by seven of the ten participants. The remaining three sisters who commented that they would have liked more time for evaluation were from the second scheme. Suggestions given to improve the situation were to have a written progress report on performance during each study block by the scheme tutor and a written report on their performance in the clinical situation to keep themselves as a source of reference for future comparison. The evaluation comments of the sisters, combined with the interview observations of the researcher and facilitators, proved useful in making changes in the schemes and helping individual sister's focus on their role performance and development.

6.11 Number and background of participating sisters

Scheme one had only four sisters and scheme two had six which was in keeping with the original proposals. However, this did give rise to the question of cost as the teaching team often out numbered that of the participants during discussion sessions.

The number and mix of sisters was found to be important both in terms of experience and personality. Both schemes had a mix of inexperienced and experienced sisters and enabled a greater range of issues to be discussed. The participants on the first scheme quickly formed a cohesive and supportive relationship with each other and the teaching team, and this was seen to have a number of benefits both to individuals and the scheme as a whole. For example, one sister who was very quiet and demonstrated external signs of anxiety during the initial part of the scheme became more confident, self assured and a vocal member of the group, which she attributed to support by peers and planning team. The supportive network also helped the introduction of critical appraisal and self and peer assessment.

The mix of sisters on the second scheme was similar to that of those on the first. However, it was generally felt by the planning team that the learning milieu was not as cohesive as that of the first. This view was supported by comments from individual group members. Contributory factors to the initial lack of cohesion was thought by the researcher to be the negative attitude portrayed by a member of the group which, from the comments made by her peers, appeared to create feelings of frustration, partly because they felt unable to challenge their peer; secondly some felt the scheme tutor should have intervened on their behalf to control the discussion and prevent the sister

reiterating her negative attitudes. Thirdly, alteration in scheme structure from once weekly meetings to three one week blocks, although favoured by scheme participants were not felt to lend itself to the establishment of a cohesive milieu. Finally, doubts about the value of the scheme by some participants did not, it was felt, help the situation.

Despite the difficulties in developing relationships, of the second scheme all ten participants stated on the evaluation form that they learnt from peer group discussions. Comments included 'sharing problems helped to resolve some of them', 'knowing others had similar problems made me feel better' and 'help give me confidence to try out new ideas'.

6.12 The scheme

The taught component of the scheme extended over a twelve week period for both cohorts, although the structure of the two schemes differed. The planning team felt that twelve weeks' was a reasonable period for achieving the main aims of the scheme. In addition, the participants on both schemes were supported for a further six months whilst completing their learning contracts and attended a post scheme review day. The majority of sisters on questioning considered the length 'about right', although some did express the view that the period could be reduced. The criticism related to what were perceived by some of gaps between sessions which had been deliberate on the part of

the planning team to see how individuals used unstructured time. 'Gaps between sessions were also to provide an opportunity for individual and group reflection on the scheme and their own performance. Given the underlying philosophy of the scheme, criticism about unstructured time is not necessarily valid.

6.13 Proposals for change

The development scheme has a built in flexibility which enabled it to be amenable to a level of modification and change when indicated by evaluation findings.

A number of minor changes were implemented without the need to convene a full planning team meeting and mostly related to alteration of course content or method of delivery following agreement between the scheme tutor and facilitators, and, if appropriate, participants. All other proposals for change required the full planning team to be convened.

Changes in the scheme structure from study days to three one week blocks were considered by three of the six participants as suiting their requirements. Following analysis of the data collected from all those involved in the scheme, the planning team have recommended that future schemes commence with a two day block and once fortnightly study day extending over a period of twelve weeks.

6.14 Theoretical content

The theoretical content of the scheme comprised of five major themes and findings from the end of scheme questionnaire indicated that only one participant felt the content was not useful to her, stating she had either covered the material before or, the content was not relevant to her work. The remaining nine sisters said the content was useful, reasons included, information and ideas to use in the future; insight into new developments and their implication, updating existing knowledge. Comments also suggested that some of the individual sessions had been a repetition of previous courses and that certain topics such as research had been difficult at times to understand. One sister commented that the sessions were 'not always as structured as I'd have like and wasted time'. However, eight of the participants said the theme objectives were realistic and relevant to their work and four said they had achieved them at the end of the twelve week period. Of the six sisters who stated they had not achieved the objectives at the end of the taught component, three had achieved them by the post scheme evaluation.

6.15 Contract learning

All ten participants regarded the use of learning contracts as beneficial. The reasons given included:

- 'useful to have an opportunity to decide what we wanted to do and how'.

- 'helped to keep me motivated'.
- 'gave me more understanding towards implementing change on the ward'.
- 'enjoyed setting out to achieve a better standard of patient care on my ward'.
- helped to identify what I needed to do and how I was going to do it'.
- 'helped me to identify problems and work out solutions'.

Although learning contracts appeared a simple concept, several scheme participants initially found the concept difficult to understand and required additional explanation. A slight reluctance was observed on the part of two participants on the second scheme to formulate contracts, which were not forthcoming until the second block. However, despite their initial reluctance the post scheme interviews indicated both were motivated towards their continued usage. The planning team, in the light of the evidence presented, were unanimous in their view of the value of this method to the development of role performance.

The size of the group and level of discussion was felt to be initially threatening by some of the participants. Also, as the majority of sisters had been used to a more formal setting and a teacher centred approach, the 'education of equals' and self directed approach was a little difficult for some to accept initially. However, post scheme discussion indicated that the

methods of teaching used were appropriate and had been beneficial.

6.16 Limitations and criticisms of the study

Researcher must be able to 'recognise their fallibility and should be prepared to match their own interpretations against other peoples' (Lewis 1969). This section highlights areas of criticism, and limitations in the reported work.

Sample size

A total of ten sisters participated in the pilot development scheme: four attended the first scheme, six the second scheme. The participants were selected on a basis of their availability to attend, and, that they were not currently pursuing other studies. Therefore, no claim is made that the sample is representative of ward sisters in general hospitals. However, despite the small numbers, vast amounts of data were collected and analysed which provided answers to the research questions.

The suggestion to increase the numbers was debated at length by the planning team. However, the constraining factors were the need to ensure that:

- each sister was observed at set intervals in her clinical environment by two observers on different occasions.
- each sister observed and spent time with the role model sister on an individual and group basis.
- all visits to clinical areas during the taught component were supervised by the facilitators.

- support be available when required during period of contract learning.

These issues are not seen as insurmountable, but they require additional resources and planning to ensure that the learning milieu remains compatible with the underlying scheme philosophy of adult education, and that those released to attend, have sufficient staff on their wards to allow their concentration to be on issues raised on the scheme and not distracted by the day to day ward management problems.

A number of sisters, after completing the scheme, expressed an interest to become role model sisters afterwards. The reasons given included the opportunity to continue to receive constructive criticism on aspects of performance, and to provide and receive peer group support.

6.17 Observer bias

The interactional relationship between the observers and respondents in the study, combined with their previous knowledge of the situation in which the study was conducted, could cause concern as to the method's reliability. A considerable amount of literature on reliability and validity in field work techniques is available and a number of internal checks for reliability and validity were built into the present study to minimise bias and were discussed in Chapter 4.

6.18 Focus of attention

The sisters not only became a focus of attention for those directly involved with the innovation but also for others within the host hospital who were aware of the scheme. Therefore, the extent to which this could have influenced the behaviour of the respondents cannot be ignored. Some sisters expressed feeling anxious when questioned by colleagues about the scheme. Further discussion revealed they felt staff would think they were inadequate as sisters and that this would affect their relationship with staff.

6.19 Author bias

The relationship that was sought between author and participants was one of collaboration. Therefore, total impartiality is not claimed nor was it feasible if the innovation process was to be fully investigated and understood. The closeness of the relationship between the author and the innovation must be recognised as a potential bias. However, the method of study has been sufficiently objective to minimise bias to within an acceptable level.

6.20 Confidentiality

Respect for confidentiality of information is of paramount importance in any study. Equally, the need for full and accurate reporting is essential if the report is to be credible and of value. In a small scale study problems can and did arise in trying to keep the identity of the respondents confidential.

Therefore, thoughtful presentation of information became a vital necessity when the respondents are identified publicly and the report available to anyone who seeks to read it.

6.21 Ownership of the data

Where an innovation is a joint collaborative effort between two or more disciplines, such as the one described in the present study between education and service, it becomes important to establish who owns the information obtained from studying the innovation. One area of potential difficulty in any study is over ownership of the data collected. It was, therefore, agreed by the planning team, author and Head of Nursing, before the commencement of the study, that information collected on individual participants during phase 1 would be restricted to the observers, scheme tutor and individual sister, until the end of the taught component and second observations; after which a composite report of the individual's progress would be provided for the Head of Nursing and appropriate managers.

The exceptions to the above would be, if the sister expressly requested her manager to be informed before the end of the twelve week taught component, or if the scheme teachers considered it was in the individual's professional or personal interest to have information disclosed earlier, and only if the individual sister agreed.

The need to establish ownership of the information was crucial to the success of the scheme, as it was felt that the sisters would

be more willing to discuss their role, and its problems if they knew how their responses were going to be treated and which aspects of their role performance were going to be reported, to whom and when.

One problem that required clarification in the present study occurred when an observer intervened in a clinical situation to pass on patient related information that was deemed to be important but omitted by the sister.

6.22 Work problems

Although some sisters had reduced their number of perceived work problems, the acceptance of most sisters to the inevitability of their problems had already been mentioned in this and previous studies. Many of the identified work problems remained unchanged at the end of the development scheme, even though some were within the scope of the sister to resolve. Due to the constraints of time it was not possible to investigate in any depth the reasons given for being unable to change the situation. This area does, I feel, warrant investigation.

6.23 Leadership

Sisters who scored low on both dimensions, consideration and structure appeared to be the least effective in their clinical environments. (A finding supported by Fleishman and Harris 1962). Changes in some of the respondents leadership scores and behaviour were evident, post scheme and appeared to have a positive effect on the individual's leadership performance.

Information obtained from the sisters suggested that feedback on their leadership performance had provided them with objective evidence upon which to objectively review their own performance. The opportunities to observe the leadership styles of others, and openly discuss ways to develop leadership skills had been instrumental in improving their leadership style.

6.24 Role stress

The post scheme findings indicated that all the sisters attending the scheme had reduced their overall stress scores, although some items still produced a high stress score in some of the sisters. However levels of stress were most noticeable in situations where:

- manpower resources were perceived by sister to be adequate to meet workload demands.
- sister felt she was supported by her manager.
- sister had a clear understanding of what was expected of her and the limits of her responsibility and authority.
- sister had confidence in herself and in her actions.
- 'rules' did not have to be bent in order to carry out assignments.
- relationships between sister and colleagues were congenial.

It is inevitable that a degree of role stress and tension be present in those who hold the office of sister. However, research has indicated that highlevels of stress can have a negative and undesirable effect upon performance. Findings from the study suggest that much can be done to minimise role stress

without the need for additional resources, and include the need for a sister to have a clear understanding of her:

- role within the organization,
- limits of responsibility and authority,
- channels of communication within the organization,

6.25 Continued development of sisters at the host hospital

Kempfer (1955) stated that 'the basic purpose of evaluation is to stimulate growth and improvement' (and) 'to assess present conditions as a basis for achieving better ones'.

Evaluation findings from the present study provided data upon which to base further schemes for the development of sisters within the hospital and which may be of value to others who may be contemplating the provision of a programme for the development of sisters.

Following evaluation of the pilot scheme, a third development scheme has been completed by six sisters, and a fourth is planned for April 1988.

The duration of the scheme is forty-six weeks, Sisters attend a briefing day approximately three weeks prior to commencement of the scheme. The taught component begins with a two-day block, followed by fortnightly study days over ten weeks, then a two-day consolidation block. The philosophy of the scheme, observation and structured feedback, the taught component and contract work are in keeping with the pilot scheme. The experiential approach used to help sisters develop a

greater awareness of their role and situation, and expose them to new experiences, have been shown to be influential in bringing about changes in the behaviour of sisters on the scheme.

In addition sisters at the host hospital now have a new job profile and summary and, an outline of their principal responsibilities compatible with the demands of their role following reorganization.

The author acknowledges that the case histories presented in this study represent only one approach to the development of sisters. There are numerous alternative approaches, some of which have been previously used and documented. Whatever the approach adopted, its success will depend to a lesser or greater extent on the ability of educators, service managers and participants to form relationships which are of a collaborative and meaningful nature. The importance of the sister's role and her need for appropriate preparation will only be fully recognised by the profession if those involved in developing training programmes share their knowledge and experience.

6.26 Recommendations

The information gained from this study leads the author to recommend that sister preparation and development schemes be conducted in an environment which:

> is characterized by mutual trust, respect and helpfulness, freedom of expression and acceptance of differences of opinion. (Page 28)

facilitates the sister's recognition and acceptance of the need to learn. (Pages 21-24,109,177)

encourages participants to have ownership of the learning experience and active participation in the learning process. (Pages 23,37,49 and 147)

provides regular feedback to individuals on their progress towards goal attainment. (Pages 26,60-63,71,72,154)

gives participants, teachers and managers shared responsibility for planning, implementing and evaluating the innovation as it progresses. (Pages 24,50-54,142-143)

exposes the sister to new experiences and the possibility of greater role satisfaction and self fulfilment. (Pages 28,108)

facilitates critical analysis of own and others role and level of performance. (Pages 21,108,134,144)

recognises the constraints and opportunities of the sister's work situation and the affect these may have on the sister's autonomy and leadership style. (Pages 65-67,84-98,110-127, 153)

is sensitive to the sister's role conflicts and expectations (Pages 67-70,98-103,113-115,141,154)

is supportive of new ideas. (Page 108)

encourages clear and concise communication. (Pages 155-156)

has a manager who is considered by the sister as supportive. (Pages 93,128,129)

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APPENDIX 1a

Summary of the measures used in the present study

	VARIABLE	INSTRUMENT
1.	Observed Role Behaviour i) Management of Patient Care. ii) Teaching iii) Ward Management iv) Personnel Management v) Nursing Research	Role Performance Index
2.	Self perception of Role behaviour	Self Assessment profile, Semi structure interview
3.	Perceived role characteristics.	Role opinion questionnaires.
4.	Work problems	Problem checklist, Interview
5.	Leadership i) consideration ii) structure	Fleishman Leadership Opinion Questionnaire.
6.	Perceived role pressures i) job related tension ii) role clarity iii) role conflict iv) role ambiguity	 Job related tension, Role clarity, Role conflict, Role ambiguity.
7.	Intent to leave	Propensity to leave index.
8.	Previous Career and Personal Development.	Questionnaire Interview schedule.
9.	Biographical Information	Questionnaire, Personal records Interview.
10.	Attainment of Scheme Objectives.	Interview Schedule.
11.	Attainment of Personal Objectives	Written Evaluation Interview.

SISTER DEVELOPMENT SCHEME

BIOGRAPHICAL INFORMATION

Date Completed: _____

NAME: _____ MRS MR MISS MS
(Please circle appropriate status)

WARD/DEPARTMENT _____

AGE: _____ DATE OF BIRTH: _____
(Please state in years)

EDUCATIONAL QUALIFICATIONS:

'O' Levels (Please state number obtained and dates) _____

_____ _____

_____ _____

'A' Levels (Please state number obtained and dates) _____

_____ _____

Please give details of:

Certificates: Date Obtained:

_____ _____

_____ _____

Diplomas: Date Obtained:

_____ _____

_____ _____

Degrees:

_____ _____

Professional Qualifications - Courses:

Please tick ✓ qualifications held or course undertaken. Write date obtained.

EN _____ HV _____ PWT _____

SRN/RGN _____ DN _____ FWT _____

RMN _____ RCNT _____ MTD _____

SCM _____ RNT _____ ONC _____

RSCN _____ Other - please state _____

ENB Courses (formerly JBCNS)

940 or 941 _____ 923 _____ 998 _____

930 or 931 _____ 176 _____ 928 _____

298 _____ 978 _____

Others - please state _____

TWO DAY PROFESSIONAL DEVELOPMENT MODULES

TEACHING
COMMUNICATION
RESEARCH
NURSING PRACTICE DEVELOPMENT

ASSESSORS COURSE: DATE ATTENDED:

MANAGEMENT COURSES:

First Line	Date Attended
Middle	Date Attended
Senior	Date Attended
Other - Please specificy	

How many years since you obtained your FIRST nursing qualification?
years.

Please state how many years you have been employed as a trained nurse.

Full time years Part Time years.

How many years have you been in your present post? years.

Have you been a sister/charge nuurse before? YES/NO
(Please delete as appropriate)

If YES - How long were you in that post? years.

If you have previously held a post of:

Nurse Manager	YES/NO	Date:
Clinical Teacher	YES/NO	Date:
Nurse Tutor	YES/NO	Date:
Clinical Nurse Specialist	YES/NO	Date:

Please list any professional journal which you read regularly.

SISTER DEVELOPMENT PROGRAMME

ASSESSMENT OF INDIVIDUAL LEARNING NEEDS
- OBSERVATION OF CLINICAL PRACTICE

DATE:

WARD:

NUMBER OF PATIENTS:

NUMBER OF STAFF:

GRADES OF STAFF:

PATIENT DEPENDENCY: I II III IV
(Monitor Categories)

OBSERVER - DESIGNATION:

SIGNATURE:

A. MANAGEMENT OF PATIENT CARE	COMMENTS	Very Good	Good	Adequate	Poor	Very Poor
	(Examples of the questions the observers would ask themselves, and behaviours they may look for)					
1. CO-ORDINATOR OF CARE						
i) Management of ward rounds.	- Sister Role - Does she contribute to discussion?					
ii) Assessment of priorities.	- Appropriate - Are they followed through?					
iii) Knowlege of the quality of care being given.	- How does sister know what care has been given and how well? - How does she check?					
2. ORGANISATION OF CARE						
i) Allocation of work	- What actually happens in practice?					
- team						
- patient	- Is consideration of nurses level of experience matched appropriately with patient care required?					
- task						
ii) Nursing process	Who assesses patients on admission?					
- Assessment of needs.	- If learner, who checks this assessment?					
- Planning, goal setting	- Are the goals realistic, measureable?					
- Implementation of care delivery	- Is the care-plan referred to in practice? Is it up-to-date?					
Evaluation of care given.	- Is this objective and related to original problem-goal?					

APPENDIX 2a
(continued)

A. MANAGEMENT OF PATIENT CARE	COMMENTS	Very Good	Good	Adequate	Poor	Very Poor
3. SUPPORTIVE ROLE						
i) Patients/Relatives	- Look for listening and counselling skills. Body language. - Are patients encouraged to express their feelings? - Does anyone support sister?					
ii) Learners						
iii) Trained Staff and auxiliaries						
iv) Others.						

B. TEACHING	COMMENTS	Very Good	Good	Adequate	Poor	Very Poor
1. METHODS						
i) Formal						
ii) Demonstration	- By example.					
iii) Supervisison	- Who supervises the learners exactly?					
iv) Use of report sessions	- As a teachinng aid?					
2. CLIENTS AND PERSONNEL						
i) Patients/Relatives	- Are opportunities utilised?					
ii) Learners	- Is the sister aware of the limitations of these various grades? i.e. do they have the skills to fulfil the care required of them?					
iii) Trained Staff						
iv) Auxiliaries						
v) Others						

C. WARD MANAGEMENT		COMMENTS	Very Good	Good	Adequate	Poor	Very Poor
1. COMMUNICATION							
i)	Patients/Relatives	Comment whether at an appropriate level.					
ii)	Trained Staff						
iii)	Learners	Whether response indicates understanding.					
iv)	Nursing Officer						
v)	Auxiliary						
vi)	Consultant	- ? is the relationship on equal terms.					
vii)	Junior Doctors						
viii)	Ward Clerk						
ix)	Others.						
2. WARD REPORT SYSTEM							
i)	Timing	How long does it take?					
ii)	Content	How many reports are there and how do they differ?					
iii)	Relevancy	Comment on whether individual nurses know what to do following the report.					

C. WARD MANAGEMENT (continued)	COMMENTS	Very Good	Good	Adequate	Poor	Very Poor
3. LEADERSHIP						
i) Decision Making	- Identify type of leader; give examples to support this.					
ii) Team Work	- Decisive, wavering, avoiding?					
iii) Assertiveness	- Are all staff working as a team?					
iv) Appropriateness of delegation	- Is sister seen as in charge? - Is this appropriate?					
4. BUDGET CONTROL						
Deployment of:						
i) Staff	- check off-duty					
ii) Time	- Does basic routine make best use of staff time?					
iii) Equipment.	- Comments on stores, borrowing, etc.					
5. MULTIDISCIPLINARY LIAISON						
	- Is the nursing viewpoint put forward?					
	- Comment					

D. PERSONNEL MANAGEMENT	COMMENTS	Very Good	Good	Adequate	Poor	Very Poor
1. TRAINED NURSES	- Ask staff -					
Review/Appraisal:						
i) formal	- How do trained staff know how they are doing?					
ii) informal	- Advice and supervision day to day.					
Interviewing skills						
i) communication	- Comment if any assessments, etc. are seen.					
2. AUXILIARY NURSES						
Review/Appraisal:						
i) formal	- How do auxiliaries know how they are doing?					
ii) informal	- Advice and supervision day to day					
Supervision	- Who do nursing auxiliaries report to? - Who evaluates their care?					
3. WARD ATMOSPHERE						
Staff morale	- Job satisfaction.					
- comment	- Team work, etc.					

E. NURSING RESEARCH	COMMENTS	Very Good	Good	Adequate	Poor	Very Poor
EVIDENCE OF RESEARCH/KNOWLEDGE BASED PRACTICE						
	- e.g. Use of Norton Scale.					
	Are traditional practices in use?					
	- e.g. Back rounds					
	Bedpan rounds					
	4 hourly observations - regardless of patient's condition.					
	Bath/Bowel/Books.					

Sister Development Planning Team
7.2.86.

SISTER DEVELOPMENT SCHEME

SELF ASSESSMENT PROFILE

Please indicate the response which most accurately describes your feelings about the way you performed the following activities today:

(Please ✓ tick the appropriate heading)

	Very Good	Good	Satisfactory	Poor	Very Poor
1. Delegated responsibilities.					
2. Allocated the staff.					
3. Communicated verbally with:					
Trained colleagues on ward,					
Medical staff,					
Learner nurses,					
Nursing auxiliaries,					
Patients,					
Relatives,					
Other disciplines, (Please state).					
4. Written communications.					
5. Managed the ward.					
6. Conducted the ward round.					
7. Taught the learners.					
8. Assessed priorities.					
9. Supported your staff.					
10. Nursing Care.					

You are invited to make any other comments overleaf about your performance as a sister to-day.

INTERVIEW SCHEDULE

NAME:

1. In your opinion does the perception of the observers on what you did match your own view of what you did on those days?

2. Is there anything that you frequently have happen or that you have to do that was not apparent when you were observed?

3. Is there anything that you would like to do but do not feel you have the time for?

4. Is there anything that you want to achieve but feel you would like help with?

5. How would you describe a 'typical' day for you on your ward?

ROLE OPINION QUESTIONNAIRE

Please read the comments on the left hand page and then tick (✓) the box under the response which most accurately describes your opinion of yourself as a sister.

I am:	Always	Mostly	Sometimes	Rarely	Never	
Organised						Disorganised
A Poor Communicator						A Good Communicator
Consistent						Inconsistent
Lacking knowledge of my speciality						Knowledgeable of their speciality
Tolerant of others views						Intolerant of others views
A Good Ward Manager						A Poor Ward Manager
Working with subordinates						Not working with subordinates
Not supported by the manager						Well supported by the manager
Approachable						Unapproachable

	Always	Mostly	Sometimes	Rarely	Never	
Respected by medical staff for my opinion	———	———	———	———	———	Rejected by medical staff for the opinions held
Spending too much time doing paperwork	———	———	———	———	———	Not spending enough time doing paperwork
Dependent	———	———	———	———	———	Independent
Aware of what is expected from me	———	———	———	———	———	Unaware of what is expected from me
Good at making decisions	———	———	———	———	———	Poor at making decisions
Free to run my ward/ department how I wish	———	———	———	———	———	Constrained by others
Willing to try out new ideas	———	———	———	———	———	Resistant to new ideas
Good at delegating responsibility	———	———	———	———	———	Poor at delegating responsibility
Always confident	———	———	———	———	———	Unsure of myself
Supportive to my staff	———	———	———	———	———	Unsupportive to my staff

Insensitive to the needs of my patients	———	———	———	———	———	Sensitive to the needs of my patients
Spending too much time in the office	———	———	———	———	———	Out on the wards most of the time
Satisfied with my job	———	———	———	———	———	Dissatisfied with my job
Always willing to talk to relatives	———	———	———	———	———	Not willing to talk to relatives

IDENTIFICATION OF WORK PROBLEMS

Due to the complexity of a sister's role, a variety of problems may be experienced which can interfere or prevent them from doing what they would like to do.

Please indicate with a tick (✓) if this is or is not a problem for you as a sister.

		YES (a problem)	NO (not a problem)
1	Rapid patient turn over		
2	Insufficient trained nurses		
3	Too many junior learner nurses		
4	Patients being admitted before their beds prepared		
5	Insufficient clerical help		
6	Interruptions from telephone		
7	Doctors' rounds at inappropriate times		
8	Conflicting medical advice		
9	Inadequate equipment		
10	Lack of linen		
11	Badly written prescription sheets		
12	Too many bank/agency nurses		
13	Too many doctor's rounds		
14	Early discharge of patients		
15	Not enough CSSD items		
16	Number of intravenous injections to be given		
17	Doing off duty		
18	Insufficient time to talk to relatives		
19	Not enough time to explain things to patient		
20	Patients inappropriately sent to your ward		

	YES (a problem)	NO (not a problem)
21 Getting regular maintenance done		
22 Nurses going off sick		
23 Lack of support from senior colleagues		
24 Preparing for doctors' rounds		

NORMS TABLE

Verbal Description	Percentile	General Supervisory Personnel N = 3008		First-Line Admin. Clerks N = 100		Foremen N = 463		Executives N = 314		Middle Managers N = 678		Bank Managers N = 114		Store and Assistant Store Managers N = 337		University Students N = 557		Educational Supervisors N = 100		Supervisory and Head Nurses N = 326	
		C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S
Very High	99	72	68	67	68	–	69	–	68	65	64	–	73	72	71	68	63	76	61	69	67
	98	69	66	–	67	66	67	73	67	64	62	70	69	69	70	65	61	74	–	67	65
	97	68	64	66	66	65	66	72	65	63	61	69	68	66	68	64	60	73	55	65	64
High	95	65	63	65	65	64	64	69	63	61	60	69	67	64	67	63	58	72	54	64	62
	90	62	60	64	63	62	61	65	60	59	57	63	63	61	64	61	57	71	52	63	58
	85	60	58	61	61	61	59	63	59	58	56	60	60	59	62	59	55	70	51	61	56
	80	59	57	60	60	59	57	61	58	57	55	59	58	57	61	58	54	68	50	60	54
	75	58	55	58	58	58	56	59	56	56	54	57	57	56	60	57	53	66	49	59	53
Average	69	57	54	57	57	57	55	58	55	55	52	56	55	55	59	56	52	65	46	58	51
	60	55	52	55	56	55	53	57	53	53	51	55	54	53	58	54	50	63	44	56	50
	50	53	50	53	54	53	51	55	51	52	50	54	53	51	56	53	49	62	42	54	47
	40	51	49	50	53	52	50	53	48	50	48	53	51	50	54	51	47	61	41	53	46
	31	50	47	49	51	50	47	52	46	49	47	52	49	48	53	49	45	60	39	51	44
Low	25	48	45	47	50	48	46	51	44	48	46	50	48	47	52	48	–	58	38	50	42
	20	47	44	46	48	47	45	50	43	47	45	49	47	45	51	47	44	57	37	49	41
	15	46	42	45	45	46	43	48	41	46	43	48	46	44	49	46	43	56	36	48	39
	10	44	41	42	43	44	41	47	40	44	42	47	44	42	47	45	41	55	34	46	38
	5	42	38	40	42	42	38	45	38	42	40	46	39	39	44	43	39	54	31	44	34
Very Low	3	41	36	38	40	40	36	44	37	41	38	43	33	38	43	40	34	52	29	42	32
	2	40	34	37	39	38	34	43	34	40	36	42	32	36	42	39	33	46	28	41	31
	1	38	31	36	–	36	27	42	31	38	35	40	–	33	38	28	29	–	–	37	29

Reproduced from Fleishman's Leadership Opinion Questionnaire (Fleishman 1960)

Office Use Only

HOSPITAL: ..... H:

SUBJECT: ..... S: 1 2 3 ☐☐☐

THE JOB AND HOSPITAL QUESTIONNAIRE

I. How often do you feel bothered by: 4 ☐

1. Being unclear on just what the scope and responsibilities of your job are? 5 ☐

( ) 1 never ( ) 2 rarely ( ) 3 sometimes ( ) 4 rather often ( ) 5 nearly all the time

2. Not knowing what opportunities for advancement or promotion exist for you? 6 ☐

( ) 1 never ( ) 2 rarely ( ) 3 sometimes ( ) 4 rather often ( ) 5 nearly all the time

3. Not knowing what your nursing officer thinks of you, how she or he evaluates your performance? 7 ☐

( ) 1 never ( ) 2 rarely ( ) 3 sometimes ( ) 4 rather often ( ) 5 nearly all the time

4. The fact that you can't get information needed to carry out your job? 8 ☐

( ) 5 nearly all the time ( ) 4 rather often ( ) 3 sometimes ( ) 2 rarely ( ) 1 never

5. Not knowing just what people you work with expect of you? 9 ☐

( ) 5 nearly all the time ( ) 4 rather often ( ) 3 sometimes ( ) 2 rarely ( ) 1 never

6. Feeling that you have too heavy a workload, one that you can't possibly finish during an ordinary working day or night? 10 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
never	rarely	sometimes	rather often	nearly all the time

7. Thinking that the amount of work you have to do may interfere with how well it gets done? 11 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
never	rarely	sometimes	rather often	nearly all the time

8. Feeling that you have to do things on the job that are against your better judgement? 12 ☐

( ) 5	( ) 4	( ) 3	( ) 2	( ) 1
nearly all the time	rather often	sometimes	rarely	never

9. Thinking that you will not be able to satisfy the conflicting demands of various people over you? 13 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
never	rarely	sometimes	rather often	nearly all the time

II.

10. How clear are you about the limits of your authority in your present job? 14 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
not at all clear	not too clear	fairly clear	clear on most things	very clear

11. Do you feel you are always as clear as you would like to be about *how* you are supposed to do things in your job? 15 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
not at all clear	not too clear	fairly clear	clear on most things	very clear

12. Do you feel you are always as clear as you would like to be about *what* you have to do in your job? 16 ☐

( ) 5	( ) 4	( ) 3	( ) 2	( ) 1
very clear	clear on most things	fairly clear	not too clear	not at all clear

13. In general, how clearly defined are the policies and the various rules and regulations of the hospital that affect your job? 17 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
not at all clear	not too clear	fairly clear	clear on most things	very clear

14. On the whole, what do you think of this hospital as a place to work? 18 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5	( ) 6	( ) 7
a very poor place	a poor place	a rather poor place	a fair place	a good place	a very good place	an excellent place

15. Considering your job as a whole, how well do you like it? 19 ☐

( ) 5	( ) 4	( ) 3	( ) 2	( ) 1
very much	quite well	like somethings, dislike others	not much	not at all

IV

16. If you were completely free to choose, would you prefer to continue working in this hospital or would you prefer not to? 20 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
prefer very much to continue here	prefer to continue here	don't care either way	prefer *not* to continue here	prefer very much *not* to continue here

17. How long would you like to stay in this hospital? 21 ☐

( ) 1	( ) 2	( ) 3	( ) 4	( ) 5
for as long as I can work	for quite a while longer	for a little longer	I would like to leave soon	I would like to leave as soon as possible

18. If you had to leave work for a while (for example, because of pregnancy) would you return to this hospital? 22 ☐

( ) 5	( ) 4	( ) 3	( ) 2	( ) 1
definitely would not return	probably would not return	perhaps, but would look around first	probably would return	definitely would return

19. How likely are you to leave your job in the next 12 months? 23 ☐

( ) 5	( ) 4	( ) 3	( ) 2	( ) 1
definitely will leave	probably will leave	uncertain	probably will *not* leave	definitely will *not* leave

20. Why are you likely to stay or leave?

. . . . . .

. . . . . .

. . . . . .

V *Now, some questions about yourself*

21. In what year did you qualify as a SRN? . . . . . 24 25 ☐☐

22. Did you have any other full-time job prior to training as a nurse? 26 ☐

1. Yes ( )
2. No ( )

22A If yes, what sort of job was it?

. . . . . .

23. How many hours per week do you work? . . . . . 27 28 ☐☐

24. Are you a senior or junior sister? . . . . . 29 ☐

25. On what shift(s) do you usually work at present? 30 ☐

1. early shift only ( )
2. late shift only ( )
3. early and late shifts ( )
4. early late and split shifts ( )
5. a conventional day (i.e. approx 9 am–5 pm) ( )
6. nights ( )
7. other (please specify) . . . . . .

26. Have you been in continuous employment in nursing since qualifying, or have you had any breaks, that is spent more than 6 months at a time away from nursing? 31 ☐

1. I have never been out of nursing since qualifying ( )
2. I have had one break only ( )
3. I have had two breaks ( )
4. I have had three or more breaks ( )

27. How far do you live from the hospital? 32 ☐

( ) 1	( ) 2	( ) 3	( ) 4
less than one mile	1–4 miles	5–9 miles	10-miles or more

28. How do you find travelling to work? 33 ☐

1. easy or fairly easy ( ) 2. difficult ( )

28A If difficult, why is this? . . . . . .

. . . . . .

29. Have you any of the following *educational* qualifications? (tick yes or no and number obtained)

	1 *Yes*	2 *No*	30 *number obtained*	
A. CSE/GCE O Levels/ general matric	( )	( )	A. ( )	29A ☐ 34
B. GCE A Levels/higher grade	( )	( )	B. ( )	29B ☐ 35
C. degree	( )	( )	subject(s).....	29C ☐ 36
D. other (please specify)				29D ☐ 37
				30A ☐ 38
				30B ☐ 39

31. Have you any *professional* qualifications other than SRN? 40 ☐

A. 1. Yes ( )
2. No ( )
B. If yes, what are they . . . . . .

32. What is your marital status? 41 ☐

1. single ( )
2. married/co-habiting ( )
3. widowed/divorced/separated ( )

33. How many children do you have? 42 ☐

( ) 0 none ( ) 1 one ( ) 2 two ( ) 3 three ( ) 4 four or more

33A How old are your children, if any? . . . . . .

34. What is/was the occupation of your husband/wife/partner? (if housewife, unemployed, retired or student please indicate) 43 44 ☐ ☐

. . . . . .

35. What is your nationality? . . . . . 45 ☐

36. Finally, if you could go back to when you were at school, would you still choose nursing as a career? 46 ☐

( ) 1 yes ( ) 2 no ( ) 3 not sure

Thank you very much indeed for your help.

If you have any more comments to make about the questionnaire, or about points which have or have not been raised, please mention them here or on the back of the questionnaire.

ROLE CONFLICT AND AMBIGUITY SCALES

The statements listed below will describe some specific 'characteristics' about 'your particular job'. They appear as follows:

JOB CHARACTERISTIC	HOW TRUE
1 Having enough time to complete my work	
2 Knowing what my responsibilities are	

For each Job Characteristic, you are asked to give one rating using the following rating scale:

Rate how true the characteristic is of your particular job;

Definitely Not True of my Job	1	2	3	4	5	6	7	Extremely True of my Job

Read each characteristic, and select the scale number that best reflects your opinion. Enter the number you select in the column.

JOB CHARACTERISTIC	HOW TRUE
1 Clear, planned goals and objectives for my job.	
2 I have to do things that should be done differently.	
3 I know that I have divided my time properly.	
4 I receive an assignment without the manpower to complete it.	
5 I know what my responsibilities are.	
6 I have to bend a rule or policy in order to carry out an assignment.	
7 I work with two or more groups who operate quite differently.	
8 I know exactly what is expected of me.	
9 I receive incompatible requests from two or more people.	
10 I feel certain about how much authority I have.	
11 I do things that are apt to be accepted by one person and not by others.	
12 I receive an assignment without adequate resources and materials to execute it.	
13 Explanation is clear of what has to be done.	

JOB CHARACTERISTIC	HOW TRUE
14 I work on unnecessary things.	
15 I don't have much say or influence with my co-workers.	
16 I don't have much say or influence with higher management	

SISTER DEVELOPMENT GROUP

EVALUATION

OVERALL PLANNING AND GENERAL ORGANISATION SCHEDULE

The purpose of this questionnaire is to enable you to comment on the Sister Development Scheme.

If you find there is not sufficient space to complete your comments, please continue on a separate piece of paper.

The information you provide will assist the planning team to evaluate the scheme and make changes to future schemes as appropriate.

Thank you for your help and co-operation.

Please state,

1. How were you selected to come on the Sister Development Scheme?

2. What information did you have before the scheme commenced and how was it obtained?

3. Did you receive sufficient information before you commenced on the scheme?

YES

3a. If 'NO', what additional information would you have liked and why?

4. Did you understand the nature and organisation of the course before it commenced?

YES NO

4a. If 'NO' - what was it that you did not understand?

5. Were the study facilities adequate? YES NO

5a. If 'NO' - please state why and suggest how they can be improved.

6. Were the library resources adequate? YES NO

6a. If 'NO' - please say why and suggest how these can be improved.

7. Did you find the clinical facilitator helpful? YES NO

7a. Please give reasons for your answer.

8. Would you have liked more contact with the facilitators?

YES NO

8a. Please give reasons for your answer.

9. Were the visits to the clinical area useful? YES NO

9a. Please give reasons for your answer.

10. Were the discussions of your observation on the ward useful?

YES NO

10a. Please give reasons for your answer.

11. In general, did you feel that the theoretical content of the scheme was useful? YES NO

11a. Please give reasons for your answer.
(You will be asked to comment in detail on each component part of the scheme on the next form).

12. Have you found the contract work useful? YES No

Please give reasons for your answer.

13. Did you learn from discussion with your peers? YES NO

Please give reasons for your answer.

14. Having completed the course, do you think the objectives specified were:

realistic YES NO

achieved YES NO

If no - please state why and what could be done to obtain a 'YES' answer.

15. Has the course fulfilled your expectations? YES NO

If no - please give your reasons and suggest what could have been done differently to fulfil your expectations.

16. Was sufficient time devoted to ongoing evaluation during the scheme?
YES NO

If no - please suggest what could have been done to improve the situation.

17. Did the study days suit your requirements? YES NO

17a. If no - please give reasons for your answer. If possible, can you suggest alternative ways of organising the scheme.

18. Please comment on any aspect of the scheme that you feel might be of value to the planning team and future scheme members.

Thank you on behalf of the planning team for your help and co-operation.

MM/CML
28.7.86

SISTER DEVELOPMENT SCHEME

SCHEME CONTENT EVALUATION FORM

The purpose of this form is to help us to monitor the relevance and relatedness of the theoretical content of the scheme. Please be as objective as possible in your comments.

When evaluating this aspect of the scheme you may find it useful to consider the following points:

- the relevance of the sessions to:
  - (i) the scheme objectives,
  - (ii) your role as a sister.
- the appropriateness of the material covered to your level of knowledge and experience.
- the opportunity to ask questions and contribute to discussions.
- the clarity and speed of delivery of the information provided.
- the degree of interest stimulated in the topic and its relevance to your needs.
- the general organisation of the sessions and style of presentation.
- the value and use of any audio visual aids.

The above points are offered only for guidance. Please comment on any aspect of the theoretical content of the scheme that you think will be of value to the planning team.

Please write your comments overleaf. You may continue on a separate sheet if necessary.

APPENDIX 3a

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister A

At the commencement of the first observational visit there were five patients on the ward, two were later discharged and one patient was admitted. Four mothers were resident on the ward. The staff on duty numbmered five, and included Sister, one Enrolled Nurse, one first year pupil and a Nursing Auxiliary.

On the second visit there were seven patients and no resident mothers. The staff of five included Sister, three Enrolled Nurses and one Nursery Nurse.

During the first observational visit the staff on duty appeared to select their own patients and then commenced to give care without any reference to sister about what should be done or by whom. Nor did sister appear to give any direction to the staff. On the second occasion sister geographically divided the ward and allocated the staff to one or other half.

The care provided was primarily be a task orientation approach. Sister reported that 'individualised care' was not undertaken unless the 'patient' was being 'specialised'. Documentation of patient information appeared to be incomplete, the absence of written plans for care was evident. A 'Kardex' style description indicated the work of the different shifts and some of the comments were quite 'objective'.

The extensive use of 'routinisation' of care gave the impression of work being efficiently completed, but without any apparent concern for individuality of the patient.

The roles of the staff (qualified and unqualified) on both occasions appeared to be interchangeable with the exception of the administration of medicines which was by a trained nurse. This impression of interchangeability of roles was confirmed verbally by sister and staff.

Only on one occasion was a learner present on the ward during an observational visit and no formal or informal teaching was observed. Sister reported that teaching was done on an 'ad hoc' basis, learners were sent to watch specific activities and encouraged to ask questions and research the answers. The observer was also informed by the sister that she (when possible) and the trained staff worked alongside the learners. However, the trained staff on duty stated they did not always do this when learners were on the ward.

Sister appeared knowledgeable about what was happening in the ward, she did a round of the patients, checked information on charts and worked at times alongside the staff. No evidence was found to indicate the use of research in the formulation of nursing action.

A consultant ward round was conducted by sister whose opinions were observed to be sought and appreciated by the consultant. She was heard and seen to volunteer information when the junior medical staff appeared uncertain, she also corrected them if they were in error.

Sister gave the impression of being appropriately assertive, supportive and an effective communicator with her medical and nursing colleagues and of establishing a good rapport with her patients. Her relationship with some of the relatives appeared to be 'distant' and on one occasion was thought by the observer to adopt a rather 'superior' attitude - at other times she seemed helpful and constructive when offering advice.

Only one observer heard sister giving a report on the patient to the duty staff. The information given appeared informative and concise. However, the staff providing the care were not seen to participate in giving the report.

The style of leadership was thought to be authoritarian, sister made all the decisions on patient care and staff followed her orders; she was not seen to delegate responsibility other than issuing instructions for tasks to be undertaken.

The ward atmosphere appeared relaxed and happy and staff gave the appearance of working as a team with sister clearly in control. One observer questioned the degree of job satisfaction for the trained staff as they had little, if any, responsibility or involvement in planning care other than in sister's absence.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister B

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit	11	8	6	1	26
2nd Visit	10	5	7	4	26

Staff on Duty

1st Visit — Sister, 1 staff nurse, one student nurse and 4 nursing auxiliaries (one pupil nurse off sick).

2nd Visit — Sister, 2 staff nurses, 1 enrolled nurse and 3 nursing auxiliaries.

On both occasions sister was observed the nursing staff were split into three teams of two nurses, one team to each bay with a nurse in charge as co-ordinator. There was a poor mix of trained staff to learners and nursing auxiliaries.

Sister was seen to assess care by observing and talking to patients and by being present at the handover reports. Her assessment of priorities appeared appropriate, (e.g. round of all patients, preparation of ward round, allocation of staff, etc.). Sister was described as not being a leader and being ill at ease at times by one observer; and as able to communicate effectively and not a leader by second observer. Learning opportunities were seen not always to be utilised. Although learners were allocated to trained staff, they were not well supervised.

Sister appeared to have little interaction with students who played a positive role at report times. No formal teaching was observed but learners were reported to be encouraged to join ward rounds and make home visits with the occupational therapists.

The poor skill mix was thought to result in the nursing auxiliaries being given too much responsibility. The care was thought to be reasonably individualised, but rehabilitation and promotion of independence was not well planned nor provided.

Despite sister's effective use of her communication skills she was thought and seen at times to be indecisive and overshadowed by other members of staff. Relatives and patients on the ward were listened to attentively and were well supported by sister and her staff and liaison between disciplines was good, and in spite of the shortage of trained staff there was a good sense of team spirit and a pleasant atmosphere.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister C

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit	9	6	4	1	20
2nd Visit	7	6	5	0	18

Staff on Duty

1st Visit Sister, 2 enrolled nurses, 4 nursing auxiliaries.

2nd Visit Sister, 1 staff nurse, 1 enrolled nurse 3 nursing auxiliaries.

Sister divided the ward geographically in half and allocated the staff in a similar manner. The senior nurse for each half of the ward organised how the care was provided - (staff appeared to go round helping each other). Staff personalities influenced how sister allocated them; she (sister) felt it was important that staff got on well together, as there was no point in having antagonism.

The care provided was primarily by a task orientated approach. A work book was in use for TPR, bowels and treatments. Only the trained staff assessed patients needs, and wrote the plan of care. The observer's impression on both occasions suggested a lack of understanding about the philosophy of individualised care. The assessment of patients' needs and the

formulation of care plans when done were by the trained staff but the standard was variable. Both observers noted the vagueness of the patient goals and evaluative comments on the outcome of care. A 'Kardex style' written report was still in use.

The skill mix of staff was thought by the observers to be inadequate for the type of patients in that ward. (It was also acknowledged that this was outside sister's control). The ward appeared to be somewhat over stocked in the kitchen, (ordering was the responsibility of the ward clerk with whom sister said she had a difficult working relationship).

The ward was staffed by trained nurses and auxiliaries. Sister leaves the supervision and training of auxiliaries and junior trained staff to the more senior emembers of her staff, stating that with 'such variety of cases coming to the ward, she is not fully aware of how to treat them so feels inadequate to teach them'.

Sister was observed on both occasions to delegate respsonsibility for patient care to the trained staff. She stated that she only got involved with direct patient care when working on a late shift. There was no apparent evidence of sister checking on the quality of care provided, and during a conversation with an observer she stated she knew her staff well enough to trust them.

Sister appeared to give priority to the medical staff and private patients; on one occasion four consultants, a senior house officer and two registrars appeared at various times in the morning. On each occasion sister left what she was doing to attend to the medical staff, she seemed to update staff following each medical visit with relevant information. These constant interruptions left little time for sister to get involved with anything else. She appeared to have a good relationship with medical, para-medical and nursing staff. Her communication with the patients and relatives was good,

explanation provided seemed easily understood. Patients and relatives appeared to be kept informed of developments.

The only problem appeared to be between sister and the ward clerk with whom relationships appeared strained. This problem, according to sister, was compounded by the fact that they lived near each other.

The system of nurse to nurse reporting did not appear to the observers to be very efficient because sister always gave the reports, but accompanied the medical staff when they visited and took most, if not all, of the telephone enquiries. She was seen on one occasion to be interrupted nine times. Average report times 15-20 minutes from night staff to sister; sister to day staff 20-30 minutes. At the lunch time handover on one of the visits, sister gave two reports due to lateness of astaff member, on the other she kept staff waiting for 15 minutes before commencing.

The care plans were only referred to for the name of the patient, but not as a means of giving information about care needed.

Sister appeared to have a laisser faire style of leadership and at times appeared to be unassertive. The only times sister was seen to delegate was in relation to patient care. She appeared 'possessive' of the medical staff and patient relative enquiries.

The ward atmosphere seemed friendly and relaxed and staff appeared to work as a team. Sister stated that any conflict was quickly identified and dealt with.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister D

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit	3	8	14	1	27
2nd Visit	3	13	9	1	26

Staff on Duty

1st Visit — Sister, 1 staff nurse, 1 enrolled nurse, 1 nursing auxiliary and 3 student nurses.

2nd Visit — Sister, 3 staff nurses, 4 student nurses and 1 nursing auxiliary.

Sister's assessment of priorities seemed appropriate. One observer commented that sister is impulsive and does things as she thinks of them.

Sister divided the duty staff into two teams on both occasions she was observed, and stated that a geographical allocation was used on the late shifts, but patient allocation within the teams on early shifts. The reason given was the evening shift had far less nurses and a poorer skill mix. Assessments of patients were carried out by both trained staff and learners; learners' assessments were not specifically checked by mentor/trained staff. Completion of assessment sheets was very variable - some were well documented, others had virtually nothing written on them.

Nursing care plans were being used and staff were attempting to give reports using the care plans. Evaluation still very much 'Kardex' type report - often not related to identified problems.

Sister's knowledge of the nursing care given was obtained from handover reports, checking observation charts, and talking to and observing patients on her rounds and sometimes participating in patient care. She was well informed about patients' backgrounds and their nursing care and progress.

On neither occasion were learning opportunities seen to be fully utilised. One observer commented that there was little time for teaching of staff as staff appeared stretched to their limits, and no formal teaching was observed. At report time learners' questions were answered but the reports were not used for teaching. Although staff worked in teams there was minimal supervision of the learners. A modified mentor scheme was in operation.

Sister communicated effectively with all grades of staff, patients and relatives and was thought to be a democratic leader but who needed to be more assertive and direct at times. The staff worked well as a team and there was a friendly atmosphere evident on both visits.

Although Sister related well to learners, her contact with them was minimal during the observtions.

Handover reports were felt to be relevant, concise and informative with good multidisciplinary liaison evident.

At the time of these observations the workload/dependencies were high and because of the ward team not being a 'stable' unit - staff changes etc., - morale at times was said to be quite low.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister E

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit	3	8	9	3	23
2nd Visit	7	11	7	2	27

Staff on Duty

1st Visit Sister, 1 staff nurse, 2 student nurses and 2 pupil nurses.

2nd Visit Sister, 1 bank staff nurse, 2 enrolled nurses and 3 student nurses.

Sister allocated staff to bays, with a weekly rotation between the ends of the ward. The staff are allocated by the nurse in charge on late duty the previous evening.

The documentation of the patients' history/assessment was fairly well completed by both trained staff and learners, but learners' assessments were not countersigned by a trained nurse as correct. Problems were often identified verbally (during the report), but not seen to be recorded in the documentation.

Nursing goals were not clearly identified and, although the care plans were kept at the bedside, they were hidden by other charts. They were not seen to be referred to and were not used at report sessions. Evaluation of care was poor and not related to identified problems. The section on the patient's attitudes and relatives' understanding of their illness was very rarely documented.

Sister was not present during handover times and was thought to be unaware of the care given, or method and quality of care delivery. Nor did she ensure that the learner received feedback and supervision. Vital information from the morning's ward round was not passed on from sister at the handover report. The observer intervened and passed on this information.

A formal teaching programme was reported to be in the process of being developed with the teaching staff. Although a mentor scheme is in operation, learners were observed to be unsupervised for most of the visits.

Sister was felt to be helpful and supportive to patients and relatives. She does, however, have a problem with the consultant making rapid decisions over discharge/transfer, leaving little time for planning these events.

There was a friendly relaxed atmosphere and staff say that morale has improved in recent months (since sister's arrival).

Learners were felt to require more active supervision and support although they stated that sister and the trained staff were always available and approachable and they were not afraid to ask for information/advice. Most students enjoyed the allocation but did not always feel they had learned a lot.

The report system seen used by a trained nurse on both occasions was concise.

The ward rounds observed were quite time consuming and information from the round was not always passed on at the appropriate time by sister.

Use of research findings as a basis for care delivery were not apparent. No relevant articles were available on the ward, pressure sore scores were not updated in spite of changes in patients' conditions and plastic aprons were worn by some staff for most of the shift.

Although sister appeared to be 'in charge' her relaxed attitude gave the observers the impression that staff (all grades) were not as closely supervised as they perhaps ought to be.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister F

Patient Dependency Levels Not applicable

Number of Patients 1st Visit 12

2nd Visit 8

Staff on Duty

1st Visit Sister, 2 enrolled nurses (who had to leave the ward for an outpatient's appointment during the morning) and 2 nursing auxiliaries.

2nd Visit Sister, 1 staff nurse, 1 enrolled nurse (sent to help in another ward at 10.30a.m) and 1 nursing auxiliary.

Sister had a good knowledge of the patients and their requirements. She was well aware of the priorities and planned the use of her time effectively on the days she was observed.

The allocation of work was task orientated, depending on the experience and expertise of staff, (e.g. nursing auxiliary - bathing; trained nurse - drugs and dressings).

The nursing care was generally well documented, although some of the nursing instructions were imprecise, e.g. check vital signs on a regular basis; needs lots of encouragement. The care plans were not referred to by the staff and their evaluation of care did not demonstrate the effects of care/treatment on patients.

There were no nurse learners but the trained staff changed fairly frequently. Sister said she was interested in teaching and was devising a teaching plan for newly qualified or newly appointed trained staff to her ward.

She appeared well aware of what care was being given and was observed to continuously check and evaluate outcomes.

Sister was seen and thought to have excellent rapport with patients and relatives and demonstrated empathetic understanding.

There was an impressive display of information and health education material on the ward for both staff and patients to look at.

Sister was professional but friendly and approachable. She was clearly in charge but involved staff in decision making and was thought to be appropriately assertive. She is also cost conscious and encourages staff to be likewise. Expiry dates of drugs in cupboards are checked frequently and she ensures stock rotation.

Staff morale quite high. No formal appraisal was operational on the ward as yet but informal appraisal occurs.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister G

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit *	5	14	4	5	28
2nd Visit *	-	19	5	4	27
	(1)	(18)	(3)	(6)	

Staff on Duty

1st Visit — Sister, one staff nurse, one enrolled nurse, one 3rd year student and two 2nd year students, plus one staff nurse from 10 - 6.

2nd Visit — Sister, two staff nurses (1 bank), two 2nd year students, one (bank) enrolled nurse and a radiographer student from 9 - 5.

Sister divided the staff into two teams (one to each end of the ward). Students spent two weeks at each end of the ward, trained staff were deployed as appropriate to the demands of the patients and available skill mix.

Sister was observed to be knowledgeable about the patients and staff relayed information to her. She was in the ward area for considerable periods of the shift and gave the handover reports to staff.

*1st Visit — It was a busy morning with a ward round, two very ill patients were causing concern and sister was holding the bleep for the Unit.

*2nd Visit — There were two policemen on the ward during the whole of the observation period guarding a patient who had been arrested.

However, the nursing process documentation was not used well. Problems were not always recorded clearly on the care plan (even when identified in the progress notes), and care plans were not used at report. Activities of living were only recorded on about one third of the patients. The paper work did not appear to be given any credence by trained staff and students said that there was no motivation from trained staff to use the care plans. Paperwork completed by students was not checked by trained staff.

There was no mentor scheme in operation and no formal teaching programme evident but some teaching was observed during the report sessions and learning opportunities were often recognised and used by sister and staff.

Ward objectives, however, were not generally discussed and learners did not always feel supported. (The ward had been short staffed recently). Learners were felt to need more supervision and help in planning their work and assessing priorities. However, the ward was quite busy on both occasions.

Although the sister expressed the need for psychological support for patients and relatives, the patients' understanding of their illness was rarely seen documented.

Health Education literature was distributed to patients and there was a small nursing/medical library at the nursing station.

Sister was felt to be approachable and friendly. She contributed to the discussion during ward rounds and has a good relationship with senior and junior medical staff and para-medical staff. She was seen to be both pleasant and helpful to visitors/relatives and supportive to patients. (She said she often takes learners with her when she is counselling patients).

Learners said they felt that they have to ask questions to obtain information which was not readily forthcoming. Changes in nursing care, especially following consultant ward rounds, were not always passed on to the learners on the days the observers were present.

Sister did appear to 'label' patients, especially at report sessions, e.g., 'He is very demanding' and 'she is precious'.

The report was always given by Sister which she stated was normal practice when she was on duty. In total, the morning report on both observed occasions took one hour to complete. The nursing staff who gave the care did not report on their patients.

Sister was seen as the leader of the ward by her staff and she used a range of leadership styles as she felt the situation dictated ranging from autocratic to democratic.

The atmosphere was relaxed and staff appeared to work as a team, although the support to learners was felt to be inadequate.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister H

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit	4	16	8	2	30
2nd Visit	3	12	11	3	29

Staff on Duty

1st Visit Sister, 2 staff nurses, 1 auxiliary and 1 2nd year student.

2nd Visit Sister, 2 staff nurses, 1 student nurse and 3 nursing auxiliaries.

Sister divided her staff into two teams, taking into account patient dependencies and staff expertise. Allocation to patients was then done by the trained nurse in charge of the teams. Appropriate allocation was difficult on the second observation because of the high proportion of nursing auxiliaries.

Sister was seen on both occasions to make a round of the patients and reassess priorities of care accordingly on completion of the report session from night to day staff. However, care plans were not referred to during the periods of observation and the nursing process documentation was not always completed fully. Sister spent much of her time in the ward patient areas and was asked to see specific aspects of care by the staff. She saw all the patients on her ward round and sat in on the handover reports.

There was no mentor scheme operational at the time of these observations but all staff were described as approachable and helpful by learners who also reported that there were some formal teaching sessions provided (not observed) and that information about relevant nursing and medical techniques was readily available.

One observer witnessed a ward round with medical staff and reported that Sister was professional and knowledgeable and put the patients' and nursing viewpoint forward. She was also felt to be a good listener and was seen to communicate effectively with patients, relatives and all staff. Staff and patients found her approachable and supportive (according to their feedback). The ward reports heard were thought relevant and concise.

The staff worked well as a team and there was a supportive team approach. Sister was felt to be a democratic leader and quietly decisive.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister I

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit	6	6	11	1	24
2nd Visit	3	6	4	11	24

Staff on Duty

1st Visit — Sister, one enrolled nurse, two staff nurses and one nursing auxiliary (one staff nurse and the nursing auxiliary were sent from another ward).

2nd Visit — Sister, four staff nurses and two enrolled nurses. Two staff nurses were away from the ward for about 1 hour. (one on escort duties and one a job interview).

Both observers stated that the ward work was not well organised. Sister also said that she sometimes had difficulty in deciding priorities. Furthermore, no guidance was seen to be given to staff in priority setting by the observers. Allocation of staff appeared vague and unco-ordinated. The sister reported that when staffing was adequate nurses were allocated to bays of patients so that there was some continuity of care for patients but this was difficult to achieve sometimes because of poor and fluctuating staffing levels. The sister was observed not to check the care given, at report she listened to the handover, but played no active role in this activity.

The nursing process documentation and record keeping was poor and neither observer saw the care plans being used. Monitoring of patient's fluid balance (where necessary) was inadequate; intravenous infusions were behind time, hourly fluids not given.

Learning opportunities were not utilised and staff appeared stressed and under pressure. There was some research literature available on the ward. However, when one observer questioned some of the nursing practices, none of the staff questioned were able to give a clear explanation of the rationale for the care.

Neither of the observers witnessed a ward round but these were said to be very prolonged.

The atmosphere on the ward was tense and anxious, little support appeared to be given to the staff by the sister. A feeling of disharmony was present and spoken of by members of the staff. The observers felt the sister distanced herself from her staff.

Patients, however, were seen to be well supported by the sister and staff who were friendly and approachable towards patients and relatives.

The handover reports were informative but the morning reports took place at the nursing station where the environment was very noisy and there were many distractions and interruptions during the report. The lunch time handover was quite lengthy - 40 minutes.

There were no learner nurses on the ward and there was no formal appraisal for trained staff at present.

SUMMARY OF MAIN POINTS FROM OBSERVATIONAL VISITS

PRE COURSE

Sister J

Patient Dependency Levels

Category	1	2	3	4	Total Number of Patients
1st Visit	0	1	2	2	5
2nd Visit	0	0	0	3	3

Staff on Duty

1st Visit Sister, three staff nurses, two 3rd year students (supernumerary)

2nd Visit Sister, two staff nurses, one bank staff nurse.

Sister was seen to allocate work according to dependency of patients and experience of the nurses. The students worked with trained staff first, later they were allocated to a patient with help/supervision of trained nurse.

The method of nursing observed was described as individualised care with much verbal passing of information but poorly documented. Progress notes identified problems and gave detailed descriptions of patients' condition, progress and response to medical treatment. Because of the nature of the clinical area some aspects, for example doing off duty and maintaining equipment, were the responsibility of other sisters in the Unit. However, sister's ability to redeploy staff and resources to meet the changing demand of the Unit appeared appropriate.

Formal teaching sessions and study days were planned and two teaching sessions were observed. One was for learners and the other for trained staff. A lot was covered in the session for the student but there was some check on learning evident. Practical on the job teaching was also observed, i.e. demonstrated use of ventilators to new staff nurse. The mentor scheme was in operation.

Assessment by sister of priorities and knowledge of care given was good. She was observed to go round all the patients on two occasions to check with staff caring for the patients, and staff reported changes to sister. She also participated in the giving of care and assessed the level of care received and delivered by close observation and discussion with nurse and patient.

Up to date literature was readily available and appeared to be used in the provision of care.

No ward rounds occurred but liaison with two medical staff was observed during which information given regarding patients' condition was clear and assertive from sister.

She was observed to be quietly considerate and caring, adopting an appropriate posture distance. Active listening and empathic communications were observed when talking to bereaved relatives. She was seen as helpful to relatives and reassuring in her approach. Both learners and trained staff found sister approachable and professional, and staff appeared mutually supportive.

The nurse in charge of each patient gave the handover report. Those witnessed appeared to give concise and relevant information, although they made little or no use of the plans of care for the patients and much of this verbal information remained unrecorded.

Six monthly appraisals were carried out on all trained staff. Progress was initially discussed after new staff settled into the routine. Regular supervision was given until essentials were grasped.

Initial and half-way interviews were completed at appropriate times and involved other sisters. Sister was felt to be quietly authoritative and knowledgeable about what she was competent and in charge. She held immense credibility with colleagues, she used appropriate delegation and was diplomatic when checking on the care given.

The ward atmosphere appeared relaxed and pleasant. A team spirit was very much in evidence.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister A

I am a good ward manager most of the time and feel free to run my ward as I wish. I am organised and good at making decisions and delegating responsibilities. I am, however, at times a poor communicator.

My opinions are respected most of the time by medical staff and I am always approachable and willing to talk to relatives. I have confidence in myself but feel I sometimes lack knowledge about my own nursing speciality and I am sometimes insensitive to patient needs.

I am dependent on others and usually tolerant of their views. I am always supportive to my staff, working with them for most of the time. Willing always to try out new ideas.

I sometimes spend too much time in the office and on doing paperwork. I know what is expected of me and I am always satisfied with my job, but I feel I lack support at times from my manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister B

I am a good manager most of the time and feel free to run my ward as I wish. I am always organised and good at making decisions and delegating responsibilities, although sometimes a poor communicator.

My opinions are respected most of the time by the medical staff and I am always approachable and willing to talk to relatives. I have confidence in myself and rarely feel I lack knowledge about my own nursing speciality or sensitivity to patient needs.

I am dependent for most of the time on others and usually tolerant of their views. I am always supportive to my staff, mostly working with them and being willing to try out new ideas.

Mostly too much time is spent in the office and I am always doing too much paperwork. I know what is expected from me and I sometimes feel dissatisfied with my job and unsupported by the manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister C

I am a good ward manager most of the time and feel free to run my ward as I wish. Although I am always organised and good at delegating responsibilities I am not always good at making decisions or communicating.

My opinions are respected most of the time by the medical staff and I am always approachable and willing to talk to relatives. I sometimes lack confidence in myself and am not always knowledgeable about my nursing speciality and sometimes insensitive to the needs of patients.

I am always dependent on others and tolerant of their views. Sometimes I work with the staff and I am always supportive to them, and willing to try out new ideas.

Mostly I spend too much time in the office and on doing paperwork. I know what is expected from me and I am satisfied with my job, but feel unsupported at times by the manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister D

I know what is expected from me and am free to run my ward as I wish, but feel at times I am not a good ward manager. I am mostly organised but am sometimes poor at making decisions, delegating responsibilities and communicating with others.

My opinions are respected by the medical staff and I am approachable most of the time and always willing to talk to relatives. I sometimes lack confidence in myself, feel that I may at times lack knowledge of my speciality and be insensitive to the needs of patients.

I am always dependent on others and tolerant of their view. Sometimes I work with the staff and am supportive to them on most occasions, always being willing to try out new ideas.

I am spending too much time in the office and on doing paperwork. I know what is expected of me and I am satisfied with my job but feel unsupported at times by the manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister E

I am a good manager most of the time and feel free to run my ward as I wish. I am usually organised and good at making decisions and delegating responsibility. Sometimes I am a poor communicator.

I feel my opinions are not always respected by the medical staff and at times lack confidence and knowledge of the speciality I am now working in. I am always approachable and willing to talk to relatives, but sometimes I am insensitive to the needs of patients.

Sometimes I am dependent on others and am usually tolerant of their views and supportive to them. At times I work with them but am not always willing to try out new ideas.

I do not think I spend too much time in the office but there is too much paperwork. I know what is expected of me and I am mostly satisfied with my job but feel unsupported by my manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister F

I am a good manager most of the time and always free to run my ward as I wish. I am usually organised and good at making decisions and delegating responsibility, although at times I am a poor communicator.

My opinions are mostly respected by the medical staff. I am usually approachable and always willing to talk to relatives. I am confident and rarely lack knowledge of my specialist area or sensitive to the needs of my patients.

I am rarely dependent on others but am tolerant of other views. I am supportive to my staff and sometimes work with them, always willing to try out new ideas.

I do not think I spend too much time in the office but there is too much paperwork to do. I know what is expected from me and am mostly satisfied with my job and supported by my manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister G

I am a good manager most of the time and feel free to run my ward as I wish. I am usually organised and good at making decisions, delegating responsibilities and communicating with others.

Most of the time my opinions are respected by medical staff and I am always approachable and willing to talk to relatives. I am confident although sometimes I lack knowledge of my specialist area, but I rarely lack sensitivity to the needs of my patients.

I am rarely dependent on others, but am tolerate of other's views. I am supportive to my staff and sometimes work with them, but not always willing to try out new ideas.

I sometimes spend too much time in the office and on doing paperwork. I know what is expected of me and am mostly satisfied with my job and the support of my manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister H

I am a good manager most of the time and free to run my ward as I wish. I am usually organised and good at making decisions but not at delegating responsibilities. I am also at times a poor communicator.

I am always approachable and willing to see relatives and my opinions are respected by medical staff. I rarely lack knowledge of my specialist area and am confident and sensitive to the needs of my patients.

I am sometimes dependent on others and tolerant of their views. I am supportive to my staff and sometimes work with them and am usually willing to try out new ideas.

I rarely spend too much time in the office but there is too much paperwork to do. I know what is expected of me and I am mostly satisfied with my job. I also feel supported by my manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister I

I am a good manager most of the time and free to run my ward as I wish. I am usually organised and good at making decisions and delegating responsibility, although at times I am a poor communicator.

My opinions are usually respected by the medical staff and I am mostly approachable and willing to see relatives. I feel confident and rarely lack knowledge of my specialist area or sensitivity to the needs of my patients.

At times I am dependent on others, and always tolerant of the views of others. I am supportive of my staff and always work with them; and willing to try out new ideas.

I rarely spend too much time in the office or doing paperwork. (I mostly do it at home). I know what is expected of me and am mostly satisfied with my job but feel unsupported by the manager.

SISTER'S SELF PERCEPTION PROFILE

BASED ON RESPONSES TO ROLE, OPINION QUESTIONNAIRE AND VERBAL CONFIRMATION

Sister J

I am a good manager, free to run my ward as I wish. I am always a good communicator, and usually organised and good at making decisions and delegating responsibilities.

I am always approachable and willing to see relatives and my opinions are usually respected by the medical staff. I rarely lack knowledge of my speciality and am confident and sensitive to the needs of my patients.

I am mostly dependent on others and always tolerant of the views of others. I am always supportive to my staff, working with them and am willing to try out new ideas.

I never spend too much time in the office but sometimes have to do too much paperwork. I know what is expected of me and am mostly satisfied with my job, but at times feel unsupported by my manager.