THE ROLE OF THE WARD SISTER IN THE MANAGEMENT OF NURSING
A STUDY OF THE ORGANISATION OF NURSING ON AN
INDIVIDUALISED-PATIENT BASIS

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I declare that this thesis is my own work
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ABSTRACT

A method is described of identifying ward sisters who manage ward nursing on an individualised patient basis. The study draws on organisation and management theory. Fifty sisters were observed for completion of a daily nursing management cycle in relation to each patient and each nurse. A classification of the total daily activity of the ward sister based on the concept of role differentiation was developed. The methods of data collection were interviews and continuous observation.

A minority of the sisters managed the nursing on an individualised patient basis. The degree to which the ward sister completed the management cycle activities was proportionately related to the extent to which the nursing was organised in relation to individual patients and nurses. Exercise of a formal managerial role was associated with high role differentiation. Characteristics of sisters identified as managers included academic qualifications and professional post-basic training which exceeded the sample average, and evidence of learning from role models rather than from formal management training.

The findings on the non-management of ward nursing are related to aspects of management theory, and to recent changes in the senior nursing management structure. It is concluded that the ward sister does not have the minimal managerial authority deemed necessary to exercise a managerial role. The relationship between management of the nursing and individualised nursing of patients is discussed. Implications for the development of the role of the ward sister and research arising from the present study are outlined.
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Introduction

The problem studied in this research was that of organising ward nursing on an individualised patient basis.

The researcher had a special opportunity to think about the organisation of nursing at ward level as a ward sister member of the Committee on Nursing (Department of Health 1972) which reviewed the role, education and deployment of the nurse. Nurses and others who submitted evidence to the Committee deplored evidence of depersonalised ward nursing and the prevalence of nursing organised on a task basis which 'at its worst reduced the patient to a series of functions' (p. 40). Many of the recommendations to the Committee centred on the need for nursing to be defined in terms of the individual, and for nursing activity to arise from the considered needs of individual patients.

Returning to work as a ward sister, the researcher tried to apply some of the thinking of the Committee on Nursing in the ward situation and to introduce more individualised patterns of ward nursing (Pembrey 1975). The questions and problems were numerous. What was meant by the term 'individualised nursing' and how was it recognised? Was it the way in which individual nurses behaved towards their patients; the way in which nurses were physically deployed in the ward; the way in which the work was allocated, for example, in terms of patients instead of tasks. What was the role of the ward sister in the achievement of individualised nursing? What resources and authority did she need to introduce changes in ward nursing practice?

The need to understand the process involved in individualised nursing became more apparent with the publication of the Study of
Nursing Care research series by the Royal College of Nursing; a number of reports described ward nursing which was non-individualised
Hamilton-Smith (1972), Lelean (1973), Wright (1974), Jones (1975). The need for a holistic approach to the study of ward nursing and a
study of the processes involved was identified through a number of
the reports. In the concluding monograph Inman (1975) described a
possible approach and emphasised the need to study ward organisation and the planning skill of the sister: 'Unless this is done it is
hardly possible either to look backwards to the causes of variations in
care or to look forwards to their effects' (p. 102). The 'planning
skill' of the ward sister became the focus of the present study on the
problems of organising ward nursing on an individualised patient basis.

Introduction to the literature review

The literature review is in three chapters. In the first chapter aspects of organisational and management literature are reviewed. First,
on the interrelationship of organisational environment, management
systems and different forms of work organisation; second, on the nature of managerial and supervisory role. These concepts are then examined in relation to ward nursing and the managerial role of the ward sister, especially as it was defined by the Committee on Senior Nursing Staff Structure (Ministry of Health 1966). The nursing concept of patient individualisation is reviewed in Chapter 2. The application of management theory to the organisation of nursing on an individualised basis is discussed.

Chapter 3 consists of a review of the role of the ward sister in relation to the wider hospital organisation, and the effect of recent organisational changes on her role. The chapter concludes with a brief review of developments in post-basic nursing education and the training needs of the ward sister.
Chapter 1

SOME ASPECTS OF ORGANISATION AND MANAGEMENT
THEORY IN RELATION TO THE ROLE OF THE WARD SISTER
The ward sister achieves nursing work within a complex organisation - a hospital. The environment of an organisation, its internal structure and organisational roles all affect the behaviour of the individuals within it. In particular, management systems, that is, means of 'organisation of individuals' behaviour in relation to the physical means and resources to achieve the desired goal' (Pugh 1971) affect organisational outcomes.

Ward nursing can be viewed as a sub-system within the complex organisation of the hospital. In turn, the ward is affected by its environmental influences, management system and structure of individual work roles. Each of these will now be considered in turn.

Organisations and their management systems are affected by the environment in which they are placed and recent organisation theory has been concerned with the nature and importance of organisational environment (Eldridge and Crombie 1974). The concept of environment is the differentiating factor between a closed or open approach to organisations. Early work did not include the concept of environment and was concerned only with the different aspects of internal organisation; that is, with closed systems. Thus Taylor (1919), founder of Scientific Management or 'task' management as he termed it (p. 30), was concerned with developing scientific laws in relation to efficiency of work performance through extreme sub-division of labour and the relationship between workers and management. Weber's work (1947) on legitimate authority and bureaucracy was concerned with the internal structure of organisations in relation to rational decision making and administrative efficiency; in particular with concepts of
specialisation, hierarchical authority structure, and formal systems of rules. The early work of the Human Relations School (Mayo 1949), was concerned with the internal social system; with group dynamics, attitude change and leadership styles.

The development of the concept of environment established a framework within which different stances, for example, the work of Blau and Scott (1963) on bureaucracy and the work of Argyris (1957) on individuals within organisations, could be interrelated (Silverman 1970).

The importance of environment as a dimension of organisation is formalised in the systems approach; in particular in the concept of open systems. A system is a set of interrelated parts, each of which is related to every other part. Both the hospital itself and the wards within it can be regarded as open systems which are interrelated and react upon each other, as well as in relation to the wider health care system of which the hospital is a part.

The idea of organisations or enterprises as open systems stems from the biological principle that an organism can only exist by exchanging materials with its environment. As Miller and Gwynne (1972) say:

'... An open system imports materials; it transforms them by means of conversion processes; it may consume some of the products of conversion for the purposes of internal maintenance and it exports the rest. These import, conversion and export-cum-exchange processes are the work the enterprise has to do if it is to live'. (p. 10) 

Further, open systems differentiate and grow by means of exchange processes with their environment. Thus the interplay between the intake of resources, the activities and the output of an enterprise make it a
living, dynamic system.

Different types of systems have been identified. The work of Burns and Stalker (1961) page 7, and the work of Trist et al. (1963) page 8, are examples of the study of socio-technical systems. Menzies' study of hospital nursing (1960) page 47, is an example of the socio-psychological approach to the study of systems.

Work on different types of environment is also relevant to the present study in that hospitals are affected by, and have to adapt to, changing environments. Emery and Trist (1965) present a typology of four ideal type environments which are differentiated by qualitative differences in their 'causal texturing'. Causal texturing is the way in which elements of the environment are interrelated with one another; these properties of the environment itself condition the possible interaction between the organisation and its environment.

The typology of Emery and Trist is arranged according to the increase of relative uncertainty that changes in the environment cause the organisation. The first two types are relatively simple, the environments being stable and non-active. The third type, 'the disturbed reactive' environment, requires adaptive behaviour on the part of individual organisations if they are to survive; it is the type which corresponds to the level of the complex environments of industrial societies.

The fourth type, the 'turbulent' environment, is differentiated by the fact that dynamic processes are occurring within the environmental field itself. Advanced societies are experiencing turbulence in their widest environments, for example, the effect of pollution on ecological balance, but also in lesser areas such as industrial
relations and the economy. Turbulence within the environment itself increases the uncertainty and difficulty of organisations trying to adapt to the environment. The instability of the environment requires constant adaption on the part of the organisation as adaption is crucial to survival, but the required rate of adaption and development, is such that the organisation becomes disorientated and vulnerable.

Burns and Stalker (1961) studied management systems in relation to their environments; in particular, how organisations operating complex technologies within rapidly changing and unstable environments have adapted. The comparative work of Burns and Stalker on management systems appropriate to different environments is of importance in the present study. It will be shown that ward nursing takes place within a highly unstable work environment and that this in turn determines the appropriate form of management and work organisation (p.192). Burns and Stalker found that successful adaption to environmental instability was characterised by 'organic' management systems in contrast to 'mechanistic' forms of management which were appropriate for stable conditions. These two ideal types of organisation (Burns 1963) represent the closed bureaucratic model in the mechanistic system and the open model - which incorporates the environmental dimension - in the organic system.

The mechanistic system, which is appropriate to a stable environment, is a hierarchical model based on specialisation. It is characterised by a structure of control, vertical communication, and specialist knowledge located at the top of the organisation; loyalty and obedience are conditions of continued membership of the organisation. This
mechanistic system was the form of management recommended by the Committee on Senior Nursing Staff Structure (Ministry of Health 1966). The appropriateness of this recommendation in the light of work such as that of Burns and Stalker and the known environmental instability of hospitals, is discussed on page 27.

The organic form of management which Burns and Stalker found appropriate to an unstable environment, is non-hierarchical, with emphasis being given to the contributive nature of special knowledge and experience to the common task. There is a network structure of control, and communication consists of information rather than instruction; knowledge may be centred anywhere in the organisation, this location becoming the centre of authority. Responsibility is diffused and commitment to the task of the organisation is more highly valued than loyalty. This organic form of management is associated with the emergence of more autonomous roles at different points within the organisation and is discussed in relation to the future role of the ward sister (p.240).

The concept of organisational environment has been explored not only in relation to forms of management but also in relation to work organisation and individual work roles. Research into the British coalmining industry (Trist et al. 1963) was undertaken throughout the 1950s by the Tavistock Institute of Human Relations. Coalmining was viewed as a socio-technical system; that is, a productive system which requires both a technological organisation and a work organisation which relates the different members who carry out the various tasks. The particular technical demands limit the type of work organisation possible but this work organisation also has independent social and psychological properties.
The authors first developed concepts to describe work organisation; they then compared two different forms of work organisation which had evolved within the same technology, and in particular the way in which these forms had adapted to the highly unstable environment of the coal face. Finally, they examined the effect of different forms of work organisation on management. The concepts developed by Trist et al. to describe work organisation included the primary task; the work the production system has to perform; work is the key transaction which relates the operating group to its environment, and thus the primary task is defined as 'the daily completion of a production cycle under all the conditions that prevail' (p. 20). The primary work group is the smallest group whose members carry out the whole set of activities constituting the daily cycle.

The activity structure comprises work roles; the jobs which people do every day and with which they become identified. The division of tasks, skill levels, the permanency of the work group and the level of disorganisation due to environmental interference are all factors which affect the quality of individual work roles.

The study proved invaluable in the present study of ward nursing. Ward nursing, like coalmining, can also be viewed as a socio-technical system which involves both technical and social organisation. In particular, the work of Trist et al. had developed ways of studying the interrelatedness of a disturbed environment, the organisation of the primary work group and the system of management. In ward nursing the primary task - the daily nursing of patients - is also carried out within a disturbed environment which makes the production task more liable to disorganisation and requires particular forms of work.
organisation and management to complete it. Thus in the present study the effect of the environment on the ward sister's own work and the way in which she organised the ward nursing team was taken into account. Concepts developed by Trist et al. were also used to describe the work roles of ward nurses (Melia 1978), in a study which complements this study of the ward sister's role.

The alternative forms of primary work group organisation open to the ward sister are differentiated in nursing as 'task allocation' or 'patient allocation'; task allocation is considered the more common method (Chapter 2). The ward sister can allocate each nurse single tasks which the nurse performs on a sequential basis for patients throughout the ward; alternatively the ward sister can allocate each nurse a group of patients; the nurse is then responsible for performing all the tasks that each patient requires. These two forms of single-task or multi-task nursing work roles have parallels in the two forms of the conventional (single-task) or the composite (multi-task) work roles of coalmining. The two different forms of work organisation are now discussed.

Trist et al. studied three systems of coalmining; traditional single place working; partially mechanised systems and systems at higher levels of mechanisation. Each production unit was considered as a socio-technical system. The comparative study was of two radically different forms of primary work group organisation, the 'composite' and the 'conventional', which had developed under the same technological and environmental conditions.

Characteristics of the composite, multi-skilled, form of work organisation are discussed first. In this form of work organisation the face workers accepted responsibility for the entire cycle of operations;
there was recognition of the interdependence of one man or group on
another for the effective progress of the cycle; there was self
regulation by the whole team and its constituent groups. This self
regulation meant that the work group had the autonomy to respond to
the constantly changing conditions of the underground situation and
thus demonstrated, according to the authors, the appropriateness of
its social structure. The composite multi-skilled work role was
the traditional role of single place workers, but was also found to
have been adapted to mechanised systems through the retention of
multi-skilled roles and internal self regulation within group working.
The authors believed that composite systems of working had evolved
over many generations to cope with the stresses and instability of the
coalmining environment.

The characteristics of the conventional single-task form of work
organisation, which is similar to task allocation in ward nursing, were
of a formal division of labour with specialised tasks carried out by a
number of groups. These over-specialised work roles and the
segregated groups prevented internal self regulation by the face team.
The authors regarded the conventional pattern of work organisation as
a divergent development; they argued that the adoption of the single-
task (one man - one task) method of the conventional pattern, compared
with the multi-skilled, self contained work role of the composite
method, was not justified by the increased technology, and that this
organisational influence from manufacturing industry was inappropriate
to the coal face. Further, the reason for this imposition and the
failure to make constructive use of certain features of the older
tradition was a failure to understand the interrelatedness of the task
and the environment.
Trist et al. state that there are two important and distinct tasks at the coal face. There is the specific task belonging to the production cycle but also the task of contending with the environment:

'... ability to contend with this second or background task comprises the common fund of underground skill shared alike by all experienced face workers. This common skill is of a higher order than that required simply to carry out, as such, any of the operations belonging to the production cycle'. (p. 47)

Production cycle tasks require relatively short training periods:

'... but the specific mining skill of contending with underground conditions, and of maintaining a high level of performance when difficulties arise, is developed only after a number of years at the face. A work system adapted to the underground situation must build this experience into its organisation, otherwise it will fail to engage the face worker to the limit of his capabilities and indeed restrict his performance'. (p. 47)

The ability of the composite groups to be self-regulating, to control themselves internally, meant that they could contend with the environment successfully.

'... The common fund of underground skill and the common identity of being a face worker have been made primary; the different skills appertaining to the different skills of the production cycle have become secondary. The emphasis of the conventional system has been completely reversed'. (p. 77)

It is known that mechanised environments require more composite forms of primary work group organisation (Woodward 1958). The effect of technology on nursing work organisation has been discussed by Brown (1976). Trist et al. noted that:

'... where coal face operations have become comprehensively mechanised, work groups have wider autonomy, greater powers of self regulation ... fuller commitment to more holistic tasks'. (p. 104)
Further, these composite forms of working required increased capacity in the workers themselves; a better understanding of the system as a whole, a wider use of discretion and increased conceptual skill. The primary work group required 'more of the judgement ... of the professional in addition to the usual underground skills' (p. 104).

The composite form of work organisation, more able to adapt to its changing environment than the conventional system, was found in the comparative study to be related to productive effectiveness, low cost, work satisfaction, good relations and social health (p. 291). Thus, to take just two of the indicators, production levels in the conventional system in terms of output per manshift at the face yielded 3.5 tons and the composite 5.3 tons. Absence rates including sickness and accidents, ran at 20% for the conventional and 8.2% for the composite system. The conventional results were considered the norm (p. 126).

The final aspect of the coalmining study to be described is the relationship between the formal management system and the primary work group. The formal management system in coalmining, as in nursing, was external to the operational environment although some management of supplies and manpower took place at the coal face. The authors found that the degree of internal managerial control was a key factor in determining the way in which the formal, external management system could work; the degree of managerial control was in turn related to the capacity of the primary work group to achieve self regulation. It has already been noted that the basic difference between the composite and conventional forms of work organisation was their ability to be self regulating.
Traditionally, management had stood in a service relationship to single place working as the groups were self regulating and co-ordinated themselves at face level. The failure of the conventional groups to achieve self regulation meant that control had to be external to the face groups, and the burden of ensuring continuity of tasks and counteracting cycle disfunction was carried by management officials. This, however, could only be done inadequately because the officials were removed from the operational environment; coercive control was inappropriate to the particular dangers of coalmining and formal lines of executive control further removed management from the coal face. Without a foundation in group self regulation, management lacked the means to weld the task groups into an effective cyclical whole - in a sense to manage.

In contrast, the self regulation of the composite teams allowed management to retain their traditional service relationship to the primary work group, which maximised successful completion of the cycle. The primary work group itself took responsibility for regulating work in the face of environmental interference, as well as responsibility for completion of the production cycle, if necessary by giving priority to crucial tasks. The increased autonomy of the composite work group exerted an upward pressure on the management system which in turn had to adapt its own role as the level of tasks was pushed up. Trist et al. suggest that the interdependence of the different roles caused by the emergence of a self regulating primary work group, and the move to a service giving relationship by management, undermined the traditional division of managers and the managed. This thinking is similar to that of Burns and Stalker (p. 7) and other work on the emergence of
organic systems of management (p. 35).

The research of Trist et al. (1963) on coalmining is now discussed in relation to the present study. In the coalmining study the authors concentrated on the effect the composite and conventional systems had on the formal management system. In the present study the focus is reversed; it concentrates on the management system of the ward sister and how this affects the organisation of the ward nursing team. Both approaches, however, concentrate on the interactive nature of the systems. The findings of Trist et al. were of help in clarifying the relationship of the ward sister to both the subordinate ward nursing team and the superordinate senior nursing management structure; the ward sister is at the dividing line of 'the manager' and 'the managed'. This ambiguous position of the ward sister is underlined by her geographical location within the hospital; thus, although the ward sister is a designated first line manager and part of the formal nursing management structure (p. 27), she is the only manager who works within the operational environment. The ward sister is therefore very close to the primary work group - and indeed is often part of it (p. 165). It will be shown that there is confusion both in theory and in practice as to whether the ward sister is a manager or a member of the primary work group; and that the ward sister's perception of her role affects the way in which the nursing is organised.

The final application of the coalmining study to the thinking behind the present study was the distinction between self regulating and non-self regulating primary work groups. It has already been noted that there are similarities between the single-task roles of the conventional coalmining system and the single-task roles of nursing task
allocation, as well as between the multi-skilled roles of the composite coalmining system and patient allocation systems in nursing.

It was believed that the distinctive feature of non-self regulation and self regulation in the conventional and composite forms of work organisation would be paralleled in the nursing systems of task and patient allocation. The present research has tried to relate the findings of Trist et al. on self regulating forms of work organisation to management theory on work organisation (p. 20). In this way it was hoped to describe the process through which the ward sister achieved a self regulating primary work group. The evidence from the comparative study of Trist et al. was that a self regulating primary work group would be more able to contend with the unstable ward environment and inherent disruption of nursing work, and more able to respond to patients as individuals, than a non-self regulating work group whose work was governed by cyclical task performance.

The internal structure of organisations

While the socio-technical study of coalmining by Trist et al. (1963) was helpful to the present study, there are limitations to the socio-technical systems approach. In particular, Silverman (1970), argues that there is a lack of sociological perspective and that the perceptions of the participants of the organisation, as opposed to those of observers, are often underrepresented in systems analysis. Further, the participants' perceptions are an important link between organisational structure and organisational behaviour (p. 218).
The value of participants' perceptions Silverman suggests, was demonstrated by Burns and Stalker (1961) who initially stressed the demands of the environment on the organisation but ultimately turned to the perceptions of the participants to explain organisational change. In particular, Burns and Stalker identified the 'capacity of the managers to lead', that is,

'... to interpret the requirements of the external structure and to prescribe the extent of the personal commitments of individuals to the purposes and activities of the working organisation', (p. 96)
as a factor influencing organisational form. This observation on the need for leadership can be applied to the ward sister as leader of the ward nursing team.

The influence of institutional leadership is emphasised by Child (1972):

'... environmental conditions cannot be regarded as a direct source of variation in organisational structure, as open system theorists often imply. The critical link lies in the decision-makers' evaluation of the organisation's position in the environmental areas they regard as important, and in the action they may consequently take about its internal structure'. (p. 10)

As Eldridge and Crombie (1974) note:

'... individual leaders or members of the dominant coalition have the capacity to exercise strategic choice and to deliberately modify organisation - environment interrelationships, either by modifying the environment itself, or by altering the technology, structure, size, or human relationships of the organisation'. (p. 81)

Thus a more precise frame of reference, as well as open systems theory, is required to examine individual roles within organisations and the nature of managerial and leadership roles; it is therefore necessary to turn to work on the internal structure of organisations.
The concentration up to this point on the extra-organisational aspects of organisation, has been an attempt to emphasise the importance of environment in any study of hospital nursing and the relatedness of extra and intra-organisational factors.

In reviewing work on the internal structure of organisations a sociological perspective is taken and the emphasis is placed on aspects of managerial role. The concept of role, in its simplest form, constitutes a cluster of rights and obligations. Banton (1965) says:

'... a role maybe understood as a set of norms and expectations applied to the incumbent of a particular position. A psychological approach is likely to concentrate upon how these ideas are held by individuals. The structural approach traces the way the sharing of norms and expectations creates networks of rights and obligations'. (p. 29)

Because social structures are becoming increasingly complex and circumstances change more rapidly than rules, 'it regularly happens that individuals have to play two or more roles that do not combine well' (p. 167); this is termed "role conflict" and Banton suggests 'it is possible that with the increasing complexity of social life the incidence of role conflict is increasing' (p. 168).

The following section on organisational role draws in particular on the work of Brown and Jaques (1965), which started in 1948 as the Glacier Project. Although the original study was made in an industrial organisation, the concepts have been explored by others (Newman and Rowbottom 1968), and have been tested in a range of organisations, including the Health Service (Department of Health and Social Security 1972), (Rowbottom et al. 1973). Overall, the aim has been to apply rigorous analysis of organisational relationships to the solution of organisational problems (Newman and Rowbottom, p.V).
A framework to the work mentioned above is provided by Newman and Rowbottom (1968). The authors stress that a rigorous definition of concepts of organisational structure, which is the purpose of their book, is not incompatible with a holistic approach to the study of organisations, such as the approach discussed on page 8. Newman and Rowbottom consider the executive system — in their analysis a complex system of co-operating power groups — as an organism required to come to terms with the different elements of its social environment in order that it might survive and promote its aims (p. 103).

Concepts of organisation structure are examined by the authors both in terms of the behaviour and roles of the individual and in terms of the whole organisation, these two aspects being seen as interactive. Thus an organisation is a system of people in a structure of work roles — the executive system. The executive system includes people in roles at all levels, and is the means whereby the work of the organisation is carried out (p. 2).

The work roles occupied by people in the executive system comprise three elements: first, prescribed work content; second, authority and third accountability. The corresponding elements or features that the individual brings to the role are capacity, power and responsibility, thus:

<table>
<thead>
<tr>
<th>Feature of role</th>
<th>Corresponding feature of individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed work content</td>
<td>capacity</td>
</tr>
<tr>
<td>authority</td>
<td>power</td>
</tr>
<tr>
<td>accountability</td>
<td>sense of responsibility</td>
</tr>
</tbody>
</table>

(Newman and Rowbottom 1968, p. 28)
These concepts of executive role are crucial to the design of the present study. The managerial role of the ward sister will be examined in terms of its prescribed work content; the managerial authority the ward sister actually has and some implications of her managerial accountability in relation to the nursing of patients. In turn, and related to the defined managerial role of the ward sister, the focus of the study will be on how the ward sister herself defines the work role of each nurse in the ward team; that is, how the ward sister prescribes the work, how she delegates authority to work and how she exacts accountability for nursing work. The way in which the ward sister defines individual work roles will be related to the way in which the nursing is organised on an individualised patient basis.

The functions of work prescription, the delegation of authority and the exactment of accountability in relation to the achievement of work in organisations are now examined in relation to the original work of Brown and Jaques (1965).

A central aim of organisation is to facilitate work (Pugh 1971, p. 10). The common characteristic of human activity classified as work is that it is directed to goals above and beyond the immediate activity itself. Differentiation between the desired end or goal and the immediate activity gives rise to the possibility of there being a variety of ways of reaching the goal, there is a situation of choice. In this situation of choice the person who is doing work, is involved in a mental process which generates feeling of effort and concern. This mental process in work is termed, by Jaques (1965), the "exercise of discretion". He suggests that work involves such things as forming perceptions of working environment, searching for usual mental associations and models
and evaluating possible courses of action (p. 74). The final outcome of the mental process, the exercise of discretion, is that the performer takes objectively observable action resulting in observable changes in the environment, moment by moment (Newman and Rowbottom 1968, p. 18).

The ability of the individual to carry out particular work is his capacity. Capacity implies not only inherent ability but also the ability to apply that capacity, which is demonstrated in work performance. Thus capacity and levels of capacity are different from such concepts as expertise or skill. In his paper 'Mental processes in work (1965)' Jaques analyses work capacity as the continuous working through of the attendant anxiety of exercising discretion; capacity is demonstrated by the ability of the individual to handle anxiety and achieve reality, to make the unconscious conscious (p. 75).

In organisations, work prescription is the way in which the organisation harnesses individual capacity to achieve organisational goals (Newman and Rowbottom 1968, p. 20). The handling of the relationship between prescribed roles and individual capacity is one of the most important issues in organisations. Without some prescription of individual function, the people who work will not be able to achieve co-ordinated action which is the purpose of organisation.

There is, however, a dilemma in the marriage of the concepts of prescription and of the exercise of discretion in that prescription is the antithesis of discretion; yet individual capacity to exercise discretion is the unique resource the organisation needs to achieve its goals. Resolution of the dilemma is achieved by determining the correct limits which should be placed on the individual's freedom to
exercise discretion; ideally, the role prescription should match the individual's capacity to work.

It is necessary to turn to the source paper 'What is work?' (Brown 1965), to understand the importance of the relationship between work prescription and the exercise of discretion. Brown states that all work, at whatever level, comprises both prescribed and discretionary elements. Prescribed elements are the boundaries set to the individual's use of discretion by his manager. Discretionary elements are the decisions the individual will have to make to achieve assigned work; the individual is authorised to make decisions and moreover will be held accountable for them.

Brown argues that explicitness in prescribing boundaries is essential for effective work. Because of the anxiety of exercising discretion the individual will, in a sense, be unable to work if he does not know how far he can go; when he will be transgressing boundaries; to what level he should exercise his discretion. The exacting of accountability - that is, requiring an individual to answer for his exercise of discretion - allows the individual to ascertain that he has exercised his discretion correctly; in this way the anxiety involved in work is removed and the individual can continue to exercise his discretion and move towards new goals. Moreover if a manager fails to set explicit boundaries he cannot hold his subordinate accountable for his work, including the failure to make necessary decisions.

Brown therefore argues against what he believes to be the common practice of leaving individuals free to assume the responsibility they feel able to discharge, in the belief that this freedom of action is
the best way to maximise work capacity. He argues that formalisation of organisation and of policy makes clear to individuals the freedom they have to act, and that without this clearly defined area of freedom, there is no freedom. This belief is similar to that of Revans (1964), who found that failures in organisation and clarity of work prescription led to anxiety in student nurses and their withdrawal from the hospital (p. 55).

The apparent antithesis between prescription and freedom to act, and a failure to understand the nature of accountability in reducing work anxiety means, as Brown notes, that many managers do not prescribe work explicitly. It was thought that this was commonly the case of the ward sister in relation to ward nursing work; the study was therefore designed to see if ward sisters did prescribe work explicitly, and further to test the relationship between explicit work prescription and accountability (if it was found), and the nurses' capacity to exercise discretion in relation to individual patients.

Managerial role

The exercise of a managerial role by the ward sister was believed to be of importance in the nursing of patients. The nature of managerial role is therefore now discussed. The common place notion of a manager as Newman and Rowbottom note (1968, p. 32) is that of a person in charge of others; the manager is accountable for the work of other individuals, his subordinates, as well as for the work he does personally. Thus the manager, because he is accountable for subordinates' work, must be concerned with the resources (the individuals) through whom he has to achieve work. Further, the manager must have authority over his subordinates if he is not to be placed in the intolerable position of
being accountable for work through people over whom he has no authority.

Brown and Jaques (1965, p. 187) see the minimal authority of a manager, relative to his subordinate, as being the power of veto on final decisions concerning role occupancy; that is, the selection of people for appointment to his subordinate roles and the removal or deselection, as it is called, of inadequate people from his subordinate roles; the kind of work that is assigned to his subordinates and the way in which it is assigned; working conditions, and finally the subsequent assessment of performance and the praise, criticism and rewards which are offered.

The manager is thus the person who regulates the individual work-capacity-reward balance of the organisation in the light of his assessment of the individual's changing capacity and the work needs of the situation. Management at higher levels will, of course, wish to retain considerable influence in these areas, but in terms of managerial authority it is inappropriate and ineffective to place someone in a managerial role, in which he is accountable for getting work done through other people, unless the managerial role involves a certain minimal authority in relation to subordinates. Unless the manager knows the extent of his authority and this is upheld by senior management he will tend to negate his managerial responsibility.

**Supervisory role**

Definition of the minimal authority of the manager makes it possible to separate out supervisory roles from those that are truly managerial. Newman and Rowbottom (1968, p. 52) define supervisory role as one that has less than minimal managerial authority; and is usually concerned
with issuing instructions about work and reporting on results and on the individuals achieving those results, the role being that of a general staff role.

The lack of defined authority in the supervisory role causes problems not only for the occupant but also for subordinates who are never quite sure who their 'real' manager is. Indeed, the authors suggest that the supervisory role is probably non-requisite - that is, inappropriate to organisations - and that it can be avoided by the manager paying ongoing attention to matters such as the assignment and assessment of work as well as making key decisions.

Drucker (1961, p. 322), also sees the supervisor role as non-requisite in that the minimal needs of the supervisor are, as in Brown's definition (p. 24), nothing less than managerial control to achieve the objectives of his department. Drucker also argues that unless the supervisor has the managerial authority that goes with the responsibility he cannot be held responsible. Further, the supervisor needs access to senior management and knowledge about the organisation's structure, goals and performance if his own department's objectives are to be meaningful.

The managerial role of the ward sister

The above distinctions between managerial and supervisory role raise questions about who really are managers and who are just supervisors; who has sufficient authority and capacity to manage, and who can properly be held accountable for subordinate work. In particular these questions can be asked in relation to the ward sister. It was thought that while she has managerial authority to assign and assess work on a daily basis, the ward sister does not have minimal managerial authority in relation to
the nurses allocated to her and through whom she has to achieve
the nursing of patients; nor does she have the minimal authority
in the deselection of unsuitable nurses from her ward. One of
the peculiar difficulties of nursing is that the majority of nurses
in the ward may be nurses in training and therefore will not be
employees in the accepted sense; the allocation, assessment (and
possible deselection) of these nurses is governed by training rather
than organisational requirements. However, it was also thought that
ward sisters do not have influence over the selection and deselection
of their trained and auxiliary staff, as well as the trainee nurses.
It was thought that these issues of authority affect the ward sister's
perception and practise of her nursing managerial role.

Issues on the nature of the ward sister's managerial role take on
a special significance in the light of recent changes in the senior
nursing management structure, as a result of the implementation of the
recommendations of the Committee on Senior Nursing Staff Structure
(Ministry of Health, Chairman B. Salmon, 1966). The terms of reference
of the Salmon Committee were to:

'... advise on the senior nursing staff structure in
the hospital service (ward sister and above), the
administrative functions of the respective grades and
the methods of preparing staff to occupy them'.

The Committee saw the word "administrative" as having "much the same
meaning as "managerial"" (p. 1), and they define administrative functions
as 'the work of ordering and co-ordinating jobs and the people who do
them' (p. 1). The job of the ward sister is defined as 'essentially
one of organisation - to assign jobs to the team under her control and
enable them to be done' (p. 29). It would seem that this is a
supervisory role with no managerial authority, especially as the ward
sister reports to the nursing officer whose role is "programming"; that is, 'working out nursing plans by determining the nursing procedures and jobs and the staff required to do them' (p. 41).

A central feature of the management structure recommended by the Salmon Committee is a hierarchical organisation according to different levels of decision-making: establishing policy (top management); programming policy (middle management) and the control of execution of policy (first line management) (p. 5). All senior nursing staff jobs were graded according to these three levels and the ward sister's job was 'controlling the work of her section and executing work'. The emphasis is on spheres of authority and lines of control as the Committee believed that difficulties in nursing administration were caused by the failure to delegate authority and make explicit the spheres of control of nursing staff below the grade of matron.

There is no attempt in the Report to analyse the nature of the ward sister's managerial and decision-making role. This omission is highlighted by the fact that the new hierarchy, based on levels of importance of decision-making, appears to be a direct translation of a theory of decision-making based on an industrial model (Paterson 1966). Moreover, the theory appears to ignore work on managerial role of people such as Brown and Jaques (1965), Drucker (1961) and McGregor (1960). Paterson, who was a member of the Salmon Committee, explicitly states (p. 206) that examples of the application of his theories can be found in the Report of the Salmon Committee.

Paterson defines the following grades of decision-making by people:

(o) vegetative, (1) automatic, (2) routine, (3) interpretative, (4)
programming and (5) policy. These decisions are banded to denote different kinds of decision (p. 44) and are 'arranged in a hierarchy of importance (p. 1)'.

'... The Board makes policy ... which is programmed by senior management ... The plan is then put into action by middle management deciding what is to be done, an interpretative decision ... Processes which are cycles of operations are decided by skilled men, routine decisions; operations which are cycles of elements of work are decided by semi-skilled men, automatic decisions'. (p. 1)

It is clear that the ward sister, as a first line manager, is placed in Band B - routine decision-making.

'... Several processes carried out by skilled workers may be co-ordinated by one person, sometimes referred to as foreman, supervisor, superintendent or junior manager. Such a manager does not prescribe what is to be done ... his decisions are only co-ordinative of the routine decisions and, to that extent, do not belong to a different kind ...' (p. 45)

Band C - interpretative decision-making - is the level of middle management, not that of the ward sister:

'... Here is the establishment of the framework of rules against which the person in Band B makes his decision. In Band C a new form of judgement is necessary - the person has to consider why a thing has to be done ... In Band B the skilled man need not consider the effects of following rules and regulations, that equation has been solved for him already, he need only know about 'the what' in order to decide process. Here is the essence of the difference in judgement on the basis of knowing 'what' and of knowing 'why'. It is the beginning of the creativeness of judgement, of the use of anticipation and prediction; the interpretative, equation-solving part of the decision process'. (p. 46)

Paterson points out that the difference between Bands C and B does not imply that people in Grade B are not capable of anticipation and prediction. Indeed some will be, but normally they will be promoted to bands where 'creative directive' functions are necessary as 'normally
this capacity is not necessary at Band B and below' (p. 46).

It is inevitable, given the constraint of these hierarchical decision levels recommended by the Salmon Committee (1966), that the sphere of authority of the ward sister did not relate to setting objectives or planning, but only to decisions about the execution of work. Policy making and the programming of care were explicitly allocated to higher levels of nursing management (p. 5).

The need to develop middle management was related primarily to the need to delegate and decentralise managerial control, and to create a new managerial role between top management and the ward level; the Committee saw the need to extend the structure to give career incentive to competent nurses to 'permit more frequent and evident progression upwards in status - reward for work well done' (p. 7).

The Committee also identified the need to develop effective middle management support for the ward sisters, who were increasingly young and inexperienced. In their analysis of the present job of the ward sister (p. 32) they noted three major problems. First, there may be too much work for the ward sister to do. Second, ward administration - co-ordinating the ward team and co-ordinating at ward level - can be difficult. Third, the job may have functions which belong to a higher level. The solution recommended by the Committee was the development of effective middle management to take over 'the programming functions of management', that is, 'working out nursing plans by determining the nursing procedures and jobs and the staff required to do them' (p. 41).

By relating function and grade to the importance of the decision taken, the Committee emphasised that:
... the contribution to be made by middle management to the common purpose would be seen to be more effective even than that of the Staff Nurse and Ward Sister by reason of the importance of the decisions taken'. (p. 25)

In summary, the role of the ward sister was influenced by the Committee's hierarchical division of managerial function related to the relative importance of policy, programming and executive decisions, and by a bureaucratic system of organisational structure with the emphasis on formal lines of control. In particular, allocation of some of the previously held managerial functions of the ward sister to the new role of nursing officer was related to the Committee's analysis that the ward sister role was too large both in the amount of work and the level of some of the activities (p. 33).

The effect of the recommendations of the Committee on Senior Nursing Staff Structure on the role of the ward sister

It is believed that the effect of the recommendations of the Salmon Committee (1966) in relation to the managerial role of the ward sister are of importance in the present study and they are now discussed.

The recommendations of the Salmon Committee and their subsequent universal implementation at the behest of the Prices and Incomes Board (1968) which disregarded the Committee's recommendation of pilot schemes, have profoundly affected systems of health service organisation as well as the clinical, teaching and managerial structures of nursing (Carpenter 1976). These effects demonstrate the interrelatedness of open systems and emphasise the critical effect the radical alteration of one system has on another. The Salmon Committee itself was set up in response to changes in the wider health care system, including the increasingly unstable environment of hospital nursing and the lack of an appropriate nursing structure to deal with it (p. 19). The ward sister's
job in particular was affected by increased patient throughput and administrative work, the reduction in nursing hours and the numbers of qualified nurses, and by changes both within the nursing team and other hospital disciplines (p. 33).

In the light of work on open systems which was published in the early nineteen sixties, and in particular the findings of Burns and Stalker (p. 7) that mechanistic systems were unable to adapt to unstable environments and hence the need for organic systems of management, it is of interest that the recommendations of the Salmon Committee reinforced the traditional bureaucratic structure of nursing; indeed it was extended with a mechanistic form of management, characterised by hierarchical lines of control and specialisation determined by the relative importance of the decisions taken (p. 27).

The closed nature of the recommendations in relation to other disciplines is also remarkable. As Williams (1969) notes, 'the Salmon recommendations are contained within the overall assumption that it is possible to reconstruct the nursing services without stimulating the need for major structural changes elsewhere in the hospital' (p. 307).

In defence of the Salmon Committee, it can be argued that the nature of the managerial structure was intended to be more organic than the way in which it was interpreted. The Committee made an important distinction between sapiential and structural authority (p. 23); that is, the sapiential authority of someone who should be heard by virtue of their expertise and the structural 'line' authority of executive role. The Committee made provision for all nurses to contribute towards nursing decisions, and suggested the use of conferences for this purpose (p. 9). Again, the Committee
recommended that training be given both 'on the job' as well as outside the hospital (p. 93), and thus the early pattern of first line management training exclusively outside the hospital (Davies 1972), was contrary to the intentions of the Committee.

However, the limitations of the Committee's recommendations in relation to the managerial and decision-making role of the ward sister is central to the research problem of the organisation of nursing in relation to the individual patient, and the implications of the recommendations are discussed below.

The failure to analyse the nature of managerial authority resulted in a failure to understand the importance of the ward sister's managerial role in its own right. This includes the need for minimal managerial authority (p. 24) if the ward sister is to meet her responsibilities. One of the reasons given by the Committee for splitting the setting of objectives, planning and the execution of work was explicitly to reduce the managerial level, and implicitly the authority, of the ward sister (p. 30). The removal of the domestic services from the structural authority of the ward sister (p. 48) also had the effect of reducing the ward sister's managerial control.

The hierarchy of decision-making which resulted in the division of planning from doing, confuses, Drucker (1961, p. 277) argues, a principle of analysis with a principle of action. While it is necessary to separate the two principles for analytical purposes, it is fallacious to carry the separation into the work itself. As Drucker says,

'... planning and doing are separate parts of the same job; they are not separate jobs. There is no work that can be performed effectively unless it contains elements of both ... one cannot, above all, do only; without a trace of planning his job, the worker does not have the control he needs for even the most ... routine chore'. (p. 278)
The insistence on a hierarchical role structure was contrary to contemporary thinking on role relationships, for example McGregor (1967). McGregor approaches the definition of managerial role through the idea of role-negotiation. He agrees that 'a manager's role is defined by a position description, which states his responsibilities and authority, and a title which locates his position in the organisational hierarchy' but argues that this definition is a gross over simplification of reality (p. 46). The actual role is affected by policies and procedures, by environmental pressures, by the individual's own characteristics and by the expectations of others; thus the process of defining role is transactional, not passive; and it is negotiated within the particular organisation and environment (p. 54).

The position is supported by Mauksch (1970), who suggests that the management of the patient becomes "a negotiated order" out of the representations and negotiations of the different actors involved in the care of the patient, and that this negotiated order 'is not the direct translation of a managerial process' (p. 192).

McGregor also stresses the particular difficulties of defining the first line manager or supervisor role 'because of the critical position these supervisors occupy between the work force and management' (p. 49); he suggests that one of the conditions for improving organisational effectiveness at this level is a better understanding and use of the transactional nature of role, by moving away from formal line management towards a service advisory relationship (p. 91).

The nature of the important managerial relationship between the matron and ward sister, and the effects of the new role of the nursing
officer, were not discussed by the Salmon Committee and were only represented in bureaucratic terms of being 'responsible to' and 'reporting to' (p. 172). Some of the considerable unease about the introduction of the nursing officer role reflected insecurity not only about the relationship of the ward sister to the nursing officer, but also about the loss of a direct managerial relationship to that 'experienced arbitrator', the matron (Webster 1967).

Finally, the nature of the critical managerial and decision-making relationship between the sister and the ward nurses, which results in the management of the nursing of the patients, is not mentioned. (Nursing Times editorial 1970), Wilson (1971). This relationship will be examined in more detail (Chapter 8).

In summary, it is thought that the establishment by the Salmon Committee (1966) of a senior nursing management hierarchy based on the relative importance of the decisions taken, and their failure to analyse the nature of the ward sister's managerial and decision-making role, are important factors in the way that the ward sister currently perceives her role; and the authority she believes she can exercise both in relation to nursing and to other disciplines within the hospital. In particular, it is thought that the lack of a proper analysis and affirmation of the managerial role of the ward sister, and the consequent uncertainty and problems of morale (Cohen 1970), British Medical Journal (1971), have contributed among other factors (p. 56), to the failure of the management of nursing at ward level; that is, the ward sister's responsibility for assessing patients' nursing needs, setting nursing objectives and seeing that these objectives are achieved. This failure to manage the ward nursing, it will be argued, is intimately
related to the failure to achieve the organisation of nursing on an individual patient basis.

The role of the ward sister in the management of nursing the patient

Developments in thinking about the nature of the ward sister's role have taken place throughout the nineteen seventies. Nurses themselves have analysed the ward sister's decision-making role, and the structures needed for more organic forms of management. Chapman (1976, b), applying sociological models to nursing, argues that 'at the bedside bureaucracy cannot work', and that the more appropriate model within the ward is a 'communications' process; a complex network of communication, with the sister as the decision maker in the centre (p. 122). Auld (1976), envisages more organic forms of nursing management when 'the role of senior nurses may well change from being that of line managers in a hierarchical structure to that of being professional advisers' (p. 51); she identifies teamwork as a way of achieving 'the essential characteristics of the organic model' within the traditional hierarchical structure.

The need for teamwork and more organic forms of working, both within nursing and in relation to other disciplines, is central to the recommendations of the Committee on Nursing (Department of Health, Chairman A. Briggs, 1972). The terms of reference of the Committee (p. 1) enabled them to take a holistic view of the role of the nurse, as well as a long term perspective 'into the final decades of this century' (p. 210), and thus the Report provides a basis for examining the current role of the ward sister. The Committee also analysed the relationship of management to the nursing of the patient, which is the focus of the present research.
The Committee agreed with evidence from the General Nursing Council for England and Wales that 'the role of the nurse must always be closely related to the needs of the patient' and that these needs are never static, but vary according to individual patients and medical and social developments (p. 3). The Report specified the importance of roles as opposed to a series of jobs:

'... since the provision of nursing and midwifery services must be directly related to the needs of the patient, nursing and midwifery should not be considered, as they so often are, simply as a series of jobs to be done, but rather as a series of roles to be discharged'.' (p. 11)

The Committee stressed that these nursing roles are related to the integrative care of individual patients:

'... professional nursing ... has as its objectives continuity and co-ordination of care in the interests of the comfort, recovery and integrity of the person being cared for'. (p. 11)

Further, there is a special responsibility incumbent on nurses by virtue of their closeness to patients to ensure continuity and co-ordination of care:

'... nurses are closer as a team to patients than any other group of National Health Service staff, and by virtue of this special relationship the comprehensive and continuous oversight of care is a central nursing role and the ensuring of the right services to the patient at the right time the responsibility of the nurse'. (p. 11)

In relation to the organisation of ward nursing the Committee emphasised the need for the work to arise from the patient, 'as the centre and origin of all the activities undertaken' (p. 11). This patient focus would avoid a 'production-line concept of care', noted in evidence to the Committee from many people, 'whereby the nurse does not care for a group of patients as individuals but performs repetitive
tasks which reduce the patients to a series of functions ... an
approach which at its worst may make the routine more important
than the patient' (p. 40).

The concept of a ward nursing team underlined the recommendations
of the Committee on the way ward nursing should be organised to meet
the needs of individual patients. They emphasised that 'the ward
sister has a unique and heavy responsibility' for seeing that patients'
needs are met, and 'in order to achieve this objective ward sisters
must think of themselves (and be thought of) as leaders of nursing teams
rather than as supervisors of individuals carrying out set tasks' (p. 41).
The ward sister's role in the management of the nursing team is to
'evolve ward policies, set objectives and monitor progress, leaving
matters of detailed implementation to whoever is leading the team' (p. 43).
This in turn involves maximum delegation of authority, and the ability of
ward sisters to free themselves from 'day to day minutiae so that they can
devote their attention to the overall planning of care in the ward' (p. 42).

Although the Committee on Nursing paid attention to the structure of
the ward nursing team they did not examine the structure of the ward
sister's managerial or hospital role. However, it is helpful to compare
the view of the Committee on the ward sister's managerial role only six
years after the recommendations of the Committee on Senior Nursing Staff
Structure (Department of Health 1966) page 26. The Committee on
Nursing emphasised management by objectives (p. 15) at all levels,
including the ward, which resulted in the evolution of ward policy, the
assessment of patients' needs, the planning of care and the setting of
nursing objectives, being seen as the specific management responsibility
of the ward sister. The Committee emphasised the importance of the
relationship between management and care, by quoting the view of McFarlane (1970) that:

'... the unique function of the nurse is to give nursing care. To this function both nursing management and nursing education are in a service relationship. Their excellence can only be judged by the excellence of nursing care which they enable'. (p. 12)

The Committee itself believed that management and care were not, as was so often stated, conflicting conceptions, but rather that 'good management is the precondition of good care' (p. 15); and that good management of the ward nursing team could prevent the depersonalisation and production-line system of care that people had deprecated in their evidence to the Committee.

In summary, the role of the ward sister as seen by the Committee on Nursing was that the ward sister has a role to be discharged, not just a series of jobs to do; that the role is centred on the needs of the patient which should be the source of all ward nursing activity; that the ward sister, as the key figure in the nursing team, has specific responsibilities arising from the concept that 'good management is a precondition of good care'; and that these responsibilities include the assessment of patients' needs, the overall planning of ward care and the management of the nursing team through the setting of work objectives and monitoring of the nursing. The role of the ward sister is now examined in relation to the concepts and practice of individualised nursing.
Chapter 2

INDIVIDUALISED NURSING
The definition of individual (Chambers's dictionary 1972) includes 'pertaining to one only, or to each one separately of a group'. Individualisation is defined as 'to stamp with individual character, to particularise'.

In trying to define what individualised nursing is, and what it is not, nurses use on the one hand words such as individualised patient care, total patient care, patient centred nursing, and on the other hand words such as depersonalised care, fragmented care, task or job centred nursing. The words task allocation and patient allocation are used to describe methods of work organisation as well as concepts of nursing. Distinctions such as patient and task allocation are an accepted part of the language of nursing, and have been used in the discussion of research findings without further elaboration (Anderson 1972, p. 168).

It is apparent that a variety of meanings is attached to these words, from describing ward nurse deployment patterns to a symbolic representation or absence of nursing itself. Bendall (1974) argues that patient centred care has never been practised and is a reification used primarily by nurse tutors to justify their teaching in the absence of nursing theory. Chapman (1976a) disagrees with Bendall and gives examples of what she understands by patient centred nursing practice although her analysis of current practice leads her to conclude that 'nursing is rarely patient centred' (p. 112) the emphasis being on tasks, resulting in fragmented care.

There are two principles which together characterise definitions of individualised nursing. The first is the recognition of the patient as an individual. The second is the recognition of the nurse as an
individual. These principles have to be maintained in the
translation of concepts of individualised nursing into a method of
nursing work organisation (Matthews 1975). Patients have to be
assigned to nurses as individuals even within a group of patients;
nurses have to be assigned patients individually even if they are
working as part of a team. Thus Grant (1977), defined the
organisation of care on an individual basis as a system 'where each
nurse is assigned to give complete care to one patient or a group',
and where 'each patient has a specific nurse whom he knows to be
responsible for his care on a particular day' (p. 29).

The principle of accountability on the part of the individual
nurse for the delegated responsibility she has been given, is also
important (Matthews 1975). Jones, W. (1977), described a system of
ward management where the nurse learner 'is encouraged to view the
patient as a whole person'. Each nurse is:

'... allocated a group of patients who then become
entirely her responsibility for that day. She will
decide, with assistance if necessary, upon the care
they need and must organise her day's work round those
patients. It is her responsibility to ensure that all
appropriate treatment, medication and nursing care is
given to her patients ... and the learner must make both
verbal and written kardex reports to her ward sister and
colleagues'. (p. 342)

Thus from the literature individualised nursing appears to be
associated with the notion of individual responsibility and
accountability on the part of the nurse for patients, and this in turn is
associated with the management of the nursing team delivering nursing
care. These associations between the concept of individualised nursing,
the concept of individual responsibility and accountability on the part
of the nurse and management of the nursing team were also found to be

These experiments are the most detailed statements in the British literature of the philosophy and behaviour of sisters in relation to the organisation of nursing on an individual patient basis. No British research has focused directly on this area although McGhee (1961), Hamilton-Smith (1972), Stockwell (1972), Dodd (1973), Lelean (1973), Bendall (1974), and Wells (1975) have identified certain aspects of ward sister behaviour which relate to the failure of patient individualisation.

The methods of organisation in the experiments are variously described as team or group nursing, total patient care, patient allocation and management by objectives but the concepts, aims and principles of management are markedly consistent. The purpose behind the methods is to achieve the nursing of the patient as an individual, 'to care for the whole person'. The aims include improved patient care and nurse training, greater job satisfaction and the development of clinical and leadership skills. Assessment of the experiments (Auld 1970, Matthews 1975 and Jones, E. 1977) involving questionnaires and interviews with nurses, showed that all the aims were felt to have been met to some degree. Auld's (1970) assessment included the views of maternity patients but they did not discriminate between their various experiences of care (p. 62).
It was possible to identify from the experiments specific behaviour on the part of the ward sister which the authors see as prerequisite for the organisation of nursing on an individual patient basis. The first generally agreed principle is the specific delegation of authority by the ward sister to the staff nurses or team leaders, in relation to the organisation of the primary work group. This delegation of authority is achieved by the ward sister being involved in the planning and setting of objectives and prescribing work relating to each patient at the beginning of the shift. The team leaders continue the process of delegation of responsibility for individual patients to the nursing team. The individual responsibility of each nurse for patients is underlined.

It was clear that each nurse had an enlarged, multi-skilled role and that the primary work group was self-regulating, responsibility for the organisation of work being shared between the staff nurses and the rest of the team, with the ward sister acting in an advisory capacity. Thus once the ward sister had delegated organisational authority to the nursing team she was freed for her own work. It was stressed, however, that the ward sister was involved constantly in exercising managerial and leadership skills, including being available for consultation, supervision and teaching, and the assessment and counselling of the nurses. The principle of accountability for the use of responsibility is also made explicit; each nurse, or in some cases only the team leaders, reported back to the ward sister on each patient that had been in their care. This was supplemented in some instances by each nurse handing over her patients to the oncoming shift, and being responsible for the written reports of her own patients.
Thus the work of the ward sister in the organisation of nursing on an individual patient basis was closely related to the daily management of the nurses. As well as general supervision and leadership, the work involved precise managerial techniques and a 'daily management cycle'. This management cycle started at the beginning of the shift with planning and precise work prescription related to each patient together with the delegation of authority to the nursing teams. It was completed at the end of the shift when the ward sister held each nurse or team leader accountable for the nursing of each patient for whom she had been responsible. This daily management cycle became the central focus in the design of the present study, and the way in which the organisation of nursing on an individualised patient basis was operationalised.

Non-individualised nursing

The importance of the daily nursing management cycle in relation to each patient and each nurse in the organisation of nursing on an individualised patient basis is emphasised by comparing work which describes non-individualised nursing. Examples of non-individualised nursing are associated with a failure to delegate responsibility for patients to individual nurses and a failure to hold each nurse accountable. Lelean (1973), in a study of communication between the ward sister and the ward nurses identified the inadequacy of the ward sister's instructions for patient care; Lelean associated this with the failure of individualised nursing. In the six wards the author observed, patients or tasks were not assigned individually to nurses; the nurses did not report back on their work to the sister, and there were a large number of days in which there was no communication between
the sister and the student nurses (p. 75). Kratz (1974) described the work of district nurses where they were nominally responsible for patients, but she identified the lack of individual nurse accountability for the nursing of these patients as one of the reasons for the observed inappropriate care (p. 155).

Bendall (1974) associated job-centred nursing with the failure of nurses to be responsible for meeting patients' needs. One of the objectives of her research 'was to validate the statement that nurses work on a 'job' rather than a 'patient' basis' and she confirmed that:

'... there was no doubt that this was so in every ward seen ... the work was organised to cover a prescribed routine and if a patient needed anything that fell outside that routine none exhibited any responsibility to meet that need'. (p. 37)

Routine work is seen as negating the principle of individual nurse responsibility for patients, and this is confirmed by patients' own experiences (Titmuss 1966, Nursing Times 1976, Reed 1976, Ashton 1977). Anderson (1972) reported a patient's comment that 'the nurses were more concerned with routine than the care of patients' (p. 135). Grant (1977) suggested that routines and task allocation are closely related and are at the opposite end of a continuum leading to the care of the patient as an individual. Forty six percent of the hospital nurses taking part in the survey of the Committee on Nursing (Department of Health 1972) agreed that 'routine tends to be more important than the welfare of the patient' (p. 18). The Committee on Nursing also found that of the 1,283 hospital nurses (755 trained) who took part in the interview survey (Morton-Williams and Berthoud 1971), seventy percent believed that a system of patient allocation would be best for the comfort and welfare of the patient and yet only twenty seven percent of the sample said that they
practised patient allocation as a form of ward nursing organisation.

The prevalence of task allocation is related closely to the issue of efficiency. Ferguson (1976) and Logan (1967) suggest that task allocation in nursing is an imposition of industrial methods related to efficient production. Bureaucratic methods are used to increase efficiency, and the bureaucratic development of the senior nursing management structure (Ministry of Health 1966) was related to the need to increase efficiency. At ward level, task allocation allows a hierarchy of tasks from the trained nurse to the untrained auxiliary (Chapman 1976a), to conserve scarce technical skills and to ensure that certain tasks are routinely performed without managerial effort.

Thompson (1967), using open systems theory, argues that the efficiency of 'custom' technological organisations such as hospitals, is threatened by the fact that the product is people, whose individual behaviour might impede organisational effectiveness. The organisation tries to reduce this possibility by standardising the processing system, and by attempting to encapsulate the inmates, extreme examples being 'total institutions' such as mental hospitals, described by Goffman (1968). The production line method of nursing task allocation (Department of Health 1972, p. 40) is an example of 'standard processing' which reduces the impact of the individual patient. Agyris (1964), suggests that organisations under stress reinforce hierarchical patterns of organisation and suppress self actualisation on the part of both inmates and staff; these primitive coping techniques focus on organisational survival rather than effectiveness. These coping strategies are demonstrated in nursing (Crossley 1973) in response to real or perceived staffing shortages in numbers and skill which lead to fear of
operational breakdown. Task allocation is one of these coping
techniques and Grant (1977) suggests that this is learnt behaviour
which will only give way to individualised care when there is
appreciation that there are sufficient staff to practise it.

Menzies (1960), in a psycho-analytical study of the nursing
service in a British hospital, identified task lists as one of the
coping techniques employed by nurses as a defence against the anxiety
which they experienced in their primary task of nursing patients.
Task allocation enabled the nurse to avoid the anxiety of nursing the
whole patient, by depersonalising both patients and nurses. Other
defensive techniques included the splitting and diffusion of
responsibility so that no single nurse was individually responsible,
as well as attempts to push responsibility upwards rather than to
delegate it.

These techniques, Menzies suggested, are dysfunctional in that
they avoid, rather than allow, the confrontation of anxiety which is
needed for growth and development. While aware of the need for change,
the nurses were unable to move from outdated and inadequate practice for
fear of being unable to handle the anxiety involved in the changes. One
of the changes suggested was a 'limited experiment in ward organisation,
eliminating the task-list and substituting some form of patient
assignment', but this was one of the changes the senior nurses felt
unable to confront (p. 40). The seriousness of the situation was
further increased by the fact that the regressed system forced the mature
nursing student to withdraw from training. Thus the profession was
losing the very people who potentially had the necessary creative
capacity and conceptual ability to bring about the necessary changes and
enable the nursing service to move from a chronic state of reduced effectiveness.

The relationship between lack of nursing management and lack of individualised nursing

There are therefore a number of complex reasons for the lack of individualised nursing. The particular interest in the present research is the relationship between the management of the ward nurses and individualised nursing. The link between the lack of individualised nursing and the lack of management of the ward nurses was empirically identified by Wells (1975). Wells approached her study 'Towards understanding nurses' problems in the care of the hospitalised elderly' through King's (1971) theory of nursing: 'nursing is a process of action, reaction, interaction and transaction between individuals and groups in social systems to achieve goals of health or adjustment to health problems' (King, p. 126).

Wells (1975) used an empirical approach to understanding the ward nurses' problems in geriatric nursing, allowing the focus of the research to be determined by the emerging issues and concepts of a series of linked studies. The problems identified through these studies were that the environment was difficult and sometimes impossible for the nursing of patients, that there was a lack of awareness, planning and monitoring at senior management levels of the services needed by the ward, and that the ward nurses lacked the ability to promote change.

At this stage Wells identified the promotion of continence as reflecting these issues and as a central problem in the nursing of the patients (p. 124). The promotion of continence became the focus of a study involving observation of all nursing activity on four of the wards,
with special reference to the nursing management of incontinence. It is the findings relating to this study which are of particular relevance to the present research. The perspective was that of the nature of interaction between nurse and patient, the interaction of the nurses being observed in relation to the patient outcome of continence promotion. Observation of nursing activity, however, altered this nurse/patient perspective as Wells recorded 'the emerging importance of nurses' work behaviour' (p. 185); she therefore turned her attention to the problem of organising nurses' work to achieve interaction and reaction with individual patients.

The important point is that the analysis has moved to the relationship between the organisation of the nurses and patient experience.

'... Nursing work on the geriatric wards was not focused on patients' needs but on routines which might or might not be appropriate for each patient. Incontinence/continence work activity was merely one aspect of these ward routines ... Essentially, nursing care was depersonalised and, because of this, was frequently thoughtless and sometimes unintentionally cruel'. (p. 185)

The work routines were based on minimal, universal needs: 'work was not organised in the sense that it was not assigned by individual patient or specific task', it progressed by area of the ward and time of day; that is, nurses accomplished the routine demanded by the time of day, for example, "getting up", from one end of the ward to the other.

'... The impression was of frantic, intense activity by nurses working in pairs or a group of three to complete the routine as quickly as possible. Individual patient preference or even necessary variation in care appeared to be obstructive to the goal, which was completion of the routine'. (p. 186)
Wells states that the implications of 'the worrisome findings' such as those from the study of nurses' work in geriatric wards are so complex that it is impossible to find either a single cause or a simple remedy (p. 187). She suggests that the findings were most likely symptomatic of limited work organisation ability, lack of continuity in reasonable staff/patient ratios, limited nurse knowledge and perception of care and the tension and stress of working under difficult circumstances (p. 188).

Wells did not pursue the problem of the organisation of the ward nurses in relation to individualised care; her recommendations concentrate on the actual nursing of the patient. She sees the need for a clinical nursing role model, and recommends a specially prepared person by developing the role of the nursing officer or clinical nurse consultant; someone with 'expert knowledge and a high level of clinical nursing skill', 'who actually provides personalised nursing care of high quality to patients and thus, by example and instruction, shows how to improve care and cope with difficult problems' (p. 255).

The limitation of this recommendation is that it does not take into account the issue of the day to day management of the ward nurses which Wells had found through her empirical approach to be of fundamental importance in the achievement of nursing; for example, the promotion of continence in hospitalized elderly patients. The introduction of a nursing expert avoids the structural reality of the fact that within the wards that were studied, the person responsible for the organisation of the nurses to achieve nursing, the ward sister, was not doing so. This issue is discussed by Duberley (1976).

The helpfulness of Wells' study is that she empirically identified the link between patient experience and the daily organisation of nursing
work. Further, her particular patient/nurse centred perspective, and her interest in the nature of nursing, resulted in the conclusion that nurses do not know how to nurse: 'everyone has assumed including nurses themselves that the nurse knows what nursing is and how to do it' but 'there was little evidence that such a process was occurring' (p. 253). And she concludes that the central problem in geriatric nursing is the central problem in all nursing:

'... nurses do not know why they do what they do ... training has encouraged us to perform ritualistic routines without thinking of the effect of such routines on patient care. Nurses have not been taught how to identify problems in patient care, how to take action to solve such problems, or how to evaluate the effects of nursing action' (p. 254).

The relationship of nursing management to individualised nursing practice

The translation of the ideology of individualised care into practice has always been of concern to nurses (Nightingale 1914), if not always realised (Vaizey 1959). Recent research evidence, particularly the work of Dodd (1973), Bendall (1974) and the Royal College of Nursing Studies Hamilton-Smith (1972), Stockwell (1972), Lelean (1973) and Wright (1974), of the discrepancy between theory and practice is now of considerable concern to the profession.

Recent efforts to reduce this discrepancy have centred on nurses seeking to link the ideology of individualisation to the management, or the process of care, of the individual patient. Thus Grant (1977), suggested that the concept of 'individualised care' may be defined as an 'ideology of management' which is 'translated into the care of a person on the basis of his unique needs' (p. 23) and she explored ways of achieving this through the use of nursing care plans. Turner (1977), writing on 'how the nurse can help preserve the patient's individuality',
emphasised 'that the techniques and the organisation of care are the tools of nursing and the way in which they are used will determine whether or not a patient's individuality is preserved' (p. 62).

The profession is increasingly seeking ways in which the individuality of the patient can be realised in daily practice. Hargreaves (1975) in a paper on 'the nursing process the key to individualised care', related the philosophy to the teaching and practice of individualised care through the nursing process, and this method is further demonstrated by Crow (1977). The Scottish National Nursing and Midwifery Consultative Committee (1976) support this approach and argue the need for adequate philosophies and models of nursing, as do King (1971) and Roper (1976).

Grypdonck (1977) describes the nursing process as 'an instrument to enable nurses to plan care'. Hargreaves (1975) describes the components of the nursing process as assessment, intervention and evaluation; that is, the identification of nursing problems and the setting of nursing objectives; nursing intervention; and finally evaluation as to whether nursing intervention has met the objectives and nursing goals for each patient (p. 90).

The Committee on Nursing (Department of Health 1972) defined the work of the ward sister to include the assessment of patients' needs, the setting of work objectives, the delegation of authority to the nursing team and the monitoring of progress. This managerial work of the ward sister is the framework for the nursing process and the link between the managerial techniques already reviewed (Chapter 1). These management techniques are work planning (setting objectives), work prescription (delegation of authority) and work assessment (the
exactment of accountability for the use of delegated authority).
Together they form the concept of the daily nursing management cycle which is the way in which the organisation of nursing on an individualised patient basis has been defined in this study.
Chapter 3

THE WORK AND TRAINING OF THE WARD SISTER
This final chapter of the literature review looks at the role of the ward sister in relation to the rest of the hospital and at her training needs. The Report of the Committee on Nursing (Department of Health 1972), like many of the reports before it Ministry of Health (1947), Goddard (1953), Central Health Services Council (1961), Royal College of Nursing (1964), Central Health Services Council (1976), identified the key role of the ward sister in the achievement of the proper nursing of patients.

All these reports emphasise the need for the ward sister to exercise social and interpersonal skills, to be clinically expert, to be able to assess and plan for the needs of the patients and ensure their nursing through the proper organisation, supervision and teaching of the nursing staff. As well as the management of nursing, the ward sister is required to organise the ward and integrate the work and requests of the medical staff and others into the daily pattern of care for each patient.

It is this dual responsibility, the management of the nursing and the management of the ward, which makes the job of the ward sister particularly testing. Evidence of the failure to achieve the proper nursing of patients is consistently related to the fact that the ward sister is unable to achieve a form of organisation and deployment of herself and the ward nurses which reconciles the management of the nursing and the management of the ward.

This problem of dual responsibility was clearly identified in the early major study of the activity of ward nurses by Goddard (1953). The analysis centred on the problems of the organisation of nursing work.
It was noted that the twenty four hour ward routine was governed primarily by the patients' physical needs but also by the impact of medical and other hospital staff. Major problems in the deployment of the ward staff, both nursing and domestic, were created by the need to complete the 'internal' ward work by 9 a.m., so that the demands of doctors and other hospital staff visiting the ward could be met during the peak hours of 9 a.m. - 12 noon. A similar problem was identified in the Central Health Services Council reports of 1961 and 1976.

Goddard found the ward sister was primarily concerned with ward organisation, the medical staff and other hospital staff. The nursing care was left to the students with little opportunity of supervision by the trained staff and virtually no planned instruction. The ward sisters spent between five and ten percent of their day in direct contact with students, of which half was devoted to reports and instructions. The staff nurses spent between fifteen and twenty percent of the day with students much of which appeared unplanned, the staff nurse more often working with the senior student (p. 123).

Formal teaching comprised 1.1% of the total time. The central difficulty appeared to be the diffuse role of the trained nurse, and the fact that the ward was both a nursing and administrative unit. The work of the trained nurse was only vaguely defined:

"Everything that is not within the ward maid's province is, ipso facto, within the trained nurse's. In these circumstances the ward sister's day cannot but be a very difficult one to organise. For a considerable part of the day she may well be the only fully trained nurse in the ward as well as being in charge of it". (p. 135)
Goddard clearly identified the separate components of managing the ward and of managing the nursing. The recommendations centred on the need to define the responsibilities of the ward sister and the staff nurse, and the need to delegate some responsibilities according to agreed principles. In particular it was believed that trained nurses should give nursing care; the Report recommended the sub-division of the ward into nursing units, with delegated responsibility from the ward sister to a staff nurse for the nursing care of a unit of patients assisted by a team of nurses, the ward sister acting in an advisory capacity.

As well as acting as nursing adviser, the work of the ward sister was seen as the management of the ward and the practical training of students. By delegating direct responsibility for the nursing of patients to staff nurses, it was envisaged that the ward sister could manage a larger sized administrative unit. The need for a personal assistant for the ward sister was emphasised, the research having been extended to review the use of ward clerks in hospitals employing them. It was observed that many were used as "errand boys" rather than as secretary/receptionists, but that the administrative work of the ward sister required that they be used as secretary/receptionists.

The recommendation of sub-dividing the ward for nursing purposes, was supported both by the advisory panel to the research and the Standing Nursing and Midwifery Advisory Committee for Scotland (Department of Health for Scotland 1955), and subsequent experiments Jenkinson (1958) and Willcock (1961) were tried. However, the identification by Goddard in the early 1950s of the increasing effect of the wider system of the hospital on the management and supervision of
nursing work was not fully accepted by the Standing Committee. Goddard had specifically extended his research to observe how the ward sister could be assisted by the proper use of a personal assistant, the provision of which was a major recommendation. It is therefore of interest that the Standing Committee specifically rejected this recommendation, as in their experience there was not enough work to require the employment of special assistance (p. 8) - the legacy of which is apparent in the wards today.

Ten years after his first study Goddard (1963) found that the ward sister was spending approximately forty five percent of her time giving direct care; he observed 'that the ward sister did not have sufficient time to cope with the full responsibilities of her post', in particular the organisation, supervision and teaching of the nursing staff. This observation was frequently supported in the nursing press (Nursing Times editorial 1958), Crouch (1972).

In 1972, nearly twenty years after Goddard's first study, the Committee on Nursing (Department of Health 1972) noted evidence of 'production line care' and 'crisis management'. While recognising absolute shortages of nurses in some areas, the Committee believed that the poor organisation and deployment of ward staff, in particular the failure to delegate adequate responsibility to trained nurses, was the more substantial problem.

The recommendations of the Committee on the need to help the ward sister define her managerial role, and delegate nursing responsibilities to nursing teams organised on a patient rather than on a task basis, reflect the long standing principles embodied in previous reports. In 1976, the Central Health Services Council stressed the need for the ward
sister to do a daily nursing round of each patient (recommendation 3409, p. 93); an activity taken for granted in their 1961 Report (Central Health Services Council 1961, Appendix A).

In 1976, also, a dying patient who was also a nurse had written from her experience:

'... it is beyond my understanding how any ward sister in charge can know what is happening to the patients unless a complete round is done once a day to speak to each patient when awake ... there were many days when my morale was at a low ebb and I was not well enough to do anything. Yet my brain was active ... I had too much time to think all day, and in the hours when I could not sleep at night. Yet no one, except my relatives and a close friend really talked to me, or took time just to listen, or to offer a helpful word of support and caring. I would have appreciated this so much. Apart from routine treatments, meals and drug rounds, I was left to fill the long hours as best I could!' (Reed 1976).

Thus the discrepancy between principle and practice, the failure to organise nursing in relation to the individual patient, is summed up.

The organisational context of nursing practice

The organisational context of nursing practice has become more complex since the 1953 study of Goddard. Then the ward was literally 'closed' to hospital staff and visitors, except at certain times during the day (Central Health Services Council Report 1961). It is now an open system, responding to numerous and almost continuous external demands, McGarrick (1967). The Committee on Nursing report 258 movements, excluding visitors to patients, in and out of one ward during seven hours of one day; nearly all the people who came consulted the ward sister (Department of Health 1972).

Mauksch, in 'The organisational context of nursing practice' (1966), examined the strains on the ward sister's role which have accumulated as
the ward sister has attempted to synthesise her growing responsibilities, in relation to both nursing and the hospital.

Mauksch identified two systems which operate interdependently within the hospital. The cure process of medicine, and the care process which includes the various tasks assumed by the hospital; the provision of hotel services and equipment and the employment of workers - including nurses - to perform tasks which emanate from the physicians. The nurse is employed by the hospital for care functions, but by virtue of being the delegate of the doctor, her role crosses into the cure function. This strain on the nurse's role is enhanced not only by changes in nursing itself, but also by the increasing specialisation within other people's roles.

The organisational structure of the nurse's role obligates the nurse to represent continuity of time, place and social organisation to the patient. In a sense the nurse represents the hospital; first, because she is in the ward; when others go, the nurse stays; she bridges the discontinuities of others, the physiotherapists, the social worker, the dietician. Second, episodic activity which is the outcome of specialisation, requires general co-ordination on the part of the nurse who takes over, when the specialists have left, work which was once hers. Thus bureaucratic specialisation on the part of others requires generalisation on the part of the nurse.

The representation of the hospital administration by the nurse is for different reasons; the hierarchy and authority of the administrator does not reach the ward, it is truncated outside the patient area. Thus the administration has to rely on the person who is there, the nurse, to implement and enforce hospital policy within the ward.
However, it is the traditional nurse-doctor relationship, the care/cure link which poses the greatest dilemmas and role strain. The nurse is placed within, and represents, the bureaucratic hospital structure whereas the doctor is mainly a free agent - a 'free wheeling artist' as Mauksch calls him - not bound by the managerial authority and rules of the hospital (Jaques 1971). The institutional mobility of the doctor who can go anywhere in the hospital, further obligates the nurse, as the doctor's delegate, to represent the continuity of time, place and social organisation that the doctor cannot represent by virtue of his independence.

The role strain is made greater by the necessity for the nurse to move backwards and forwards between the care and cure functions. Although nursing itself is bureaucratically organised it has to move into, and respond to, the 'free wheeling' of the doctors. Thus any number of doctors, each independent of the other, can come to one ward sister and give medical prescriptions which the ward sister then has to sort into some order and integrate with the nursing and maintenance systems of the ward. The ward sister's desk, as the author notes, 'is the locus where care and cure meet'.

Mauksch states that the ward sister is quite alone in the difficult task of determining priorities both between and within care and cure; of integrating the various requirements of doctors and others with the nursing, and converting these, within the limits of a bureaucratic staffing structure, into a daily pattern of activity and care for each patient. In this task she, and therefore nursing itself, is vulnerable to pressures, in particular as Walker (1967) in 'Nursing and
ritualistic practice' noted, to the power of medical sanctions and incentives, an analysis supported by Dodd (1973).

Mauksch (1970) illustrates the power of medical sanctions and incentives and the institutionalisation of nursing, by following the 'career' of the patient's chart:

'... one of the tragedies with the patient's chart is that, while it is intended to be within the care system it in fact had ended up with the core system of institutional maintenance, recording and reporting. This means that the rewards for the nurse, for example, are in giving a bath because it has to be charted and, next door, the patient who is desperately looking for someone to talk to and to listen can find no nurse. In other words, to a large degree care in the hospital has no legitimising devices and much of it is attached to a low prestige group, nursing'. (p. 198)

In considering the development of the ward sister's role in the light of these strains Mauksch concludes that the major - if as yet unaccepted - task of the nurse is to be the representative of patient care, across all the boundaries, by providing continuity of function within the patient care unit. He anticipates this role being formalised as a sub-speciality of nursing knowledge and education. Mauksch sees this integrative task of the nurse as a necessary - and indeed inescapable - part of the nurse's role not only because she is there, but also because the nurse has the symbolic status as the delegate of the doctor which enables her to exercise considerable, if informal, authority in relation to other disciplines and hospital departments, a status which the administrator cannot achieve.

The nurse thus represents the administrative, social and physical sub-structure of the hospital. Through her each patient in the ward experiences not only the nurse's ability to nurse but also her ability to synthesise the health care system she represents, and to negotiate
her various hospital roles in a way that enhances the patient’s care. Thus as the author notes, the nurse is held responsible for tasks which are assigned to other departments ‘none of which are under the jurisdiction of the nurse, but the nurse is expected to lure the proper agent to the unit at the right time to do the right thing’ (p. 126). This task of the ward sister is well recognised (Nursing Times editorial 1972), Laver (1977).

The analysis by Mauksch of the organisational context of nursing practice emphasises the complexity and difficulty of organising nursing in relation to the individual patient. Given that the ward sister sees this as desirable, is clear about the nature of this primary task and has the capacity and knowledge to achieve it, her strategic organisational position between care and cure functions, and the increasing bureaucracy of the hospital make it even more difficult. The strain and vulnerability of the ward sister’s position is clearly identified by Mauksch and confirmed by Cortazzi and Route’s (1975) research into ward sisters and other hospital members where a finding was ‘the unsuspected loneliness of the ward sister’.

In that the ward sister is the advocate for the patient, her vulnerability in turn reflects the vulnerability and loneliness of each patient within the health care system. ‘To feel ill is to feel unadventurous, to want to retreat from life, to have one’s fear removed, and one’s needs met without effort’ (Titmuss 1963). The recognition of the vulnerability of the patient as an individual person who, needful in sickness, is dependent on the health care system and therefore vulnerable in relation to it, is a particular and traditional responsibility of nursing (Williams 1974), McGilloway (1976).
responsibility is expressed in the profession's protective and nurturant image, one that remains the public's image of the nurse (Department of Health 1972, p. 23).

The training needs of the ward sister

Thirty years ago, the Interdepartmental Working Party on the Recruitment and Training of Nurses (Ministry of Health, Chairman R. Wood, 1947), reviewed the position of the nursing profession. Its radical recommendations, based on extensive research, included a two year nurse training related to the educational needs of the student and experimental training units. These radical recommendations were unacceptable to the nursing profession (Abel-Smith 1960) and most of the recommendations have not been met today, although many of the principles of the Report of the Working Party are embodied in the recommendations of the Committee on Nursing (Department of Health 1972) which are awaiting implementation (Nursing Times 1978, p. 428).

The Working Party commissioned research into the intelligence of nurses in the belief that this had qualitative implications, and that 'the level of intelligence or educability of the potential nurse is of decisive importance, both as regards her training and her professional practice' (p. 17). The Working Party were especially concerned with the capacity and outlook of ward sisters who, they believed, affected the welfare of the patients and the efficiency of the hospital as a whole (p. 92). The teaching and supervisory role of the ward sister was also seen as crucial in the proposed training wards.

The radical nature of the Working Party's approach was demonstrated in an experiment undertaken by the members of the Working Party themselves (p. 94) to test thirty two trained nurses for 'stability
of temperament, (2) competence, (3) leadership, (4) kindness, (5) ability to instruct, explain and organise, and (6) reasonableness of views'. The procedure included (i) biographical and personal questionnaire, (ii) two tests of intelligence, (iii) group discussion, (iv) test of skill as instructor, (v) written views on questions of nursing life and discipline, (vi) assigned tasks of nursing responsibility and, (vii) sociometric and projective devices (p. 95).

This early work in developing criteria and techniques for the selection of ward sisters has not been followed, and the profession still has no scientific basis for the selection of ward sisters, and no measure of their subsequent performance.

However, the need for adequate intellectual capacity, leadership skills, and adaptability in the light of increasingly complex work, was emphasised in the Royal College of Nursing's First Report of a Special Committee on Nurse Education, A Reform of Nursing Education (1964, Chairman H. Platt). The Committee recommended an entrance requirement of five 'ordinary levels' for state registration training and further preparation for staff nurses to become ward sisters. The Committee envisaged that the ward sister would be able to:

'... teach and supervise, to administer and organise. She would participate in providing skilled nursing care and would supervise and direct the more advanced technical procedures. She would have an understanding of social, psychological and environmental influences which affect behaviour patterns; she would be able to communicate effectively with others and to establish a therapeutic relationship with patients'. (p. 30)

The recommendations of the Platt Committee were also not accepted, the then Minister of Health stating that 'I think we need a minority of nurses of very high calibre for senior administrative and teaching posts
but the average nurse is, in my view, of sufficient calibre for present and future needs' (reply to a Parliamentary Question 1966).

The Standing Nursing Advisory Committee's Report on The Post Certificate Training and Education of Nurses (Central Health Services Council 1966) which resulted in the setting up of the Joint Board of Clinical Nursing Studies in 1970, commented that 'the concept of systematic and progressive education for the registered nurse receives little recognition' (p. 5). The Committee noted that:

'... the fact remains that the sister needs knowledge and skills additional to those acquired as a student in training and 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'. (p. 8)

In their review of the position of post-basic education, the Standing Committee noted that the most substantial contribution to the formal training of the ward sister were two three month courses, one in ward teaching and administration offered by the Royal College of Nursing, and one arranged by King Edward's Hospital Fund, in which the main subjects were administration, teaching and staff relationships. These courses were available to a negligible number of the 20,358 ward sisters in post in general hospitals on 30th September 1964 (p. 6).

The Standing Committee, subject to the Salmon Committee's (1966) recommendations, suggested a four week course for preparing all ward sisters, which should include aspects of ward administration, teaching methods and information about health and welfare services (p. 8).

With the implementation of the Salmon Committee's proposals, all ward sisters for the first time received some formal preparation for their job though this was confined to managerial aspects. In the light
of these new developments, the King's Fund discontinued its residential courses for sisters which, while more comprehensive, could only be offered to about forty ward sisters a year (Peers 1967). The management training needs of sisters, and the development of first line management courses following the recommendations of the Salmon Committee, have been studied by Williams (1969) and Davies (1972).

Williams, in a study of the attitudes of sisters and the organisational constraints on their role and performance, identified a high level of 'pre-set' activity, for example, ward sister behaviour dictated by medical rounds or standing nursing orders such as written reports. There was very little communication between the ward sister and her nursing superiors (0.5%) whereas her daily communication with the medical staff was substantial (10 - 11.5%). The author noted that the ward sister's job was changing under the pressure of technical innovation, and that her behaviour was determined by specific environmental and organisational influences and the adjustment of the hospital itself to these changes.

In the light of these organisational implications, and theories on organic forms of management and the work of professionals in organisations (Etzioni 1964), the author questioned the assumption in the Salmon Report and other reports on hospitals that there are certain 'principles of management' that can be learnt and applied. He suggested the need for 'organisational learning' and that it may be beneficial to train hospital members in general social skills, rather than specific management skills.

This recommendation on the need for organisational learning was based on the belief that management involved social skills, and an
ability to understand the organisation as a whole. Williams found that the sisters did not understand the parameters of their profession and were unable to articulate their understanding of what was nursing and what was not nursing; they needed help in defining their own role and in understanding and relating to the hospital as a whole. He suggested that training should help the sister increase her competence in areas where she already had discretion, but also that the ward sister be helped to understand and use her sapiential authority in relation to doctors and others. While the major training aim was organisational learning, the author did see some specific managerial concepts such as the delegation and communication of authority as potentially useful to the ward sister.

Williams found that ward sisters were unclear about the meaning of management and suspicious of managerial innovation, for example, the centralisation of service departments, which they saw as undermining their authority. Further, the ward sisters identified their job and satisfaction as patient orientated rather than concerned with management and this is confirmed by Haywood (1968) and Davies (1972, p. 33).

Davies, in her study of the members of four first line management courses, found that the sisters 'did not see their managerial role as being integral to patient care' (p. 30). She identified the influence of traditional role models, and the difficulty of the sisters in innovating changes on return from their courses because of the value system of the hospital. This finding is supported by Kahn et al. (1964), who noted the conflict that results from a person being removed from their role set for training, and then being asked to change their behaviour when the role set remains unchanged. Davies, like Williams,
believed that understanding of the organisational constraints of
the role by the sister herself, and others involved, is a
prerequisite for effective change. Another important factor is
the need to develop the conceptual skill of the sister to fulfil a
complex role which:

'... involves an ability to recognise problems
areas, analyse the factors involved and reach a
decision on insufficient information. This
requires a flexibility of approach and an ability
to determine objectives and decide on priorities'. (p. 103)

Developments in post-basic nursing education and the assessment
of ward sister performance are beginning to take place. A first step
in the formal assessment of ward sister performance began with the
introduction of a system appraisal by the National Nursing Staff
Committee (1970). This development is new and not without its
difficulties (Jones and Rogers 1977), but it does provide for a yearly
appraisal of the ward sister by her immediate superior, countersigned
by a senior nurse manager. The specific aim is 'to develop managerial
talent', and the assessment also includes sections on patient care,
relationships and teaching.

In a comparative study of the provision of continuing education for
nurses in the United States of America and in England and Wales, Taylor
(1975) believes that the need for continuing education has been
recognised in this country but 'that the vast majority of nurses have no
access to continuing education' (p. 31). The current problem in the
provision of post-basic education is possibly more one of finance than of
access (Nursing Times editorial 1977). Courses for trained nurses are
provided by the Royal College of Nursing; universities and
polytechnics also offer facilities for post-basic nursing studies. The
Joint Board of Clinical Nursing Studies is developing and rationalising the provision of specialised clinical courses, but like all post-basic nursing education its activities are curtailed by inadequate funding (Nursing Mirror editorial 1977). Local provision of in-service training and study days for trained staff are also affected in this way.

The principle of continuing education is fundamental to the recommendations of the Committee on Nursing (Department of Health 1972) and it makes provision for a wide variety of post-basic education. The Committee also proposes that both basic and post-basic nursing education should be financed through the Area Education Committees (p. 103) and thus for the first time post-basic education will be funded in its own right.

In conclusion, in the thirty years since the Report of the Working Party (Ministry of Health 1947), the job of the ward sister has radically changed (Department of Health 1972, p. 8) and it is suggested that the education of the ward sister and the particular preparation for her job has lagged behind these changes. Managerial training is being developed, but post-basic clinical and teaching preparation remains haphazard and usually no formal evidence of preparation in these areas is required for appointments to the position of ward sister. The need for the ward sister to develop social and psychological skills especially in assessment, communication and counselling has long been recognised (Ministry of Health 1947) and there is increasing evidence of the need for conceptual ability to cope with a complex role (Menzies 1960), Trist et al. (1963), Dodd (1973), Inman (1975). The formulation and development of these various skills has
been hampered by the failure to develop criteria for the selection of ward sisters and measurements of their subsequent performance. Development of measures of ward sister performance in relation to the management of nursing on an individualised patient basis is the purpose of the present study which is now presented.
Chapter 4

EXPLORATORY WORK
Introduction

The exploratory work presented here was an important part of the study; it was from this initial work that evidence of the crucial relationship between specific aspects of the ward sister's behaviour, the ability of the nurses to nurse and the patients' experience of the nursing became apparent. Further, this empirical work confirmed and strengthened the link with the theoretical framework which had been tentatively developed during the literature review.

The exploratory work was an attempt to gain a holistic view of ward nursing. The observations included the work, behaviour and perceptions of the ward sister and the nurses; the observed experience of selected patients; and the effect of certain environmental factors, such as interruptions, on ward organisation. These observations were unstructured, the researcher turning her attention to whatever interaction, pattern of organisation or incident seemed the most fruitful at the time, regardless of who was involved. The observations of the researcher, although conditioned by her experience and values as a nurse, allowed the opportunity, not normally available to a nurse, to try and understand the patterns and relationships of the ward as a whole.

Limitations of method, time and personnel meant that only two aspects - the ward sister's behaviour and the nurses' work roles (Melia, 1978) - of the complex relationship could be explored in the main project. For this reason the exploratory work is recorded in some detail to try and convey the complexity of organising ward nursing in relation to individual patients.
Access to the hospitals and ward sisters

Seven hospitals were involved in the project. Two hospitals used in the exploratory and pilot studies, and a third used in the main study, were part of one hospital group; the other four hospitals were from separate groups. In each case the District Nursing Officer was approached about the possibility of the hospital being included in the study; all agreed to participate. An initial meeting was held with senior nursing managers. Later the researcher was introduced, usually by the Senior Nursing Officer, to the ward sisters; this first introduction of the researcher to each sister was very brief, and the researcher had therefore to rely partly on the nursing managers' initial communication of the study to the sisters. The researcher then contacted each sister either by going to the ward or by telephone, to explain the study in more detail and to ask permission to interview her and then to observe her. Fifty two sisters were approached and all agreed to take part in the study.

The study was greatly assisted throughout by the help and cooperation of nursing management; in the exploratory stages this included a meeting with four nursing officers to find out if any ward sisters in their units were practising 'patient allocation'. Three of the four nursing officers did not know of any sisters who were practising 'patient allocation'; the surgical unit nursing officer knew of one sister and arranged for the researcher to interview her; the Principal Nursing Officer knew of a ward sister who was implementing team nursing and arranged an introduction. The setting up of the study was time consuming for both nursing management and the researcher alike, indicating the amount of communication and effort that has to take place between the different levels of the nursing structure.
Exploratory interview with a sister who had practised 'patient allocation'

The purpose of this first interview was to identify factors which would be important in the design of the main study. In particular, Sister E was interviewed because the nursing officer knew that she had practised 'patient allocation'. The nursing officer asked the sister if she was agreeable to an interview; once this was confirmed the researcher rang her to make an appointment.

At interview, which took place in the sister's office, the researcher explained that she was involved in a study to compare the differences between 'patient allocation' and 'task allocation' as methods of organising the delivery of nursing care. In particular she was looking for wards in which 'patient allocation' was practised for inclusion in the study.

The sister explained that she had practised 'patient allocation' both abroad and in the present ward but had discontinued because of staff shortages.

After obtaining details of the ward and nurse staffing levels, the researcher asked the sister to describe the way she currently organised the daily nursing. She was able to do this simply and quickly and an outline is given below:

07.30 Night nurse reports to sister and the first shift of nurses; sister allocates the work

Work is allocated both in clusters of tasks - for example, a bed bath is combined with toileting and mobilisation - and also as single tasks, for example, naso-gastric suction is done as a separate task round

07.40 - Sister does a round of the patients and then
08.00 joins the nurses in helping with the morning's work
12 noon Patients’ lunch
13.30 Sister reports on the patients to the second shift; the report is combined with teaching, and is joined by nurses from the first shift if possible

The researcher asked specific questions to gain more information on methods of work prescription and work accountability. Allocation of work was supplemented by a written nursing care plan for each patient; these were accessible to the nurses. The sister did not ask the nurses to report on their morning’s work as she "knows what is going on" by working with the nurses, and by being able to observe the sixteen patients in the ward easily.

The sister was asked what she saw as the priorities in her job as a ward sister. She defined these as ‘clinical work with patients’ linked with ‘helping the nurses’. She saw herself as both a ward sister and a clinical teacher with overall responsibility for the ‘co-ordination of patient care’. ‘Paperwork’ was the least important activity.

The researcher then asked the sister to describe the way she had organised the nursing when she had had enough staff to practise patient allocation. The patients were divided into two groups, mixing high and low dependency patients; one senior nurse and one junior nurse were allocated to each group of patients. Responsibility for the organisation of work was delegated to the senior nurses by the sister; at the end of the morning she received a ‘feedback’ report from the nurses.

The sister commented that she thought the nurses responded well to the increased responsibility associated with patient allocation. The method required that introductory course nurses were taught the
technical specialties of the ward, including the management of intravenous fluids, naso-gastric suction, dressing and drains, but this was 'no problem'.

The sister described her own role, when practising patient allocation, as that of 'back up' and 'consultant'.

Summary

This initial interview was of importance in the design of the study. First, the ward sister was able to describe two different ways of organising the nursing, and the way in which this affected her role. She clearly identified patient allocation as being associated with increased nurse responsibility, formally delegated from the ward sister; this was linked with the need for 'feedback' reports. The ward sister behaved as a 'consultant' to the nurses.

When patient allocation was not possible because of staff shortages, the sister behaved more like the other nurses. Instead of being the 'backup' and 'consultant' she was directly involved in giving nursing care. Responsibility for the organisation of the work was no longer delegated to the nurses and therefore the 'feedback' reports were discontinued, the sister relying on the more informal method of 'seeing what was going on'.

The interview encouraged the researcher to pursue the idea of patient individualisation being linked with increased nurse responsibility, and with specific managerial behaviour on the part of the ward sister.

Second, the interview confirmed the suspected difficulty of finding 'patient allocation' wards to compare with 'task allocation' wards, as this was the only sister whom the nursing officers suggested
might be practising patient allocation. This, together with subsequent exploratory work, led to the rejection of the idea of a comparative study, and recognition that the first need was for a descriptive 'identification' study of different methods of organising ward nursing.

Exploratory interviews with five ward sisters

The purpose of this stage of the exploratory work was to interview and observe a number of sisters to see if there were differences in the way in which they organised the nursing. The purpose was also to gain information about the sisters' working environment and perceived role which the interview with Sister E had indicated as important variables.

The first four interviews were conducted in the same hospital; the two surgical and the two medical sisters of the adult male and female wards were interviewed. Each ward was of a different physical design and had between twenty two and twenty four beds. The fifth interview was with a sister in the large hospital in the group who was in charge of an 'L' shaped fifty two bedded radiotherapy ward containing both male and female patients; it was known that this ward sister deployed her nurses within two teams.

Four of the five interviews were taped; one ward sister did not agree to this and the interviewer recorded the interview verbatim as far as possible. The tape recorder was used to gain the richest possible data for exploring the ward sisters' view of their role and aspects of their job; it was not intended to categorise this data in any detail. The interview was semi-structured (Annexe 1 ) and allowed discussion of issues raised by the ward sister or interviewer in the light of the initial questions.
The interview was divided into three areas; first, questions related to the ward environment and to the concept of the ward as an open system, and the way in which changes outside the ward had been experienced within the ward (Questions 1, 2, 3); second, the ward sister's perceptions of her role, and related to this, any constraints which prevented her from working and from running the ward as she would like (Questions 4, 5, 6, 12); third, the sister's perception of her role in the organisation of the nursing and the management of the nurses, with special reference to the individualisation of nursing care (Questions 7, 8, 9, 10, 11).

The ward environment

The degree to which the ward environment had become unstable was explored with the following categories in mind:

Changes in demand: Patient turnover; patient dependency; doctor generated work; 'other' generated work; nurse training requirements.

Changes in supply: The quantity, quality, composition and continuity of the ward nursing team.

Changes in organisational structure: The introduction of the Salmon structure of senior nursing management, in particular the new post of the unit nursing officer; the removal of the ward domestic services from the control of the ward sister, and the growth of functional management.

Findings

Changes in demand

All the sisters identified a number of factors which, in recent years, had made the nursing and the ward more difficult to organise,
and had increased the demands on the ward sister and the nurses.

Patient turnover

The turnover of patients had increased. One ward sister commented:

'There is a big turnover, they go out much quicker. The elderly go out much quicker too; sometimes I feel we hurry them, but what can you do?'

Another sister remarked on the increased dependency of her patients, related to medical advances in radiotherapy.

'When I came the number of patients requiring two hourly nursing care would average ten to twelve, whereas today, for example, there are twenty one'.

Increases in medical staff

The increases in the number of medical staff, and the amount of time spent on medical ward rounds was another important issue. One sister in the small hospital said:

'In 1960 there was just one registrar for the three surgical wards; now there are one senior registrar, two registrars and three housemen - you normally have three rounds a day, counting the consultants'.

The sister in charge of the radiotherapy ward was working with eight consultants and accompanied ten consultant rounds a week. A major part of her work was co-ordinating the medical and other care.

Interruptions

All the sisters mentioned the problem of frequent interruptions in their work, in particular telephone interruptions. Four of the sisters did not have ward clerks.

Supply of nurses

The major problem in the supply of nurses was the degree to which the ward sister was dependent on trainee nurses, and the frequency with which they changed. One sister said:
'It used to be a month at a time, some you would get for a fortnight or three weeks, and it was just dreadful'.

Another sister was grateful for even six week allocations:

'I have had them for six weeks recently and this is grand'.

Another problem was fluctuations in the staffing, and the difficulty of planning when there was short term 'lending':

'Of course you get help from other wards, but by the time you get it the day is going on'.

Changes in senior nursing management structure

The sisters were asked how the changes in the nursing management structure had affected them.

Two sisters saw the changes primarily as the loss of Matron:

'Salmon has been introduced instead of Matron for a start'.

Another sister also missed the matron but felt that the introduction of a nursing officer had not affected her work.

'I miss the Matron - not as a person, but as a figure-head. But it hasn't affected me on the ward. The No.7 doesn't interfere very much. Occasionally I tend to not listen I suppose - I feel as if I have enough to get on with on the ward, teaching the student nurses, and involvement with the patients - I don't worry a great deal about the front office'.

The sister in the radiotherapy ward welcomed the new post of the unit nursing officer:

'Obviously there is much closer contact with the Unit Nursing Officer, she is here every day, whereas before if it was Deputy Matron, she was here perhaps twice a week. I find it just excellent. Being around and knowing about the department as much as she does - the particular person in post - lots of little things that crop up from day to day that are new to me. Just the mere fact of having somebody else around who knows the problems ... somebody who really understands'.
Ward services

Three sisters mentioned problems relating to the cleanliness of the ward, and the loss of ward sister control over the domestic staff:

'Although we don't supervise the domestic staff, we still have to see the work is done. There is a domestic supervisor to do that now, but I am not too happy about this really because I think it is better under the ward sister'.

The problem appeared to be that the ward sister, while no longer in control, still felt responsible for the ward services but could not rely on them being provided. This conflict was illustrated by a sister referring to a ward linen top up system.

'We have a topping up system now which I don't think is altogether successful. I don't think it is done on a proper topping up basis, whereas a proper topping up system - you should be able to forget about it'.

The ward sister's role

In answer to the questions on what the ward sisters saw as their role, four of the sisters gave similar answers. The sister who was implementing team nursing answered differently about her role and this is discussed separately (page 95).

The four sisters, all of whom came from the one hospital, identified their role as the care of the patients and the training of the nurses:

'The safety of the patient first; second, the training of the nurses'.

'The care of the patients - keeping up a good standard of nursing - and the student teaching - trying to make them into this type of nurse. Always trying to achieve the impossible'.

Three of the four sisters saw their jobs mainly as supervisors and were unhappy when, because of staffing shortages, they had to be 'pairs of hands'.
'I would like more staff nurses because I don’t see why I should be a working member of the team, because if I am a working member of the team I can’t supervise'.

The fourth sister wanted to be nursing like the other nurses:

'I would rather do the nursing and care for the patients - but that is me'.

She found it difficult to achieve her daily work:

'I never have enough hours in the day... it is probably bad organisation on my part...'

Another sister mentioned the co-ordinating aspects of her role:

'Integrating the medical staff with the nursing staff - tying the whole thing in - co-ordinating the lot. The cleaners too, they all come into it, and the porters and xray'.

Daily work priorities

The question "what are the most important daily jobs for you to do: what would you be unhappy about if you had to leave it out?" was helpful in obtaining the orientation of the sisters. Time for the patients and nurses was given priority.

'I must get round the patients'.

'I like to get round the patients quickly in the morning, look at the charts. I like to see their meals out and if they are eating'.

'Time for the patients and the nurses. The doctors are round anyway so you fit them in'.

One sister specifically mentioned work concerned with the management of the nurses:

'Seeing that the nurses have got their jobs to do and have a report'.

The sisters appeared to find it difficult to conceptualise their role in relation to their daily activities, which appeared to be mainly determined by the current external demands such as nursing staff shortages or doctors rounds. As one sister said:
'You just do your job and never think'.

**Daily organisation of the nursing**

In all the wards the daily organisation of the nursing was governed by a known routine:

'They all know the routine'.

'We have a basic routine that they all learn'.

The work was allocated on a task basis:

'We allocate pre and post op. care, dressings, medicines, general bed making, bed bathing - this sort of thing, but not actually patients'.

'... then we do a mouth care round. Their dentures and mouth rinse - the junior nurses do that. The auxiliaries might help with the rinse and brush the dentures but actual oral hygiene, proper oral hygiene, the junior nurse does'.

One sister gave more detail of how she organised the nursing:

'I have to "divide my nurses into two" because of the two small wards - it is not like one big ward. I tell them exactly which ward they are going to be in and I try to make it that they are in one ward one day and the other the next day, because they get a bit depressed if it is all old people they are looking after'.

This sister mentioned that the ward routine, 'a detailed list of what times certain things are done' was modified by special tasks given to the nurses at the daily report; individual patient written nursing care plans were also used:

'They also have a nursing care plan for every patient. Some nurses don't read it - I think in some places they are not encouraged to read it'.

**Accountability mechanisms**

The sisters were specifically asked how they knew what work had been done and whether the nurses had to report on their work. None of the sisters required the nurses to report back; they checked on the work 'by watching':
'They report if there is anything I don't know about'.

'At 4 p.m. I say "are the fluid balances done, girls?" I don't check then but I know the next day if they weren't done'.

Summary

It was possible from the interviews to gain a general picture of the way in which the ward sisters viewed their roles and the way in which the nursing was organised.

All of the sisters saw their work as mainly concerned with patients and nurses. Three of the sisters saw their role as primarily that of supervisors, while one liked actively to be involved in the nursing of the patients. There was limited conceptualisation of the components of the role, and none of the ward sister's nursing management role.

The nursing in all four wards was organised on a task basis. Three of the sisters allocated the nurses to the whole ward; one divided the ward into two sections with the physical structure of the ward appearing to be the influential factor.

It seemed that the patient's day was determined by a ward task routine, with minimal intervention by the ward sister in the daily organisation of the nursing. One sister mentioned the use of the daily report to the nurses and the patients' individual written nursing care plans in modifying the daily ward routine.

None of the sisters required the nurses to report on their work and there was therefore no evidence of awareness of the need for accountability, or of formal management of the nurses.
Exploratory observation of nursing activity in four wards

Purposes of the observation

It was felt that research into the way in which the ward sister organised the nursing in relation to individual patients required direct observation in the wards. At the exploratory stage the purpose was to observe the ward activity as a whole; to try and gain some understanding of the relationship between the ward sister's management of the nurses, the way in which the nurses worked and the care the patients received.

A second purpose was to identify the most appropriate foci of observation, from a possible choice of the ward sister, the nurses and the patients. A choice also had to be made between recording all or selected activities.

A third purpose was to explore the most appropriate method of observation. Here the choice lay between participant or non-participant methods; between continuous observation or activity sampling.

The researcher had no experience of observation techniques, and one of the purposes of the exploratory work was for her to be taught to observe by a colleague who was an operational researcher experienced in observing ward nursing activity. At the beginning of the exploratory work, the researcher recorded the ward observations longhand with no categorisation, while her colleague simultaneously recorded the same observations using an activity code list; the two methods were then discussed. In this way the researcher realised the need for some organisation of the activity recordings and designed and tested a code list of thirty five activities.
It also became clear that activity observation was time consuming and was limited as a research tool in helping to understand nursing, unless used in conjunction with other methods. At the beginning of the ward observation permission was obtained by the researcher to sit in during all the report sessions between the sister and the nurses and to join any reports between nurses. The researcher was also able to see the written nursing care plans and ward work books. The purpose was to test whether these were fruitful sources of understanding the decisions and organisation underlying the subsequent nursing activity, and ways in which this information could be recorded.

A further method tried at this stage was an interview with the ward nurses to discover their perceptions of the way in which the nursing was organised and the effect this had on patients and on their own work ability and satisfaction. Two of the sisters kindly made arrangements for the researcher to interview any nurses who were interested. These interviews took place as group discussions during the latter period of observation so that some of the observations could be discussed.

The exploratory work also included observation of selected patients to see if it was possible to observe the outcomes of the nursing organisation on them. A 'patient's day' is discussed on page 93.

Feedback to the nursing staff involved in the exploratory work

The researcher offered feedback on the ward observations to each of the four sisters and to any nurses who were interested. Three of the sisters asked for information and the researcher saw each of them, within a week of the observation period, to give them a broad outline
of the way in which their own days had been spent, the number of times they had been interrupted and by whom, and some observations on the way in which the nursing was organised. A number of nurses were also given an outline of their activity.

These sessions proved invaluable in reassuring the sisters and nurses that the researchers were not interested in 'individuals' or in 'catching them out'. It was also possible to discuss the effect of the observers in the ward. The nurses' interpretations of the findings were valuable and allowed the researcher to discuss much more freely, particularly with the sisters, the perceived difficulties and isolation of their jobs.

**Observation plan**

Each ward was observed for one day from 07.30 - 16.00 hours and the following day from 12.45 - 21.30 hours. The total observation time between the four wards was sixty two hours and twenty one minutes. Weekdays and weekends were included.

The purpose was to discover the most productive times and days for observing ward activity; to test the length of time each observer could observe, and the number of nurses and patients which could be observed at any one time.

**Findings**

**The sisters' management of the nursing**

The day started with the sister and staff nurse receiving the handover report from the night nurse.

Two sisters then did a complete round of the patients, one taking twenty five minutes and the other thirty minutes. Another sister saw nearly all the patients during the early part of the morning. One
sister was not observed to do a systematic ward round and she did not see all the patients.

At about 08.30 the nurses on the first shift, excluding the auxiliaries, received a report on all the patients from the sister; in two wards the sisters gave separate reports to the junior and senior nurses.

The reports were a mixture of information, teaching and work prescription; some of the work prescription was precise, for example:

'Please give him high calorie drinks four hourly, and observe what food he eats at meal times';

'S tand him up to urinate two hourly';

'Help her to exercise her left hand; make sure she talks to you'.

Although work prescriptions for individual patients were sometimes given, it was noted that they were given to the group of nurses; no single nurse was made responsible for carrying them out, except on rare occasions. Thus individual responsibility for fulfilling the prescriptions was never defined.

Allocation of work

No patients were allocated to the nurses, except in one instance (page 93). Often there was no verbal allocation of work, the sister relying on the known work routine. Where work was allocated it was task-centred; for example:

'Nurse (second year student) do the dressings, take Nurse (introductory course student) with you. Nurse (Enrolled Nurse) attend to the old ladies, the four hourlies, push fluids. Leave Staff Nurse the intravenous fluids and the admissions. Everybody can do baths, except those doing dressings'.
Deployment of nurses

It can be seen from the above example that the amount of work co-ordination required between the nurses, to meet patients' individual needs, would have to be considerable. However, no one had responsibility for co-ordinating the work; the two trained staff worked alone.

There was a similar pattern in another ward where the sister worked alone with patients, the two staff nurses worked together, a second year student and auxiliary worked alone and a first year student worked for part of the morning with a clinical teacher. The nurses were deployed on a ward basis though one sister allocated the nurses between the two sections of the ward; this sister reported separately to the two groups of nurses on their patients. The disturbance to the work organisation caused by 'borrowing' nurses, mentioned by sisters at interview, was observed when the staff nurse had to be 'lent' to another ward shortly after the sister had reported to her; the auxiliary was then alone until the staff nurse returned later in the morning.

Work organisation by the nurses

It was observed that further informal organisation of work was continued by the nurses themselves. They worked together on tasks like bedmaking and bathing patients in the bathroom. The nurses tried to co-ordinate some of their work; for example, an auxiliary planning to give a patient a bath checked that the staff nurse would be able to do the patient's dressing afterwards. The sister and nurses attempted to check the progress of the morning's work by asking each other, or by asking the patients.
Inevitably, within the 'one nurse - one task' system co-ordination was difficult. A list of ward tasks observed to be carried out by different nurses in one ward is given below:

- bed baths
- baths
- stripping beds
- making beds
- water jugs
- mouth washes
- oral hygiene
- cleaning dentures
- shaves
- drugs
- blood pressure recordings
- temperature, pulse and respiration recordings
- weight recordings.

The informality of the organisation and lack of clear individual work boundaries meant that some tasks were repeated; for example, a nursing auxiliary was observed to strip and remake a bed that had previously been stripped by a senior nurse and then made by a junior. Tasks could be done in the wrong order; for example, patients' oral temperatures were taken just after they had finished their cups of tea. The sister noticed this and commented:

'Just after their (the patients) tea! The nurses just don't think'.

Nursing management in relation to individual patients

While the nurses, in some instances, had authority to exercise discretion in relation to allocated tasks, they had no authority in relation to individual patients. The lack of defined responsibility for patients meant that nursing patients, as opposed to performing series of tasks, was outside the remit of any of the nurses.

It was observed that some of the junior nurses were unsure about approaching or helping patients; this appeared not always to be lack of skill or insight into the patients' needs, but lack of authority to act.
Senior nurses and the permanent auxiliaries were more confident about exercising their discretion in relation to patients. A nursing auxiliary was observed to repeatedly encourage a patient, who had had a cerebral vascular accident, to exercise her weak arm and hand and to speak and read aloud; the auxiliary also taught the patient to sit down safely. This auxiliary then encouraged a first year student nurse, who had spent much of the shift uncertainly waiting, to help in the rehabilitation of the patient. It was observed that once the student had been given some authority - in this case by the auxiliary - to nurse the patient she became actively involved in her care, including assisting the physiotherapist and then teaching the patient to turn the water taps so that she could wash her hands independently.

It has already been mentioned that while a number of individual patient prescriptions had been given by the sister at the report, the mechanism for translating these into nursing action, that is, the delegation of authority to an individual nurse to fulfil the prescription, was not used.

Thus, it was observed that the nurses were sometimes waiting and under-occupied while the nursing prescriptions had not been fulfilled. Moreover, the sisters became frustrated at the apparent lack of response to their specific requests. But because the sisters had not made nurses individually responsible for fulfilling the prescriptions, they could not hold them individually accountable when the work was not done. Only 'group accountability' was possible; on one occasion a sister was observed to call all the nurses together and remonstrate with them about ignoring her specific request to increase a patient's
fluid intake; it was apparent from the ensuing conversation that none of the nurses had recognised the prescription as her individual responsibility.

**A patient's day**

There was only one occasion where a patient was specifically allocated to an individual nurse for his entire care. The patient had suffered a myocardial infarction and was very ill. The patient was continuously observed by the researchers from the ward door from 07.50 - 16.00 hours on one day.

The nurse had been given precise work prescription for the patient, as well as responsibility for his overall care. She was observed to fulfill the work prescription, and to give a report to the sister on her nursing. This was the first time that the management cycle of the sister delegating authority to a nurse for a patient, and a subsequent accountability report from the nurse, had been observed.

Differences were also observed in this patient's experience when the nurse was acting in a multi-skilled patient centred role, compared to patients' experience when the nurses were in single task roles. The observation also showed that these two roles were incompatible. The sister had asked the nurse to encourage the patient to rest after his bedbath, and the nurse, after completing the patient's observations, settled him to rest. At this point the normal method of nursing organisation by single task roles disturbed the patient. The nurse responsible for shaving all the patients woke the patient and shaved him; this was completed at 11.14. At 12.02 the auxiliary cleaned the patient's locker top and disturbed him; at 12.05 a first year nurse accompanied by a clinical teacher gave the patient an injection.
In the afternoon the nurse responsible for the patient recorded his blood pressure and temperature at 13.39. At 13.51 the nurse responsible for the ward blood pressure round approached the patient to record his blood pressure, but was stopped by the sister who was by the patient's bed. Two minutes later the nurse responsible for the ward temperature round re-recorded the patient's temperature. The following day the nurse reported that the patient was "very exhausted and has hardly slept".

This example indicated the complexity of organising nursing on an individual patient basis. Second, it showed that different forms of nursing organisation - the multi-skilled patient centred role or the single task role - affect the experience of the patient, and the ability of the nurses to achieve nursing.

Summary

The exploratory work indicated that the ward sister was the crucial agent in determining the form of work organisation which in turn either enabled nurses to nurse patients, or prevented them from doing so.

The critical behaviour required of the ward sister appeared to be associated with active daily management of the nursing. This behaviour, drawing on management theory (p.22), would involve the ward sister in delegating authority to individual nurses to exercise their discretion within prescribed limits, and subsequently require the ward sister to hold the nurses accountable for their exercise of discretion.

The exploratory work indicated that while three of the four ward sisters recognised their role as supervisors, none of them saw the need actively to manage the nurses. The lack of ward sister management of the nurses meant that the nurses had no individual authority to nurse
patients and, as a result, the ward sister's work prescriptions for individual patients were not always met.

The ward work routines, which were substituted for active nursing management, made it difficult for the nurses to co-ordinate and order their work; and difficult to modify the routine to take account of individual patient's needs.

**Interview with the sister who was implementing team nursing**

The ward sister's role

The sister who was implementing team nursing was experiencing changes in her own role, as a result of the different organisation. She said:

'I find it is still quite difficult to answer what my role is - I am still trying to look at it. I think it is such a different role from the one I had before. Before, I was properly in the middle ... now I see myself as being more detached in one way and more attached in another way - more attached to the problems I hope. Certainly I have had more time to go and do my job and speak to the patients and the relatives, and communicate properly'.

While this sister had identified her job as primarily communicating with patients and relatives, and had increased the amount of time she was able to devote to this daily priority, she was still frustrated about the lack of time to identify patients' problems.

'What is exceptionally frustrating about my day is that I know there are many patients that I really don't know what their problems are, especially the patients who are up and dressed.'

**Management of the nursing**

The principle of delegation of authority to the nurses to organise the daily nursing, and so free the sister for her role of communication, was achieved through the use of team nursing. The sister allocated each team leader a group of patients. The team leader gave a report to her
own team of nurses, organised the nursing within the team, wrote
the nursing Kardex and gave a feedback report to the sister and
other nurses in the afternoon.

The sister thought that the sense of responsibility and decision
making of the nurses had improved; previously 'very few people were
thinking for themselves' now 'they are really taking an interest'.
She described the nurses taking special effort with individual patients
and urging their colleagues, to whom they were handing over, to do the
same.

The achievement of a self-regulating primary work group involved
the sister in formal daily management activities including the
allocation of nurses and patients, keeping team leaders informed of
changes in medical policy during the morning and receiving work
accountability reports from the team leaders in the afternoon.

Observation of the sister who was implementing team nursing

The ward in which the sister was practising team nursing was the
last of the five wards to be observed. By this time the researcher
had decided to use a pre-coded method of recording the ward sister's
activity. The main purpose, therefore, of the eighteen hours and
seven minutes of observation, over four days, was for the researcher
to be taught how to use a code list and recording form. The observation
period was also used by the researcher to develop an appropriate code
list for the study of the ward sister.

The actual recordings of the ward sister's activity during this
period were limited, but it was observed that the daily work of this
ward sister was different from that of the other sisters. Her day was
spent mainly on formal communication with patients, relatives, doctors
and others, and on managerial and supervisory activities with the nurses.

The activities of the daily nursing management cycle were observed; that is, a nursing round of the patients, prescription and delegation of work to defined nursing teams who were responsible for groups of patients, and the subsequent receiving of accountability reports from the team leaders who reported on each patient in their team. The nursing the patients had received was discussed with all the nurses attending the report, and the patients' future nursing was planned and delegated during this time.

Summary and development of study

This sister, like the four others who were interviewed, defined her role as concerned with patients and nurses. However, in contrast to the other sisters, she described her daily activity as primarily concerned with the management of nursing. She was able to conceptualise this new role and described the daily use of the management techniques of work prescription, delegation of authority and subsequent work accountability. This daily cycle used in relation to the organisation of individualised nursing is defined by the researcher as the 'daily nursing management cycle'.

The interview confirmed that it was possible to find a ward sister who described her role as primarily managing the nursing, and who further appeared to employ precisely the management techniques described by Brown and Jaques (p. 20), to achieve defined responsibility and accountability of nurses for patients.

In the light of this finding the main study was designed to identify those sisters (possibly a very small number) who fulfilled
this 'daily nursing management cycle', and to describe and compare them with 'non-manager' sisters.
Chapter 5

METHODS
Design of the main study

The exploratory work was a first attempt to identify the necessary relationship between the ward sister, nurses and patients to achieve the organisation of nursing on an individual patient basis; it had confirmed the existence of both 'manager' and 'non-manager' ward sisters.

In the light of the exploratory work a decision had to be made on the design of the study. It would have been ideal to study the three components, the ward sister, the nurses and the patients simultaneously to show their interrelatedness and, in particular, to explore the important relationship which was emerging between the degree to which the ward sister managed the nursing and the patients' experience.

The researcher and her colleague were available for the study at this time (October 1975), and a research assistant was due to be appointed for the last two years of the three-year project. The plan was for the two senior researchers each to design and carry out her own study, each being intended to link with the other. At this stage, therefore, both researchers had to define precisely the limits of their studies.

The researcher's colleague carried out a nurse/patient interaction study based on continuous observation, to describe the work patterns of nurses in relation to patients. This study was undertaken in the same wards and at the same time as the study of the ward sister. The research assistant analysed data from the nurse/patient interaction
study (Melia 1978), using the sociological model of primary work group organisation developed by Trist et al. (p. 9).

It appeared from the exploratory work that the degree to which the ward sister managed the nursing was a critical variable in achieving, or not achieving, the organisation of nursing in relation to individual patients; this, therefore, became the focus of the study reported in this thesis.

The study comprised two stages. First, a sample of fifty sisters was identified as being either manager or non-manager sisters. Second, the work and characteristics of seven of the manager sisters who met, or most nearly met, the criteria for the organisation of nursing on an individualised patient basis, were described in more detail. Throughout the study the ward sister was studied in relation to her organisational environment. The literature and exploratory fieldwork had indicated that the behaviour of the sister was affected by the organisational environment within which she worked. Therefore the management behaviour of the ward sister had to be understood in relation to the rest of her role, and to the particular environment within which she was placed.

The exploratory work had confirmed that the proportion of manager to non-manager ward sisters was likely to be small; therefore a large sample was required if enough manager ward sisters were to be identified for further study. The importance of a sample large enough to describe differences in ward sister behaviour and to identify manager and non-manager ward sisters is emphasised. Lelean (1973), in a study of formal group communication between the ward sister and
the nurses and its effect on patient care, was unable to test the hypothesis because no formal communication system could be identified in the six wards of the main study (p. 10). The daily management of the nurses is largely dependent on the employment by the ward sister of the formal group communication system, for example, work prescription and accountability reports; therefore Lelean's findings were noted in the design of the present study. However, the researcher was prepared, in spite of the exploratory work, for negative findings; that is, no evidence of a formal daily management cycle, because that in itself would have been useful information.

The need for a large sample placed constraints on the amount of time which could be devoted to 'identifying' each sister, if time was going to be left for more detailed study. Two decisions had to be made; what was a 'reasonable' sample, and what was a reasonable amount of time to spend on the identification study. One year was available for data collection, analysis and some initial feedback to the ward sisters involved in the study. It was decided that three months of data collection time was available for the identification study, if that was to be analysed and a further study designed and the data collected and analysed within the year. Three months of continuous data collection, excluding observation at the weekends, meant that it was possible to interview fifty sisters and observe them for one day each.

The problem of observer bias was likely to occur on just one day of observation when the sister would be unused to being observed; it is for this reason that the first day of observational data is normally discarded. However, to have increased the observation by just one day
for each sister would have doubled the data collection period from three to six months. Further, no conclusions could be generalised from even two days of observation.

The sample for the identification study was fifty general medical or surgical ward sisters from five hospitals; data were obtained on fifty random weekdays. Each sister was observed for one full shift from 07.30 or 07.45 to 16.15 or 16.30 hours. It is stressed that the method was to record whether certain activities did, or did not, take place in a given sequence on any day and that this was the criterion for the selection of manager sisters; the amount of time devoted to the activities was not the criterion.

It is emphasised that the unit of measurement adopted in the study was a random day, from which no generalisations may be made. It was, however, possible to state whether the management cycle activities were, or were not, performed on the given day; whether each sister’s stated daily work priorities were observed and to describe the broad categories of her activity on the day of observation. It was also possible to measure across the sample; for example, the number of sisters who were observed to do a nursing round of the patients on the fifty random days. The observations would have to be repeated over a period of time before any predictions in relation to consistency and generality could be made.

The effect of observer bias needs to be considered; it is probable that a number of the sisters behaved differently as a result of the single day of observation, but it is the view of the researcher that even if this was the case, this would not have affected the
findings. First, because of the constraint of one day of observation, the activities of the sister were broadly categorised and represented large proportions of time; therefore changes in behaviour as a result of the observer's presence are unlikely to be reflected. Bias affecting the management cycle activities was more important as these were discrete activities which differentiated the manager and non-manager sisters. For this reason the categorisation of these activities was based on qualitative criteria (Chapter 8), and not solely on measurements of time. Categorisation by time was tried but abandoned because it did not, in the view of the researcher, reflect observed differences in ward sister behaviour, and could also have been subject to observer bias. Second, in relation to the problem of bias, it is suggested that completion of the daily management cycle requires a conceptual ability on the part of the ward sister; if there is no concept of the need for certain behaviour the ward sister cannot behave in that way even if observers are present. This view is supported in the findings (p. 178).

A further limitation of the study was that only the ward sisters themselves were studied. The role of the ward sister is an organisational role which can be perceived at different levels (Newman & Rowbottom 1968, p. 8) and in different ways by the actors themselves, as well as by others, depending on their own organisational role. Williams (1969), found that the ward sister role was perceived differently by senior nurses, administrators and the sisters themselves. The findings reported in this study are the facts and perceptions reported by the ward sisters. Others, including patients, are likely
to have perceived the same situation differently; their views are not recorded.

A limitation in the collection of the observational data was that only the work of the sister was observed in relation to the activities of the daily management cycle. It is possible that other nurses, particularly the staff nurses, also undertook activities concerned with the management of the nurses, such as work prescription and work checking; authority to carry out management activities would have to be delegated from the sister, but in a well established nursing team this authority would be implicit and not delegated on a day to day basis.

The question whether it is reasonable to expect a formal daily management cycle in relation to any of the nurses also has to be explored. The need for formal as opposed to 'informal' management has already been explored (p. 23). The need for a daily management cycle in ward nursing can be discussed in relation to the concept of time-span capacity; that is, 'the individual's capacity to carry out tasks of given levels of work as measured in time-span' (Jaques 1965, p. 115). The primary task, that is 'the daily completion of the production cycle under all the conditions that prevail' (Trist et al. p. 9), in ward nursing is the achievement of nursing in relation to some twenty to thirty individual patients whose needs change daily, if not more frequently. This primary task is performed by a group of mainly trainee nurses who are still learning to assess and meet patients' needs and whose work is frequently interrupted and disorganised because of the particular environment within which they
Exercise of discretion in this situation is laden with anxiety (Menzies 1960); the functions of the management cycle in reducing anxiety and in achieving the primary task are discussed on page 207.

Further, the work group itself is unstable; different nurses make up the team day by day; with the exception of permanent staff nurses and nursing auxiliaries, the whole team changes over a period of eight to twelve weeks. It is against this background that the sister has to organise the nursing and that the concept of the daily management cycle was tested.
THE IDENTIFICATION STUDY

As explained earlier (p. 101), the purpose of the first stage of the study was to identify 'manager' and 'non-manager' sisters and this required a fairly large sample. The need for a large sample influenced the type of research instruments that could be used; in particular, the methods had to be related to the processing of a large amount of data. The problem therefore was to structure the data sufficiently for them to be analysed without sacrificing any of their content.

The exploratory interviews with six ward sisters, and the sixty two hours of unstructured observations were the source for the methods of data collection used in the main study. These methods were:

1. Checklists:
   (a) Checklist of work problems
   (b) Checklist of daily work priorities

2. Semi-structured interview: the ward sister's description of the daily organisation of the nursing

3. Questionnaires:
   (a) Questionnaire on the ward sister's resources and aspects of her work
   (b) Questionnaire on the ward sister's background

4. Non-participant continuous observation of the ward sister's activity.

Each of the methods is now considered in turn.
1. **CHECKLISTS**

The checklist is an instrument which 'in most respects ... behaves like a questionnaire' (Fox 1976, p. 235). It is primarily used for information seeking, and can provide nominal or ordinal data. Because a checklist is highly structured it is useful to obtain mass data, and is quick and easy to use. This tight structure also imposes limitations, and Fox suggests that the use of the checklist is limited to superficial data. Oppenheim (1966), on the other hand, believes a checklist is an instrument which can be used to explore subtle and complex processes; he gives an example of a checklist successfully used to explore the dimensions of autocratic and therapeutic attitudes held by psychiatric nurses (p. 96). Both Fox and Oppenheim, however, agree on the need for the checklist to be based on prior empirical study, 'ideally with open ended questions'. Careful piloting is also required to ascertain that all the significant elements have been included in the list.

The exploratory interviews and observations were the empirical work on which both checklists were based. The literature on the work of the ward sister (Chapter 3), in particular the work of Goddard (1953) and Walker (1967), were sources for the checklist of daily work priorities. Mauksch's (1966) work on the organisational context of nursing practice, together with the empirical work, helped to define the categories of the checklist of work problems; the researcher also drew on her recent experience as a ward sister in compiling this list.
1(a) The checklist of work problems

The intention was to use the checklist of work problems at two levels. At the superficial level the list was just a list of daily work problems experienced by ward sisters, which could be analysed in terms of common problems, or in terms of problems resulting from different hospital environments. At this superficial level the fifty-one problems drawn from the empirical work were placed in five categories: nursing resources; ward maintenance and support services; interruptions; medical work; admission and discharge policy.

At a deeper level, drawing on organisational theory, it was hoped to explore:

(a) The dimensions of organisational instability generated by open systems, as experienced by ward sisters;

(b) evidence of the strategic organisational position occupied by the ward sister;

(c) the strains on the role resulting from:

(i) The lack of control that the ward sister has over hospital and medical generated work; (Mauksch, p. 61)

(ii) the lack of control the ward sister has over ward services essential for nursing patients, but supplied by other departments;

(iii) the lack of control the ward sister, in spite of being a line manager, has over nursing policy and resources (Newman & Rowbottom, p. 19).

The original list of problems identified by the ward sisters and categorised into the superficial categories, is given below.
Items and categories of the pilot checklist of work problems

Admission and discharge policy

the number of emergency admissions
not knowing the diagnosis of admissions
admissions arriving in the ward before their beds are ready
patients who should really be in other wards
the number of patients who are transferred to or from the ward
keeping accurate records of the number of admissions/discharges
patients being discharged at too short notice

Medical work

getting doctors to keep to the hospital drug rules
doctors not giving patients enough explanation
the number of separate medical rounds in the day
the number of consultants who come to the ward
getting conflicting orders from different doctors
the number of tests the doctors order
the number of medical students

Interruptions

interruptions from the telephone
interruptions from the doctors
interruptions from the nurses
people always coming to the ward sister
visiting times
the amount of time spent looking for people
being unable to complete one job at a time

Ward maintenance and support services

getting the ward cleaned properly
getting patients' notes and x-rays
getting ward furniture/equipment repaired or replaced
getting enough linen
the design of the ward
porters taking patients from the ward without asking

Nursing resources

nurses going off sick for the odd day or so
getting extra help when the ward is heavy or busy
the number of heavy/handicapped patients
arranging the off duty to give adequate cover
having to lend nurses to other wards
the hours the part time nurses work
trained staff moving frequently
being given, or having to keep, unsatisfactory staff nurses
not enough nurses who can supervise or teach
student/pupil nurses allocated for too short a time
having to leave junior nurses in charge
working in with the clinical teacher or tutors
finding enough experience for students and pupils
the feeling that you have no one really to turn to for help
The checklist was originally tested on four nurses in the Research Unit, three of whom had recently been ward sisters. The list was then tested on sixteen volunteer ward sisters/charge nurses from a group attending a research appreciation course; seven of the ward sisters were representative of the general medical and surgical ward sisters to be included in the study and nine were not representative. However, at this stage the checklist was being tested for understanding of the items, layout, ease and time of completion as well as relevance, so all the volunteers were included.

During the analysis of the pilot study six of the checklists were discarded (three incomplete lists, three where some of the items were not relevant); of the remaining ten checklists each item was analysed for the number of times it occurred as a problem. There was good discrimination between items. The items were then grouped into the five categories and those with the lowest scores in each category were deleted until the checklist had been reduced to a total of thirty items, all of which could be presented on one page; there were ten items in the nursing resources category and five items in each of the other categories.

During the pilot work the ward sisters/charge nurses had been asked to record any extra problems that were not on the list; a recurring one 'having to have extra beds in the ward' was substituted for a redundant item in the admission/discharge policy category. Throughout the pilot phase two versions of the checklist were used with the items arranged in a different order to control for bias resulting from the ordering of the questions, and this method was retained in the final form.
The checklist of daily work priorities

The main purpose of the checklist of daily work priorities was to assess the degree of importance the ward sister attached to the activities which comprised the daily management cycle, compared with other daily activities. To achieve this the list contained the items 'do a ward round of the patients', 'give the nurses a report on the patients', 'check that the nurses have their work for the shift' and 'ask the nurses to report on their work'. These items were placed among other frequently observed ward sister activities, categorised as work with patients, nurses, doctors, and nursing management.

A second purpose of the checklist was to build up a profile of the stated important daily work activities of each sister so that it could be compared with her actual activity, which was to be subsequently observed. To achieve this purpose each checklist item had to be a discrete activity which was easily observed and likely to occur in the ward sister's daily activity; as a result of pilot work items which did not meet these criteria were excluded. The item 'attend a unit meeting', although not a daily activity, was retained as the ward sister's attitude to work with nursing management was of special interest and the item was discrete and well understood. The final checklist (Annexe 3) contained twelve items.

At the pilot stage the sixteen respondents were asked to rank the items in the work priority checklist; they found that while they could select priority items they experienced difficulties in ranking them. For example, 'the round of patients' and 'giving a report to
the nurses' were held to be of equal importance. The checklist was therefore revised and re-piloted and in the final version the sisters were just asked to place an extra tick against those items given priority.

Analysis of the pilot study forms showed that there was good discrimination between items. For example, two items 'giving nurses a report on the patients' and 'doing a ward round of the patients' scored nine and ten respectively, while items such as 'attending to patients' meals', 'writing the nursing kardex' and 'accompanying the nursing officer on her round' scored nought to two. In contrast to the checklist of work problems where low score items were excluded, low score items were retained on the revised checklist of work priorities, because the sisters' perception of non-essential aspects of their work was of equal interest. The middle score, non-discriminating items such as 'supplying information to the nursing officer' and 'accompanying the registrar on his round' were excluded. The checklist was used in two different orders to control for bias resulting from the order of the items.

During the pilot work it became evident that there were areas of work, rather than discrete tasks, that the ward sister felt she should be doing but did not have enough time for - or in some instances - skills for. The relationship between what the ward sister perceived as job priorities, and what she actually did, could be examined by comparing the job priority checklist and her observed work. However, the tight structure of the checklist precluded the opportunity to explore the ward sister's perception of what she would like to do,
given more time, and the conflicts between what were formally recognised parts of her role but were not achieved. In order to try and examine the sisters' desired work, a space was left on the form for adding aspects of work that the sister might like to give more time to, and this question was specifically raised during the interview.

In summary, while the checklists imposed certain limitations they obtained data which were easily collated. It is believed that a checklist is not necessarily confined to superficial data but can be used to obtain different levels of data, provided the dimensions are common and provided that the checklist is developed from adequate empirical work. It is felt that the checklist of work problems achieved different levels of data to some degree (Chapter 6), while the data of the checklist of daily work priorities remained restricted.

2. **SEMI-STRUCTURED INTERVIEW: the ward sister’s description of the daily organisation of the nursing**

The purpose of the interview was to obtain the sister’s own description of the way in which she liked to organise the daily nursing. The questions were developed during the exploratory work; the interview schedule is given in Annexe 1.

The interviewer ensured that she received information on 'how the nurses know what work to do', 'how the nurses work' and 'how the ward sister knows what work has been done'. These questions elicited information on work prescription, the way in which the nurses were allocated work and the way in which the ward sister received feedback on the work the nurses had done. Often it was not necessary to ask
the questions specifically, as the ward sister gave the information as she described her daily work pattern and that of the nurses.

It is the view of the researcher that this semi-structured interview in which the ward sister described the organisation of a typical ward day was the most useful instrument used in the study. All the ward sisters were able to describe the organisation of the day simply and quickly as the information was related to the specific day they were describing. It was possible, with very little questioning, to gain information about how the ward sister perceived her role, and in particular her managerial role, by the way she described her daily work in terms of the organisation of the ward and the nursing. The ward sisters varied in the degree to which they seemed conscious of a management role; that is, the degree to which they identified the activities of work prescription and allocation, the supervision of work and work accountability. A number of sisters did not mention work associated with these activities; apart from accompanying medical rounds and giving an information report to the nurses, they did not differentiate their own work from that of the nurses.

Again, the sisters varied between those who could communicate a clear perception of their role and what they wanted to achieve each day in the ward, and those sisters who found it difficult to identify any planned role for themselves or the nurses. This second group of sisters did not relate the nursing to patients, but described the day by fixed, mainly externally-determined events such as meals and doctors’ rounds.
Analysis

The interview schedule was hand-analysed under the following headings:

Prescription and allocation of work

Sister  (a) gives early morning report to the nurses
(b) verbally allocates work

Deployment of nurses
to
(a) ward; section of ward; patient group
(b) deployment of nurses to tasks; to patients

Nurses work
alone; in pairs; in specified junior and senior nurse
pair; in teams

Division of work
All nurses can do all work; different work for senior and
junior nurses

Accountability mechanisms
(a) each nurse reports back; some nurses report back
(b) all nurses from first shift attend handover report;
some nurses from first shift attend handover report
(c) nurses write kardex; nurses tick work list; nurses
report 'special events'; sister 'checks by being
in ward'.
3. QUESTIONNAIRES

(a) Questionnaire on the ward sister's resources and aspects of her work

The purpose of the questionnaire (Annexe 5), was to obtain factual information on the ward sister's resources and the degree to which she was involved in work with nursing management and education and in hospital policy making. The questionnaire was designed to be administered by the researcher.

(b) Questionnaire on the ward sister's background

The purpose of the questionnaire (Annexe 6), was to obtain information relating to school academic achievement, nurse training and experience and career plans. Decisions were made, in the light of the pilot work, not to include questions on father's occupation; marital status; country of origin and nurse training school.

The questionnaire, which was based on the questionnaire designed by Social Planning and Community Research for the Committee on Nursing (1972, p. 250), was administered by the researcher, but was designed so that it could be self-administered if necessary.

Both questionnaires were pre-coded. The codes were transferred by the researcher on to coding sheets and the data were then punched and processed by computer. The researcher hand-analysed the data for an interim report to the hospitals involved in the study. The two sets of data were cross-checked.

Administration of the checklists, interview and questionnaires

While the researcher tried to indicate in the introduction of the interview that she was aware of some of the aspects of a ward
sister's job and sympathetic to the problems, she did not say that she had been a ward sister herself unless the sister asked her.

The primary purpose of indicating some identification with the ward sister's job was to encourage the ward sisters to speak freely about their work, problems, and relationships; secondly, it allowed the sisters to use nursing terminology and avoided the need for detailed explanations. This mode was particularly helpful when the ward sisters were describing how they liked to organise the nursing and reduced the time needed for the interview.

The interview consisted of five separate sections. First, a brief introduction of the purposes and methods of the study; second, the administration of the factual questionnaire (Annexe 5); third, the ward sister's own description of the daily organisation of the nursing; fourth, the two checklists and fifth, the questionnaire on the ward sister's background.

The sister then completed the two checklists (Annexes 2, 3). The sisters appeared to enjoy completing the checklist of work problems and frequently commented on their own experience of the problems. In contrast, the completion of the checklist where the sister was required to indicate her daily work priorities, appeared to make some of the sisters anxious, possibly because of difficulties in determining priorities between the items as 'all were equally important'. Other sisters had no difficulty in selecting their daily work priorities.

The interview was completed with the administration of the questionnaire on the ward sister's background (Annexe 6). While this was factual it included personal questions and, from experience
gained during the exploratory work, it was placed at the end of the interview when the sister was more relaxed. Further, it was designed to be self-administered if necessary so if time was short, or the sister preferred, she could complete the questionnaire herself.

The length of the interviews, all of which took place in the ward, varied between twenty five and forty minutes; sometimes they were extended by the sister which was of benefit to the researcher who gained further insight as a result of this informal discussion.

In summary, it was felt that the interview was the most successful aspect of the data collection. The combined use of questionnaires, semi-structured interview and checklists produced rich yet easily analysed data and did not require too much time on the part of the ward sister. Personal interviews are considered extravagant in terms of the researcher's time (Treece and Treece 1973), and while they imposed certain constraints (p.126), it was felt that the insights gained during the administration of the interviews was worthwhile.

4. NON-PARTICIPANT CONTINUOUS OBSERVATION OF THE WARD SISTER'S ACTIVITY

The ward sister activity code list

A code list of thirty five activities was developed from the exploratory work (Annexe 7). The purpose of the code list was to record all the observed activities of the ward sister under five categories: (1) the daily nursing management cycle; (2) the daily work priority checklist; and categories relating to (3) nursing, (4) ward and (5) hospital centred activity.
The code list recorded the management cycle activities separately. As stated on page 97 these were: the nursing round of the patients; written work prescription; oral work prescription; and receiving oral work reports from the nurses. Other codes which involved the sister in exchange of information, supervision and interaction with the nurses were also recorded separately; these were: information reports to or from nurses; teaching; talking with nurses; and giving direct care to patients with nurses.

The rest of the ward sister's activity was categorised into broad areas of work associated with the nursing, the ward and the hospital so that a picture of each sister's day could be gained, against which to set the study of the management cycle.

A code was used to indicate whether the sister herself or others initiated each activity, thus making it possible to compare the proportion of the day the sister spent on discretionary self-initiated activities with the time spent on non-discretionary activities, initiated by others. Williams (1969) in his study of ward sisters' activity had found a high level of 'pre-set', non-discretionary activity. Further, he showed that the ward sister spent approximately eleven per cent of her time in communication with the doctors but only about 0.5 per cent with nursing management; these data had been collected shortly before the introduction of the post of the unit nursing officer. One of the purposes of the present study was to describe the ward sister's work with nursing management in the light of recent changes in the structure. Thus the work of the sister with nursing management and with the medical staff was
separately coded so that the two could be compared. Further, the weighting of the categories for each ward sister day could be distorted by a single non-discretionary activity on the ward on the observed day; for example, a long medical round. This non-discretionary work reduced the amount of time the sister could spend on nursing activities and thus the categorisation of discretionary and non-discretionary work was helpful.

The recording form

The recording form (Annexe 8), includes the number, type and time of each activity; the number and grade of nurse involved in the activity; the number of patients involved; who initiated the activity and the location of the activity. The form also included a column for recording the number and type of interruptions to the ward sister's activity. The form was designed so that the data could be punched directly from the form and stored on disc.

Timing of activities

The design of the study (p. 102), which involved only one day's activity being observed for each sister, required that the activities were broadly categorised and therefore the coding of a large number of detailed activities would have been inappropriate.

The same principle applied to the timing of the activities; the purpose was not to record detailed timings of each activity but to build up broad categories. It was therefore felt that the use of a stop watch was unjustified, especially as this could have increased observer bias - a number of sisters expressed anxiety about work study
methods. Accuracy of timing was however important, especially as many of the activities such as conversations, were of less than one minute's duration. A digital watch, which flashed the hour, minute and second, was used for timing the activities.

Each time a new activity was initiated by the ward sister the starting time was recorded; the next activity, and therefore the next starting time, terminated the previous activity timing. The timing for each activity on each recording page was summed and had to correspond with the total of each page, as well as the total observation period. Each activity was accorded a time in minutes, in both the hand and computer analysis. If there was more than one activity within the minute, the minute was divided according to the number of activities; for example, two activities would be awarded .5 of a minute. Thus there may be slight over- or under-timing of activities of less than one minute's duration. The method means that categories of activities of very short duration, such as conversations with patients or nurses, are likely to be overweighted and this should be taken into account in the interpretation of the findings.

Categorisation of activity

The categorisation of the activity was governed by the way in which the data were collected. It has already been noted that each sister in the identification study was only observed for one day and therefore no conclusions can be drawn about probability, consistency or typicality. The data can only be viewed as fifty random ward sister days.
However, these days can be used to identify first whether the management cycle was performed by each sister on the given day; second, whether the activities given priority on the daily work priority checklist were in fact observed on the day of observation. Third, the degree of role differentiation practised by the sister on the observed day can be analysed. A role differentiation classification was developed and this is described in Chapter 7.

**Analysis of activity form**

The activity forms were initially hand analysed by the researcher and the research assistant. The length of time spent on each activity alone or with nurses was totalled for each code (Annexe 10). The total time for each code was recorded on the summary sheet (Annexe 11). These totals were then summed and compared with the total observation time; a discrepancy of up to five minutes (one percent) was allowed on the day's observation. The totals were converted from minutes to percentages of the total time.

As well as being hand analysed the checklists, questionnaires and the activity data were computerised. A programme was written which enabled the researcher to analyse separate activities or categories of activity in relation to individual sisters; its purpose was simply to organise the data and no statistical tests were performed. It is the view of the researcher that computerisation was a mistake which resulted in the inappropriate use of the computer and delayed the study.
Originally it was intended to correlate the interview with the observational data. However, the observational data were fifty individual ward sister days; analysis of activity across the sample was meaningless as the purpose of the study was to identify the differences between the sisters. Statistical tests based on each of the fifty days would have conveyed a precision that was unjustified. Further, the researcher believed that the computer would assist in the handling and organisation of the large amounts of activity data, but had not appreciated the time required to learn and then perform the tasks of cleaning and editing data before it could be processed.

In the event, the type of quantitative analysis particularly suitable for computer handling proved inappropriate as a means of analysing the activity of the ward sister. While the broad categories of the ward sister activity have been analysed on a time basis, this proved inadequate as a basis for the classification of the management cycle activities. It is believed that the qualitative classification adopted, while more subjective, is a more enlightening and appropriate way in which to handle the essentially exploratory nature of the study.

**Training of the observer**

Both the researcher and the research assistant, who shared the observation of the ward sisters, were taught to observe by their colleague who was responsible for the nurse/patient interaction study (p.100). The research assistant had twenty hours of training experience in observing ward nurses using an activity code list.

The ward sister code list had been developed in consultation with the research assistant who was also a nurse, and who was familiar with
the objectives and theoretical background of the study. In particular, the discrete management activities of the nursing round of the patients; written work prescription; oral work prescription and receiving work reports from the nurses were discussed by both observers. Attention was paid to the distinction between a nursing round of patients and talking to patients; written work prescription and writing the nursing kardex and between prospective work prescription and retrospective information. During the data collection phase the researcher and research assistant had a short daily handover period, and often a longer period for discussion when the observation was completed, so that queries about classification of activities could be settled.

Tests for inter-observer reliability

The researcher and the research assistant simultaneously observed a ward sister's activity for half an hour during the morning observation period to test for inter-observer reliability. This was done once in the middle of the study and once near the end. There was good agreement on the classification of the activities but some minor discrepancies on the timing of activities.

In retrospect, the researcher feels that the training of the observer and the testing for inter-observer reliability, were only adequate. In particular, not enough time was given to the researchers working together to become familiar with the final ward sister code list before the main study began; this observation in no way detracts from the quality of work of the research assistant who was entirely reliable and conscientious, but underlines the need for adequate
preparation with the instrument being used, as well as general training in observation, before the main study begins.

The design of the study required the researcher to interview the sisters at least one week before they were observed. This condition involved the researcher in visiting each hospital before the observation period started. Normally, the researcher was able to observe in the morning and interview in another hospital in the afternoon. Where the hospitals were far apart this was impossible and on six half shifts out of the hundred, the researcher's colleague was the observer for the ward sister study. It is possible that some inconsistency was introduced as a result, but the researcher is satisfied that even if this was the case, it has not affected the final classification.
Introduction of the study to the ward sisters

The researcher introduced herself as a nurse from the Nursing Research Unit, University of Edinburgh, and a member of a team of two nurses and one non-nurse who were doing a study of ward nursing, with particular reference to the role and work of the ward sister. The researcher indicated that the job of the ward sister was complex, often difficult, and had been affected by the recent changes in nursing and the health service. The purpose of the study was to find out how the sisters themselves saw their jobs, what they saw as the problems and how they liked to run their wards.

The researcher explained that she would like to interview the ward sister for about half an hour to forty minutes, and then at a later date to be chosen by the ward sister, the researcher would like permission to spend one complete day (07.30 - 16.15) on the ward observing her; on the same day, but only between 08.00 - 12.00 hours her colleague would like permission to observe the work of the nurses. It was explained that the observation of the ward sister would be divided between the researcher and the research assistant, the change over taking place at 12.30; the third member of the team would be carrying out the morning observation of the nurses alone.

It was emphasised that the observers were non-participant, and that they would stand just outside the entrance to the ward in the open wards and at a convenient observation point, out of the way of nurses and patients, in the other wards. The observers would be wearing ordinary white hospital coats with a name badge.
Permission was asked for the researcher or the research assistant who was also a nurse to join any report sessions the sister had with the nurses; an assurance was given that no individual patient details would be recorded. The anonymity of the sisters and nurses was guaranteed.

It was promised that each of the five hospitals taking part in the study would receive a report on the findings when the study was completed, and that each sister who had been involved would receive a 'feedback' letter giving an outline of her work on the day of observation (Annexe 12).
THE COMPLETE PILOT STUDY

As explained on page 100 the project involved two studies which were designed to be linked. The development of the methods for the two studies, as well as the different methods used in the ward sister study, had taken place in sections. It was therefore necessary to test the envisaged method of the study as a whole and the pilot study was undertaken for this purpose. Its aims were:

1. To test the division and sequence of work among the three researchers involved in the total project, of which the ward sister study was a part.

2. To test the administration of the ward sister interview in the ward situation, and to test the timing and sequence of the questionnaires and checklists.

3. To do a further two days of continuous observation of the ward sister to retest the recording form and code list; to continue the training of the observer and to test for observer reliability.

4. To test the code list for recording the management of nursing activities, and the subsequent analysis of the major categories of activities.

The hospital used for the pilot study, which was conducted in two wards, had already supplied one of the five wards used in the exploratory work. It was a general city hospital of 550 beds, and was used for the training of medical students as well as student and pupil nurses. The two wards were the male and female wards of a gastro-intestinal unit which served both medical and surgical patients. Each ward had sixteen beds in an open ward, and was easily observable.
The hospital was selected for the pilot study because of the contact and co-operation already established, as well as its accessibility. One of the two ward sisters included in the pilot study had assisted the study in the very early stages with an interview. It was not the purpose of the pilot study to collect new data, but rather to test the administrative and data collection methods of the joint study; therefore, the further assistance of a sister who knew a little about the study was invaluable. The two sisters were approached about participation in the pilot study through the nursing officer and both agreed to take part in the interview and observation.

Both sisters were interviewed on the same day. The interviews took place in the sister's office; one lasted twenty five minutes, the other, with some interruptions, lasted thirty five minutes. The researcher's explanation of the study and the sequence of the factual questionnaire, followed by the ward sister's description of the daily organisation of the nursing and her completion of the daily work priority and work problems checklists and the background questionnaire, proved satisfactory. Some items of the checklist of daily work priorities were found not to be daily activities and the checklist was modified.

Piloting of the activity code list

The activity code list was tested for two specific reasons. First, to check that the code list of forty one activities was sufficient to classify all the observed activities of the ward sister, and, related to this, that the data could be analysed by reducing the activities into the broad categories of activity required to describe
the ward sister's day. Second, the activity code list was tested to make sure that each of the activities relating to the daily management cycle and the work priority checklist was separately coded. Each sister was observed for one week day from 07.30 - 16.00 hours using the code list of forty one activities. No problems were encountered during the two days of observation.

The coded activities were analysed to check that the completion or non-completion of the activities of the management cycle could be shown, as well as concordance or discrepancy between the observed activities and the stated daily priorities of the work priority checklist.

During the analysis a number of redundant codes were found for activities which came within the two broad categories of primary and technical nursing. It was not necessary to identify the specific activities within these two categories, and thus two codes only were substituted to represent the categories. The only exceptions were the specific activities of supervision and distribution of meals which was an item on the work priority checklist, and the administration of drugs which was known from the exploratory work to be a time-consuming activity which was often 'non-discretionary', that is, the ward sister had to carry out the task if there was no other trained nurse on the ward. The decision to use only two codes for all the activities comprising the two categories of primary and technical nursing was discussed with the other observer, and the activities to be merged into each category were agreed. Two extra codes, interaction with the ward clerk and interaction with the ward domestic were added to
the activity code list; thirty-five codes were used for the main study. They are shown in Annexe 7.

The recording and analysis of the activity of two ward sisters' days confirmed that it was possible to observe and record satisfactorily first the completion or non-completion of the activities which comprised the daily management cycle; second, those activities given priority by the sister on the daily work priority checklist; and third, the rest of the ward sister activity for grouping into categories to give a broad picture of how the ward sister actually spent her day. These categories were satisfactory and, in particular, could be used to determine the amount of discretionary time the ward sister had in the day when she could initiate activities, and the amount of non-discretionary time where the ward sister's activity was largely determined by someone else.

Findings of the pilot study

The daily nursing management activities comprised the nursing round of patients, work prescription and allocation, and receiving work accountability reports from the nurses. Together, these activities represented the daily nursing management cycle and the principles of work planning, prescription, delegation and subsequent work accountability in relation to patients and nurses. The findings of the pilot study in relation to the management cycle are given below.
Sister PI

The early morning report to the nurses

The night nurse gave an information report to the sister and all the nurses on the first shift. There was no verbal work prescription or allocation of work by the sister.

The nursing round of the patients

A complete nursing round, lasting fifteen minutes, included all sixteen patients; this activity had been ranked the most important daily activity by the sister.

Report to nurses

An information report, lasting forty minutes, was given to the second shift nurses by the sister; this activity had been ranked the second most important daily activity by the sister.

Accountability report from nurses

The nurses on the first shift were not asked to report on their work, and no method of formal work accountability was observed. 'Asking the nurses to report on their work' had been ranked as an important daily activity by the sister.

Other activities in the ward sister's day

Activities in the morning were fragmented, consisting mainly of ward administration and interaction with the doctors. There was little patient or nurse interaction, although the sister supervised a pupil nurse doing a dressing and did a drug round before lunch, accompanied by a student nurse. The sister had ticked the item on the checklist 'attend to the patients' meals' as among the most important daily jobs for her to do, but her own lunch time coincided with that of the patients. Most of the afternoon was spent accompanying a consultant on his round.
Sister P2

The early morning report to the nurses

The night nurse gave an information report to the sister and nurses on the first shift. There was no verbal work prescription or allocation of work by the sister, apart from 'the 8a.m. observations'.

The nursing round of the patients

An incomplete nursing round of some patients, lasting five minutes, was observed. This activity was ranked as one of the three most important daily activities by the sister. On this day the sister was acting up for the nursing officer and was 'on call' for five other wards; she was called away from the nursing round to another ward for three minutes, and on return immediately became involved in giving nursing care, accompanied by a student nurse.

Report to nurses

An information report on the patients, lasting thirty three minutes, was given by the sister to the nurses on the second shift; this activity was one of three most important daily activities selected by the sister.

Accountability report from the nurses

The nurses on the first shift were not observed to report formally on their work; the sister had said at interview that they 'would report anything that was necessary'.

Other activities in the ward sister's day

The ward sister spent twenty seven minutes early in the morning nursing some patients, accompanied by a student. A consultant started a round at 08.40 hours and the rest of the ward sister's
activity in the morning was fragmented between work with the doctors, administrative activities and brief conversations with patients, nurses and other hospital staff. The ward clerk was off sick and this possibly increased the administrative activities. The sister did a brief drug round before lunch, accompanied by a student who received some teaching. This sister did not rate the supervision of meals as part of her daily activity, and she was not involved in the serving or supervision of the patients' meals. The afternoon was spent mainly in the office, but finished with another consultant round.
THE MAIN STUDY
The sample
The hospital sample

The five hospitals in the sample, three in England and two in Scotland, were chosen to represent different types of general hospital. All the hospitals were associated with schools or colleges of nursing which trained students and pupils for the general register and roll. Three of the hospitals in the sample were selected for convenience; two were selected purposively because they were associated with a tradition of individualised care.

The hospitals varied in location and size; it was intended that they would reflect different organisational environments and resources. Hospital A, set in a rural area, was the smallest with 206 beds. Hospital B with 256 beds, was situated on the outskirts of a city and provided some clinical experience for the city's medical students. Hospital C with 450 beds was the teaching hospital for an industrial midlands town. Hospital D, set in substantial grounds, had 834 beds and served a well-defined community on the outskirts of London. Hospital E, a teaching hospital in inner London, had 988 beds; the medical school was on the same site. All of the hospitals were built before 1948.

The ward sample

The initial list of wards was obtained from nursing management; the researcher then selected all the wards which met the criteria of speciality and size (p.139). The sister, who had to be in sole charge or the senior of two sisters, was then approached about inclusion in the study. Fifty two sisters were invited to take part in the study and all agreed to be interviewed; one of these sisters was unhappy about being observed, and at interview another sister was discovered to be both a
departmental and a ward sister; these two sisters were excluded from the study.

The number of sisters from each hospital, and the type and design of the wards are given below:

**TABLE 1** Number of sisters, type and design of ward, by hospital

<table>
<thead>
<tr>
<th>Hospital</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sisters</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Type of ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Surgical</td>
<td>2</td>
<td>-</td>
<td>5</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Design of ward</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open 'Nightingale'</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>'L' shaped</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>surgical</td>
</tr>
<tr>
<td>Divided</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>medical</td>
</tr>
</tbody>
</table>

The sample of fifty wards comprised twenty two medical wards; seventeen surgical wards; six orthopaedic and five gynaecological wards; highly specialised wards were excluded. It was hoped to confine the sample to wards of between twenty and thirty beds but six of the fifty wards fell outside this range, the smallest ward being of eighteen beds and the largest thirty three beds. None of the wards were recently built apart from the surgical block of Hospital E and a medical ward in Hospital C. Conditions were particularly confined in the medical wards of Hospitals B and E; in Hospital B each of these wards was on two
levels which meant that drug trolleys etc. had to be transferred by lift.

The hospitals represented wards of both open and divided design; there were twenty six open 'Nightingale' wards and twenty four divided wards. The divided wards were either 'L' shaped open wards, sub-divided open wards or consisted of two, three or four similar sized rooms. In many of the wards the patients' lavatory and washing facilities and the ward storage space were considered inadequate by the staff.

The majority of the sisters' offices were unsuitable for interviewing because of frequent interruptions; on a number of occasions the interview with the sister took place in the linen cupboard or equipment room as that was the only quiet space. The poor quality of the sisters' working environment, in particular the lack of a quiet space where they could see people without fear of interruption, or could sit quietly to think or plan, was perhaps an important influence on the way the sisters did spend their time; a number of sisters commented on the strain of never being free from actual or anticipated interruption.

The ward sister sample

Age

Of the fifty ward sisters, twenty three (46%) were under thirty years of age; seventeen (34%) were between thirty and forty; ten (20%) were over forty years of age. There were age differences by hospital; in each of the three non-teaching hospitals (A, B, D) the majority of the sisters were over thirty; in each of the two teaching hospitals (C, E) the majority of the sisters were under thirty years of age.
School and academic qualifications

Analysed by the highest qualifications obtained, seven (14%) sisters had no formal academic qualification; twenty nine (58%) had the General Certificate of Education at ordinary level or the equivalent; fourteen sisters (28%) had the Certificate at advanced level; none of the sisters had a degree. There were differences by hospital:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>No qualification</td>
<td>2</td>
<td>1</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Ordinary levels</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Advanced levels</td>
<td></td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

Nursing qualifications and post-basic training

All the sisters were registered general nurses; nineteen were certified midwives. Four of the sisters were registered mental nurses; two were registered sick childrens' nurses and one was a health visitor. Two sisters held the orthopaedic nursing certificate and three sisters the certificate of the British Thoracic Association. Ten sisters had taken post-basic courses of which half were in intensive care. One sister held the Diploma in Nursing; four others held Part A of the Diploma; three sisters were studying for Part A of the Diploma and one for Part B.

Forty seven of the sisters had attended a first line management course, all of which had been for nurses only. One sister had attended the Royal College of Nursing's three month course for ward sisters.
Of the thirty nine sisters working in the English hospitals, twenty one were General Nursing Council assessors for the ward assessments of the State final examination; all of these sisters had taken an art of examining course; another nine sisters had taken the course in preparation for becoming assessors.

**Turnover of sisters and career plans**

There was a difference between the non-teaching and the teaching hospitals in the average number of years the sisters had been in their present posts. The average was five years for the sisters in the three non-teaching hospitals (A, B, D) but only two years for the sisters in the two teaching hospitals (C, E). Forty of the sisters intended to remain as ward sisters. Four sisters were planning to become nurse teachers, four to become nursing officers and two sisters to nurse in the community; the intended changes were greatest in Hospital E where of the twelve sisters interviewed three were becoming nursing officers and two were going into community nursing.
Chapter 6

FINDINGS: THE WARD SISTER AND THE ORGANISATION
The purpose of this chapter, the first of three in which findings are presented, is to provide a background to the later and more detailed findings on the ward sister's work. The aim is to describe the ward sister as a member of a large organisation and to indicate some of the influences on her work; findings are presented on the ward sisters' perceptions of their resources, working environment and work problems. The position and authority of the ward sister as a first line manager is explored in relation both to nursing and to the wider hospital organisation; the general nature of managerial role is discussed on pages 23 and 24.

The findings are first presented in relation to the ward sisters' managerial control over resources, particularly the supply of nurses. The allocation of the trainee nurses was officially governed by their training requirements; while the ward sisters had day to day managerial control of the trainees none of the sisters had any influence in relation to the selection, number, seniority of the trainees, or length of time they were allocated to the ward. The average length of stay per trainee per ward was eight weeks (range 4-12 weeks); thus the composition of the trainee group, which constituted the major part of the ward nursing force, changed frequently; there was also some 'lending' and 'borrowing' of nurses between wards on a day to day basis.

In addition to the rapid turnover of trainee nurses, in three of the hospitals (C, D, E) the staff nurses also only stayed for an average of ten months (range 4-18 months). In two hospitals (A and B) the majority of the trained staff were permanent. Four of the five hospitals employed nursing auxiliaries as permanent staff though they tended to work part time, as did some of the staff nurses. The sisters were asked what
influence they had over the selection of their trained staff and auxiliaries; thirty four percent of the sisters felt they had some influence; thirty percent had a little influence and thirty six percent of the sisters said they had no influence.

Thus the sisters had virtually no authority in relation to the selection and supply of all the ward nurses. Second, the sisters had no control over the rapid turnover of the trainee nurses or over the composition of the team which changed almost completely every two months. Third, the sisters could not balance the team between senior and junior nurses; forty seven of the fifty sisters said they did not make any distinction between 'senior' and 'junior' work, the frequent reason given being that they often did not have a balanced team. This finding, that the sisters did not organise the nursing in a hierarchy of tasks, was supported in the observation of the work of the nurses in the fifty wards (Melia 1978), and is contrary to commonly expressed nursing opinion (p. 46).

In summary, the findings indicated that although the ward sisters were designated first line managers and were responsible for the management of the nursing, they did not have the minimal authority that Brown (p. 24) or Drucker (p. 25) deem necessary to exercise a managerial role.

The sister's immediate manager, the nursing officer, was the person through whom the sister obtained resources. Forty eight of the wards had a nursing officer and received at least a daily visit from them. The average time that each sister was observed to spend in contact with the nursing officer was under one percent, except in Hospital D where it reached one percent (an average of five minutes), excluding time
spent by two sisters attending unit meetings. Forty two of the fifty sisters said that they attended unit meetings on a regular basis, commonly once a month. The sisters expected to attend every unit meeting and the impression at interview was that they were a readily accepted part of the ward sister's life. However, when ranked against the daily priorities of ward work, the sisters accorded a low priority to attending unit meetings (p. 171).

The sisters were asked if they 'acted up' for the nursing officer. Eighteen sisters said that they acted up more than once a week; fourteen sisters said they acted up occasionally and eighteen sisters said that they never acted up. There were differences by hospital; all the sisters in Hospital B, seventy five percent in Hospital E and twenty one percent in Hospital D said that they acted up frequently; none of the sisters in Hospitals A and C said they acted up. Two instances were observed where the nursing officer 'acted down' by working in the ward for part of a shift.

Seventeen (34%) of all the sisters were members of either nursing or hospital committees; eleven (22%) of these sisters were members of hospital committees which were concerned with policy in areas such as the care of the dying patient, the misuse of antibiotics, hospital building, staff consultation, theatre liaison and catering. The finding, therefore, was that a minority of sisters was involved directly in the wider work of the hospital; the nursing unit meetings were the major avenue through which the sisters' views were represented and passed on through the hospital structure.

As well as being responsible for the nursing care of patients, the ward sisters also had a responsibility for the teaching of the trainee
nurses; their resources and involvement in educational work are now discussed. Seventeen (34\%) of the wards had no clinical teacher, seven wards had a clinical teacher for one day per month, fourteen had one for approximately two days a month and twelve had a clinical teacher for eight or more days per month. There were major differences by hospital. At the time of the survey Hospital B had no clinical teachers; Hospital A had clinical teachers for two of the six wards. Hospitals D and E had clinical teachers for approximately three quarters of the wards. Hospital C had clinical teachers for all the wards; this hospital also had by far the greatest amount of clinical teacher time per ward with an average of 5.3 days per month, per ward.

Twenty one of the thirty nine sisters working in the English hospitals were General Nursing Council assessors, and the remaining eighteen sisters had assessments carried out in their wards. This recent involvement of the ward sister as an assessor is likely to have increased her contact with nursing education; it might also have influenced her ward work. For example, in Hospital E a sister was undertaking a total patient care assessment on the day she was observed and this accounted for just under ten percent of her day, comprising twenty six interactions with the nurse.

The authority of the ward sister in relation to the wider hospital organisation is now discussed; her position in relation to service departments which particularly affected the work of the ward was explored through the work problem checklist. The thirty items of the checklist comprised five categories (p.110): (1) ward services and maintenance, (2) interruptions, (3) admission and discharge policy, (4) the medical staff, (5) nursing resources. The relative importance of the individual items as presenting a perceived problem to the ward
sister is shown below:

**TABLE 3** Perceived work problems by percent of sisters

<table>
<thead>
<tr>
<th>Category</th>
<th>Sisters</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Interruptions from the telephone</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>1. Getting enough linen</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>3. Admissions arriving before their beds are ready</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>1. Getting the ward cleaned properly</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>1. Getting ward furniture repaired or replaced</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>1. Getting patients' notes and xrays</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>2. Being unable to complete one job at a time</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>4. Getting doctors to keep to the hospital drug rules</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>1. The design of the ward</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>5. Arranging the off duty to give adequate ward cover</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>4. Doctors not giving patients enough explanation</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>2. People always coming to the ward sister</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>3. Number of patients transferred to or from the ward</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>3. Patients who should really be in other wards</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>2. Interruption from the doctors</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>5. Not enough nurses who can supervise or teach</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>5. Student/pupil nurses allocated for too short a time</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>5. Getting extra help when the ward is very busy</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>5. The number of dependent/handicapped patients</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>3. Patients being discharged at too short a notice</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>4. Conflicting orders from different doctors</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. The number of separate medical rounds in the day</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. Being given, or having to keep, unsatisfactory staff nurses</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. Trained staff moving frequently</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3. Having to have extra beds in the ward</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. The number of tests the doctors order</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2. Interruptions from the nurses</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. The feeling that you have no one really to turn to for help</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

The findings of the checklist, analysed by category and hospital, are presented below.

While certain problems such as interruptions from the telephone, getting enough linen and getting the ward cleaned were universal, there were differences in the categories and in some specific items between
hospitals. Analysed by all the categories Hospital C had the most points, followed by Hospitals B, E and D; Hospital A had the least number of points. Each sister allocated one point to each perceived problem and therefore there was a possible score of 250 in each category, except the nursing category where the possible score was 500.

1. **Ward services and maintenance**

   This category included the highest proportion of problems and received 132 points. The four items relating directly to services, 'getting enough linen', 'getting the ward cleaned properly', 'getting ward furniture repaired or replaced' and 'getting patients' notes and x-rays', all came within the top six problems on the checklist and constituted 56.6% of the problems for the sisters in Hospital E ranging to 46.4% for the sisters in Hospital A. The other item in the category, 'the design of the ward' was seen as a problem for different reasons by sisters with different ward designs. Two thirds of the sisters in Hospital A were not happy with the facilities of their open Nightingale wards and both divided and open wards were seen as a problem by some sisters in the other hospitals. The only design which met with universal approval by the sisters concerned, was the modern 'L' shaped open ward in the surgical block of Hospital E.

2. **Interruptions**

   Problems relating to interruptions received 96 points. Interruptions from the telephone was the biggest problem of all and was mentioned by forty three sisters. Interruptions by nurses was seen as a problem by only three sisters. The sisters in Hospital C had the highest level of perceived interruptions (52.5%), although this was the
only hospital that had a full time ward clerk in each ward; the three hospitals without ward clerks (A, D, B) came next. The sisters in Hospital E, with part time ward clerks, had the least number of perceived interruption problems (25%).

These perceptions of the number of interruptions were confirmed during the observation period. Hospital C had by far the greatest number of observed interruptions, with an average of 72 interruptions per sister per day (range 44-113). Hospital E, where the sisters perceived the least interruption problem, had the smallest number of observed interruptions averaging 44 per sister per day (range 12-80). The other hospitals came in the middle of the range; Hospital B averaged 60 interruptions per sister per day (range 51-70); Hospital A averaged 57 interruptions (range 26-82) and Hospital D averaged 46 interruptions per sister per day (range 14-60).

The finding that the sisters in Hospital C had the highest level of perceived and observed interruptions is likely to be related to the finding that these particular sisters also spent the most time on ward administration, although they were the only sisters supplied with full time ward clerks (Table 4). This finding is discussed in more detail under the section on the ward sister and the organisation (p. 153).

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Percent of day spent by ward sister on administration by availability of ward clerk and by hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>part time ward clerks</td>
</tr>
<tr>
<td>D</td>
<td>no ward clerks</td>
</tr>
<tr>
<td>A</td>
<td>no ward clerks</td>
</tr>
<tr>
<td>B</td>
<td>no ward clerks</td>
</tr>
<tr>
<td>C</td>
<td>full time ward clerks</td>
</tr>
<tr>
<td></td>
<td>Percent of day</td>
</tr>
<tr>
<td>E</td>
<td>8.3</td>
</tr>
<tr>
<td>D</td>
<td>11.2</td>
</tr>
<tr>
<td>A</td>
<td>12.8</td>
</tr>
<tr>
<td>B</td>
<td>13.7</td>
</tr>
<tr>
<td>C</td>
<td>16.8</td>
</tr>
</tbody>
</table>
3. Admission and discharge policy

This category attracted 71 points. 'Admissions arriving before their beds are ready' was a problem for twenty-nine of the sisters and ranked third out of all thirty problems. The sisters in Hospitals B and C had the highest number of problems in this category (40%), whereas the sisters in the rural Hospital A had the least problem (3%). The items 'the number of patients transferred to or from the ward', 'patients being discharged at too short notice' and 'admissions arriving before their beds are ready' were all problems for at least fifty percent of the sisters at Hospital C. Hospital A was the only hospital where the sisters did not have major problems with 'admissions arriving before their beds are ready'. As already noted, this item comes third out of the thirty items and was a problem for eighty percent of the sisters in Hospital B, sixty-seven percent in E, sixty-three percent in C and fifty-eight percent in Hospital D.

4. Medical staff

Problems related to the medical staff received 57 points. The most important problem, mentioned by nineteen sisters, was 'getting the doctors to keep to the hospital drug rules'; this applied to sixty-seven percent of the sisters in Hospital E. The sisters in the two teaching hospitals had the majority of problems relating to the medical staff, with those in Hospital E (35%) having over twice and those in Hospital C (30%) nearly twice as many problems as the sisters in Hospital A (16.5%) and Hospital D (15.5%). The number of separate medical rounds in the day, which was expected to attract a high score, was a minor problem only.
5. **Nursing resources**

It is notable that the smallest number of problems were in this category; it comprised ten items compared to the five in each of the other categories and attracted 50.5 points (101 for 10 items). The two most important nursing problems 'arranging the off duty to give adequate ward cover' and 'nurses going off sick for the odd day or so' held ninth and tenth place out of the thirty problems. Each of the other nursing items was mentioned by less than a quarter of all the sisters. The sisters in Hospital B had an outstanding number of problems associated with the supply of nurses (38%), followed by the sisters in Hospital D with 24.5%. The sisters in the two teaching hospitals came lowest with 15% (C) and 12.5% (E). The particular items which placed Hospitals B and D at the top were those items designed to pick up anxieties about nursing shortages in quantity and quality. Thus 'arranging the off duty to give adequate ward cover' was a problem for eighty percent of the sisters at Hospital B and over half (53%) of the sisters at Hospital D, but for none at Hospital E. Again, eighty percent of the sisters at Hospital B felt they did not have 'enough nurses who could supervise or teach' while out of the twenty sisters in the two teaching hospitals only three (15%) felt this was a problem. Having to lend nurses to other wards was a problem for forty percent of the sisters in Hospital B, thirty seven percent in Hospital D and twenty percent in Hospital A, but again no problem for any of the sisters in Hospitals C and E. Forty two percent of the sisters in Hospital E, however, felt that the student and pupil nurses allocated for too short a time.
Discussion: the ward sister and the organisation

Studies have been made of differences in organisational climate and how this can affect individual performance. Revans (1964), demonstrated a relationship between aspects of hospital morale and length of patient stay. Cortazzi and Route (1975) explored the concept of sick and healthy work groups in hospitals and in doing so 'learned of the unsuspected loneliness of the ward sister'. Mauksch (p. 60) described the ward sister's function in representing the continuity of time, place and social organisation of the whole hospital.

The work problems checklist was designed to see how important organisational factors were at ward level; to see if the particular organisational environment of a hospital was experienced at ward level, and could be perceived and described by the ward sisters as a sub-group within the organisation. The findings showed clusters of different problems associated with different hospitals; that is, the problems were common to the hospital rather than to the individual wards.

These findings are tentatively discussed in terms of the control, or lack of control, the ward sister had in the different problem areas. It is thought that some items were perceived as problems because the ward sister had no control over them; whereas other items over which the ward sister had control were not perceived as problems. For example, interruptions from the telephone were experienced as a problem by forty three sisters whereas interruptions from the nurses, which exceeded the number of telephone interruptions in twenty four wards and were over double the number of telephone interruptions on another seventeen wards, were perceived as a problem by only three sisters.
The most frequent problems were associated with areas where the ward sister had no managerial control, but at the same time had to ensure services and work that were vital to the daily care of the patient, be it getting the ward cleaned properly or getting doctors to keep to the hospital drug rules. Feelings of anxiety in these areas were likely to be heightened not only by the lack of control, but also by the relative importance the sister placed on these areas of work. It is likely, for example, that the ward sister wished to give high priority to the cleanliness of the patient and his immediate environment; to adhere rigidly to the drug rules in the interest of the patient's safety and to welcome and treat the new patient as 'an honoured guest'. Thus problems such as getting enough linen, getting the doctors to keep to the hospital drug rules, or new admissions waiting in the ward for hours before their beds were vacant, produced anxiety and conflict.

This issue of control might also explain why the nursing problems came relatively low on the list. The ward sisters did have day to day managerial control over the ward nurses, and sapiential authority in relation to adequate supplies of nurses to meet patients' needs; thus perception of the nursing problems could have been altered by the degree of control that the ward sister had. However, if the nursing resources were limited, and this was apparent in some wards in Hospitals B and D, the sisters' anxiety was centred on problems of nursing supply; this anxiety was reflected in answers to the checklist.

The perception of problems might also have been linked with different perceptions of role. For example, there seemed to be different attitudes towards the doctors in the teaching and non-teaching hospitals; the higher level of perceived problems in the teaching
hospitals possibly reflected different attitudes to control at the medical/nursing boundaries, such as giving information to patients and discharge procedures.

Influences on ward sister behaviour, however, were not confined to nursing or hospital issues. The findings indicated that the sisters in the different hospitals were working within very different organisational environments and that characteristics of the particular environment permeated the daily ward activity.

An example of the way in which the environment, or open system, influenced the ward sisters' work was observed in Hospital C. This hospital probably had more nursing resources than any of the others in the sample; the sisters expressed no major problems about the quality, quantity or stability of the ward nurses. There were full time ward clerks on every ward; there were ward resources such as a plated meal service; the amount of clinical teacher time was well above average for the sample; the ward sisters did not act up for the nursing officer; and the sisters appeared to be more involved in the affairs of the hospital than usual. Compared with Hospital B, which had problems of staffing and supervision, no ward clerks or clinical teachers, frequent acting up by all the sisters and a poor physical environment, the differences were great. But when the environment factors were added Hospital C became the hospital with the severest problems; these are possibly reflected in the higher amount of time spent on administration and the highest number of perceived and observed interruptions in the ward sisters' work, in spite of the employment of ward clerks (p. 150).

The influence of the wider environment on the ward sisters' work was illustrated from observation of one of the surgical ward sisters in
Hospital C. This ward sister had three admissions in the ward waiting for beds; she tried to get the admitting doctor, who was in theatre for much of the day, to resolve the problem which he did by asking the sister to transfer, immediately, three post-operative patients to another hospital. A recent change in transport policy meant that the ambulance service would not transfer non-emergency patients without forty eight hours advance notice. The sister thus set about arranging a taxi to transfer the patients and a nursing escort to go with them; for safety she also organised a nurse to remove temporarily the glass drainage bottles of one of the patients. These administrative problems took most of the afternoon, but what was most evident was the stress involved for the ward sister in having to tell the patients they were for immediate transfer, and then having to justify the action to them and to their relatives whom she tried to contact by telephone. In fact the sister considered trying to get the doctor to change his mind on the transfers, but she would then have been confronted with telling the admissions, who had been waiting since the morning, that there were no beds for them.

This example illustrates the direct involvement of the ward sister in work which was generated at different levels in the system, and over which she had no control; it further illustrates the strain and isolation of a role in which the sister alone represents the continuity of social organisation to the patient and is forced to bridge the discontinuity of other people and services; in this case, the admissions department, the ambulance service and the doctor.

It is against this background of a complex organisational role that the more detailed findings on the management of the nursing by the ward sister are now presented.
Chapter 7

CLASSIFICATION AND FINDINGS OF THE WORK
OF THE WARD SISTER
Introduction

As indicated on page 104, time-based quantitative analysis of the ward sisters' activity was found to be inadequate. Two alternative systems of classification were developed. The first classification, based on the concept of role differentiation, was generated by the observational work itself; to the extent to which a classification system can be an early step in theory development, it represents a grounded theory approach (Glaser and Strauss 1967). The second classification, of the work of the ward sister in relation to the daily management cycle, draws on qualitative criteria as well as the sequence and completion of the activities which comprised the management cycle (p. 184). These two classifications are thus intimately linked to the findings - and indeed are part of them. The development of each classification system and the relevant findings are therefore presented together.

Development of classification of the work of the ward sister on the basis of role differentiation

The role differentiation classification was developed on the basis that ward nursing consists of three major tasks; first, the identification, specification and organisation of nursing; second, the delivery of nursing care; third, the evaluation of that care. A 'professional' model where the nurse is an autonomous worker would combine these three tasks within the one role. However, the study is concerned with the achievement of nursing in a situation where the majority of the work force are in training or are untrained. Within such a situation, the ward nursing team combines different work roles and different grades of nurse to meet the two major tasks of the management of nursing and the delivery of nursing.
The classification of the observed work of the ward sister was first based on the fact that the ward sister is a line manager (p. 27); no one else in the nursing team has the structural authority to fulfil this unique aspect of her role.

Second, the classification was generated by the observational work itself. The exploratory work had indicated that four out of the five ward sisters did not fulfil their unique managerial role. During data collection for the main study it was observed that the majority of sisters did not fulfil the managerial aspects of their role and, further, that a number of them did not appear to differentiate their role from that of the trained nurse, the trainee or even the nursing auxiliary; that is, a number of sisters spent the majority of their discretionary time not on the identification, specification and organisation of nursing but on the delivery of nursing. The majority of their time was spent on relatively unskilled tasks such as stripping and making beds or cleaning patients' lockers; the point is not whether these are proper tasks for the ward sister to perform, but that a number of sisters performed these tasks instead of managing the nursing; moreover, other staff were available to perform these tasks. The exceptional task was the administration of drugs; on eleven wards from four different hospitals, the sister was the only trained nurse on duty on the early shift and therefore could not delegate the administration of controlled drugs.

The role differentiation classification is thus arranged from work that is common to all members of the nursing team graduated through to work that is unique to the ward sister. A summary of the classification is given below:
Works alone on nursing tasks
Social interaction with patients and nurses
Ward administration
Works with nurses and patients/supervises nurses
Formal communication with patients and nurses
Manages the nursing

These categories are based on observation of the ward sisters' activity apart from the management of nursing category which is derived from concepts of patient individualisation and management.

Previous classification of ward sister activity (Goddard 1953), Scottish Home and Health Department (1967), included the ward sister's work in the categories used to classify the work of ward nurses generally, with an administrative category added to include the sister's administrative work. The categories were: basic nursing; technical nursing; unskilled/domestic work; administration. In the present study these categories were found to be inadequate for the classification of the management of nursing activities. The role differentiation classification is an attempt to classify the ward sister's activity in relation to a defined management of nursing role; and to differentiate this from activities associated with the delivery of care and activities associated with ward and hospital work.

Each category of the classification in terms of role differentiation is described below:
Works alone on nursing tasks

Works alone on work that could be delegated to any, or to some of the team; no role differentiation:

Unskilled work
- Distributes food
- Gives primary care to patients
- Gives technical care to patients
- Gives medicines to patients

Social interaction with patients and nurses

Interacts with patients and nurses on a social, non-specific level; no role differentiation:

- Talks with patients
- Talks with nurses

Ward administration

Administers first by routine; for example, orders stores. Second, administers by virtue of special knowledge associated with the role; for example, works with the medical staff. The role is differentiated from that of the ward nurses but some aspects could be delegated to certain members of the nursing team, including the ward clerk:

- General administration, clerical work, telephone
- Interacts with hospital personnel
- Interacts with medical staff
- Interacts with patients' relatives
- Interacts with nursing managers

Works with nurses and patients/supervises nurses

Supervises by virtue of supervisory role and expertise; major role differentiation from working alone; can delegate work supervision to trained staff and teachers:

Unskilled work with nurses
- Supervises meals
- Gives primary care with nurses
- Gives technical care with nurses
- Gives medicines with nurses
Formal communication with patients and nurses

Some aspects of formal communication are unique to the role of the ward sister and can only be received or handed on by her; other aspects of formal communication can be delegated to trained staff;

High role differentiation:

- Reports to nurses
- Teaches nurses
- Writes nursing reports
- Observes patients

The nursing round of patients might have been placed in this category, but in this classification it was placed in the management of nursing category because it is included in the management cycle.

Management of nursing

Manages by virtue of managerial role; is alone responsible for the delegation of authority to other members of the team, and for exacting the subsequent accountability for the use of delegated authority. The managerial function is unique to the ward sister and cannot be abdicated:

- Defines work: nursing round of patients
- Prescribes work: written and verbal work prescription
- Delegates authority to work: allocation of work
- Exacts accountability for work: accountability reports

Limitations of classification

The classification adopted is open to different interpretations and has certain limitations. The purpose of the two categories 'working alone' and 'working with nurses/supervision of nurses' which contain the same activities, was to distinguish the sisters who spent the majority of their discretionary time working alone on nursing tasks from those who performed the same tasks with nurses; this second category is classified as supervision but in practice the quality of the supervision varied; in
some wards the sister interacted with the nurse on a variety of tasks; in other wards she was just helping with the stripping and making of empty beds, with minimal sister/nurse interaction.

In recording activities associated with the categories 'social interaction' (no role differentiation) and 'formal communication with patients and nurses' (high role differentiation), the observers were not close enough to hear all the content of the sister's conversations. The conversations with patients and nurses were nearly all of short duration (under one minute), and much of the interaction was non-specific, but it is possible that some of these social communications should be correctly placed in the category which is concerned with the special information the ward sister would seek and receive as part of her job. Conversely, the nursing round of patients would also include some social interaction.

The two categories of 'social interaction' and 'formal communication' are differentiated because patients complain about lack of specific information (McGhee 1961), and research has demonstrated the benefits of specific information from nurses to patients in reducing post-operative pain and anxiety (Hayward 1975) and in reducing physiological stress and aiding post-operative recovery (Boore 1976). Lelean (1973), documented the importance of formal communication in ward nursing and the lack of communication between the ward sister and the nurses. Observations from the present study indicated that there were differences in the amount of time the sisters devoted to formal communication with patients and with nurses, a difference that would be lost in an overall category of 'talking' with patients and nurses.
It is recognised that the nursing round of patients could be classified as 'formal communication' but it is classified as 'management of nursing' because the exchange of information could be used as the basis for the assessment and planning of the individual patient's care. The 'management of nursing' category is an attempt to isolate the activities relating to the nursing round of patients, work prescription, allocation of work and work accountability. It can be argued that information reports, working with nurses and indeed all ward sister/nurse interaction could be classified as management activities; that the degree of management precision required in the management of nursing category is both unnecessary and unrealistic, and accounts for the small amount of activity recorded in this category. It is precisely this argument that is being contested in this study.

The role differentiation of the ward sister

The categories in the role differentiation classification are as follows:

Category 1 : Works alone with patients
Category 2 : Works with nurses and patients
Category 3 : Receives and gives nursing information
Category 4 : Manages the nursing team.

The role differentiation score is built up as shown below:

One point : more time spent in Category 2 than in Category 1
One point : more time spent in Category 3 than in Category 1
One point : equal or more time spent in Category 4 than in either Category 1 or Category 2. The score ranges from nought to three points.
Table 5 (pp. 167-170) shows how each sister allocated the time she spent with patients and nurses, and the degree to which she differentiated her role from that of the other nurses. As seen from Table 5, forty seven of the fifty sisters allocated some time to each category of activity, but the role differentiation score shows that the range of time in the low and high categories varied considerably. Only three sisters obtained a score of three which indicates high role differentiation; apart from one sister, the least time was spent by all sisters on the management of nursing activity. Twelve sisters did not obtain any role differentiation score. There was some variation by hospital, with Hospital E obtaining the highest average role differentiation score.

Figure 1 (p. 166) illustrates the different way in which the two sisters who least or most differentiated their role from that of the ward nurses, spent their time.
Figure 1.

PERCENT OF DAY SPENT ON CATEGORIES OF ACTIVITY INDICATING EXTREMES OF DEGREE OF ROLE DIFFERENTIATION, BY TWO SISTERS *

<table>
<thead>
<tr>
<th>Activity</th>
<th>'Manager' sister</th>
<th>'Non-manager' sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of the nursing team</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>Receiving and giving nursing information</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>Working with patients and nurses together</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>Working alone with patients</td>
<td>5%</td>
<td>19%</td>
</tr>
</tbody>
</table>

* both sisters had 5 nurses, including a staff nurse, on duty; the 'manager' sister had 30 beds in the ward and the 'non-manager' 27.
TABLE 5  ROLE DIFFERENTIATION BY DISCRETIONARY TIME SPENT ON PATIENT AND NURSE-CENTRED ACTIVITIES, BY HOSPITAL, BY SISTER

<table>
<thead>
<tr>
<th>SISTER</th>
<th>HOSPITAL A</th>
<th>HOSPITAL B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01 04 02 10 03 07 * 05 06 08 09 11</td>
<td></td>
</tr>
<tr>
<td>Percent of total day</td>
<td>% % % % % % % % % %</td>
<td></td>
</tr>
<tr>
<td>Category 1 Works alone with patients</td>
<td>5 8 0 2 13 12 19 24 9 8 9</td>
<td></td>
</tr>
<tr>
<td>Category 2 Works with nurses and patients</td>
<td>4 6 0 10 16 3 9 20 11 18 4</td>
<td></td>
</tr>
<tr>
<td>Category 3 Receives and gives nursing information</td>
<td>4 10 17 9 17 24 12 10 3 18 12</td>
<td></td>
</tr>
<tr>
<td>Category 4 Manages the nursing team</td>
<td>3 1 7 10 7 3 3 4 5 3 3</td>
<td></td>
</tr>
<tr>
<td>Role differentiation score</td>
<td>- 1 2 3 2 1 - - 1 2 1</td>
<td></td>
</tr>
<tr>
<td>(possible score 3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* In each hospital the order is medical then surgical sisters (including orthopaedics and gynaecology)
<table>
<thead>
<tr>
<th>SISTER</th>
<th>HOSPITAL C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of total day</td>
<td>% % % % % % % %</td>
</tr>
<tr>
<td>Category 1</td>
<td>Works alone with patients</td>
</tr>
<tr>
<td>Category 2</td>
<td>Works with nurses and patients</td>
</tr>
<tr>
<td>Category 3</td>
<td>Receives and gives nursing information</td>
</tr>
<tr>
<td>Category 4</td>
<td>Manages the nursing team</td>
</tr>
<tr>
<td>Role differentiation score</td>
<td>2 - 3 1 1 - 1 2</td>
</tr>
</tbody>
</table>

(possible score 3)
<table>
<thead>
<tr>
<th>Category</th>
<th>Works alone with patients</th>
<th>Works with nurses and patients</th>
<th>Receives and gives nursing information</th>
<th>Manages the nursing team</th>
<th>Role differentiation score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of total day</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
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<tr>
<td>SISTER</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Category 1</td>
<td>9</td>
<td>14</td>
<td>25</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Category 2</td>
<td>4</td>
<td>11</td>
<td>24</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>Category 3</td>
<td>8</td>
<td>16</td>
<td>17</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Category 4</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Role differentiation score</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

(possible score 3)
### Table 5: Role Differentiation by Discretionary Time Spent on Patient and Nurse-Centred Activities, by Hospital, by Sister

<table>
<thead>
<tr>
<th>SISTER</th>
<th>40</th>
<th>41</th>
<th>43</th>
<th>44</th>
<th>46</th>
<th>47</th>
<th>48</th>
<th>45</th>
<th>49</th>
<th>51</th>
<th>50</th>
<th>42</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of total day</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
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<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Category 1</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works alone with patients</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>18</td>
<td>5</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Category 2</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works with nurses and patients</td>
<td>6</td>
<td>12</td>
<td>3</td>
<td>5</td>
<td>11</td>
<td>5</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>13</td>
<td>2</td>
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</tr>
<tr>
<td>Category 3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receives and gives nursing info</td>
<td>23</td>
<td>26</td>
<td>22</td>
<td>15</td>
<td>16</td>
<td>15</td>
<td>14</td>
<td>13</td>
<td>9</td>
<td>13</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Category 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manages the nursing team</td>
<td>10</td>
<td>10</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>0</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Role differentiation score</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

(possible score 3)
The relationship between role differentiation and the management of the nursing on an individualised patient basis is discussed on page 212. First, findings on other aspects of the sisters' work are given.

The ward sisters' stated and observed daily work priorities

One of the purposes of the research was to discover the sisters' stated daily work priorities and to see whether they were able to achieve them. The checklist of daily work priorities (p. 112) was used to obtain the sisters' stated priorities. The fifty sisters allocated each task on the list two, one or no points according to the importance they attached to it in their daily work. Table 6 shows the overall importance of the twelve tasks.

TABLE 6 Daily work priorities in order of importance by number of points allocated by all sisters

<table>
<thead>
<tr>
<th>Number of points (Possible points = 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do a ward round of the patients</td>
</tr>
<tr>
<td>Give the nurses a report on the patients</td>
</tr>
<tr>
<td>Check that the student/pupil nurses are managing their work</td>
</tr>
<tr>
<td>Give some nursing care to a patient</td>
</tr>
<tr>
<td>Accompany the consultant on his round</td>
</tr>
<tr>
<td>Ask the nurses to report on their work</td>
</tr>
<tr>
<td>See that the medical tests are carried out</td>
</tr>
<tr>
<td>Write up the nursing kardex</td>
</tr>
<tr>
<td>Supervise the patients' meals</td>
</tr>
<tr>
<td>Attend a unit meeting</td>
</tr>
<tr>
<td>Get x-rays and test results for a ward round</td>
</tr>
<tr>
<td>Accompany the nursing officer on her round</td>
</tr>
</tbody>
</table>

The sisters varied in the degree of importance they attached to the daily work priorities. The greatest variation was in the item 'give some nursing care to a patient'; all the sisters in Hospital B and sixty three percent of the sisters in Hospital D rated this a very important
daily item, whereas twenty percent and twenty five percent in Hospitals A and C and only eight percent of the sisters in Hospital E did so. All the sisters who rated giving nursing care as very important were observed to spend a proportion of their time on this activity. Supervising patients' meals was rated an important item by the majority of sisters, except in Hospital E where seventy five percent of the sisters did not consider this an important task.

There was greater agreement between hospitals on the importance of a daily nursing round of patients and a daily report to the nurses - the two most highly rated priorities overall. However, although every sister was observed to give the nurses a report, only seventeen of the forty eight sisters (35%) who rated the nursing round of patients as an important or very important daily task, were observed to do a complete nursing round; the definition of a complete nursing round is given on page 181. The discrepancies were greatest in Hospitals B (100%) and D (89%) and least in Hospital C (25%). In Hospitals A and E the discrepancy was fifty percent.

The discrepancy was even greater between stated importance and actual observation of the item 'asking nurses to report on their work'. Only five out of the forty two sisters (12%) who rated this as an important or very important daily task were observed to ask either all or some of the nurses to report on their work.

It was thought that there would be certain areas of work to which the ward sister would like to give more time but which did not come in her daily priority list; thirty three of the sisters (66%) mentioned work to which they would like to devote more time. Teaching and working with the nurses was by far the most common item selected by twenty five sisters;
six sisters mentioned counselling, talking to nurses about their problems, discussing their role with them or being able to devote more time to nurses' reports. Seven sisters would have liked more time to "really talk to patients"; as one sister said, "to be able to talk to a patient with a pressing problem and to give one's whole attention without fear of interruption".

In summary, the sisters rated interaction with patients and nurses as their most important daily work and in some of these interactions there was no discrepancy between stated and observed work. However, great discrepancies were observed between stated and observed priority given to the management cycle activities of 'a ward round of the patients' and 'asking nurses to report on their work'.

These discrepancies between statement and action raise a number of issues. The impression gained at interview was that all the sisters 'knew' that the ward round of the patients, and to a lesser extent, 'asking nurses to report on their work' were important ward sister activities, but it appeared that only some of the sisters had 'internalised' the importance of these activities or had the ability or knowledge to be able to achieve them in their daily work. Further there was evidence that even if the ward sister did rate the management of the nursing as an important daily task this was difficult to achieve in the light of other pressures. For example, the sisters spent, on average, twenty eight percent of their day on non-initiated work, the largest proportion of which was time spent with the medical staff (Table 7, pp. 174-175).
<table>
<thead>
<tr>
<th>TABLE 7</th>
<th>PERCENT OF DAY SPENT ON NON-INITIATED WORK, BY SISTER, BY HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL A</strong></td>
<td></td>
</tr>
<tr>
<td>SISTER</td>
<td>01</td>
</tr>
<tr>
<td>Work initiated by others</td>
<td>39</td>
</tr>
<tr>
<td>of which:</td>
<td></td>
</tr>
<tr>
<td>Time with medical staff</td>
<td>11</td>
</tr>
<tr>
<td>Time with nursing officer * +</td>
<td>-</td>
</tr>
<tr>
<td><strong>HOSPITAL C</strong></td>
<td></td>
</tr>
<tr>
<td>SISTER</td>
<td>13</td>
</tr>
<tr>
<td>Work initiated by others</td>
<td>37</td>
</tr>
<tr>
<td>of which:</td>
<td></td>
</tr>
<tr>
<td>Time with medical staff</td>
<td>23</td>
</tr>
<tr>
<td>Time with nursing officer *</td>
<td>1</td>
</tr>
</tbody>
</table>

* under 1% (about five minutes)
+ Two wards in Hospital A had no nursing officer
<table>
<thead>
<tr>
<th>SISTER</th>
<th>HOSPITAL D</th>
<th>HOSPITAL E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32 33 34 35 37 38 25 26 27 28 29 30 31 20 21 22 23 24</td>
<td>40 41 43 44 46 47 48 45 49 51 50 42</td>
</tr>
<tr>
<td>Work initiated by others of which:</td>
<td>53 43 16 13 34 29 27 29 34 27 17 29 15 22 19 34 22 52 42</td>
<td>36 16 34 29 20 35 54 28 25 15 22 36</td>
</tr>
<tr>
<td>Time with medical staff</td>
<td>7 22 6 2 20 11 11 15 19 6 5 8 1 11 6 7 8 43 20</td>
<td>22 11 20 15 4 16 22 17 16 14 9 10</td>
</tr>
<tr>
<td>Time with nursing officer *</td>
<td>1 2 * 2 1 * 1 * 2 1 - * 4 * * 2 * * 3</td>
<td>- - 2 * 4 - 4 * * - * -</td>
</tr>
</tbody>
</table>

* under 1% (about five minutes)
The amount of time spent with the medical staff together with the negligible amount of time the ward sister spent with senior nurses (an average of under one percent) supports the view of Walker (1967) that the ward sister's work incentives and sanctions, and therefore her orientation, are provided mainly by the medical staff.

In summary, the findings up to this point are that the ward sister occupied a complex nursing and organisational role but had little managerial authority. The majority of the sisters did not substantially differentiate their role from that of the ward nursing team and spent the least amount of their discretionary time on management of nursing activities. While there were no discrepancies between stated daily work priorities and observed daily activities which required only a low role differentiation, there were gross discrepancies between stated daily priority and observation of the highly differentiated activities associated with the management of the nursing. The degree to which each ward sister actually defined and managed the daily nursing of each patient is now presented.
Chapter 8

CLASSIFICATION AND FINDINGS OF THE WORK OF
THE WARD SISTER IN RELATION TO THE DAILY
NURSING MANAGEMENT CYCLE
A summary of the findings presented in this chapter on the completion of the activities of the daily nursing management cycle is given below. The findings showed a low degree of management of the nursing and that in forty one out of the fifty wards the nursing was not organised on an individualised patient basis. Table 8 shows that only a minority of the sisters completed any one of the four activities which comprised the daily nursing management cycle; only two sisters completed each activity in the cycle. In three out of the four management cycle activities the majority of the sisters did not undertake the activity at all; the majority of sisters were placed in the low degree of management/non-individualised organisation of nursing category.

<table>
<thead>
<tr>
<th>Completion of activities</th>
<th>COMPLETE</th>
<th>INCOMPLETE</th>
<th>NONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of management</td>
<td>HIGH</td>
<td>MEDIUM</td>
<td>LOW</td>
</tr>
<tr>
<td>Degree of patient</td>
<td>INDIVIDUALISED</td>
<td>NON-INDIVIDUALISED</td>
<td></td>
</tr>
<tr>
<td>individualisation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Nursing round of patients | 17 | 23 | 10 | 50 |
| Verbal work prescription  | 9  | 10 | 28 | 47 * |
| Verbal allocation of nurses | 10 | 14 | 23 | 47 * |
| Accountability reports    | 5  | 7  | 38 | 50 |

TOTAL SCORE (200) 41 54 99 194 +

* 3 not classified
+ 6 activities not classified
The classification and findings are presented under five separate headings which together represent the activities and sequence of the daily management cycle. They are: (1) the nursing round of patients; (2) written work prescription; (3) verbal work prescription; (4) allocation of nurses and (5) accountability reports.

The findings in relation to each of these activities are subdivided into three categories: (i) completely performed; (ii) incompletely performed and (iii) not performed. These categories are placed on a 'degree of management' continuum which represents the degree to which the nursing was organised on an individual patient basis. Thus categories (i), (ii) and (iii) are correlated with the continuum high medium low degree of management; this in turn represents individualised through to non-individualised organisation of the nursing. The categorisation and the schema are shown below:

<table>
<thead>
<tr>
<th>Category of activity:</th>
<th>(i) complete</th>
<th>(ii) incomplete</th>
<th>(iii) none</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of management:</td>
<td>high</td>
<td>medium</td>
<td>low</td>
</tr>
<tr>
<td>Degree of patient individualisation:</td>
<td>individualised</td>
<td></td>
<td>non-individualised</td>
</tr>
</tbody>
</table>

The degree to which each sister completed the nursing management cycle is shown in Table 9.
TABLE 9  DEGREE TO WHICH MANAGEMENT CYCLE ACTIVITIES PERFORMED, BY HOSPITAL, BY SISTER

<table>
<thead>
<tr>
<th>SISTER</th>
<th>HOSPITAL A</th>
<th>HOSPITAL B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing round of patients</td>
<td>1 1 2 2 2 - 1 - 1 1 1</td>
<td></td>
</tr>
<tr>
<td>Verbal work prescription to nurses</td>
<td>- - - - 2 1 2 1 - -</td>
<td></td>
</tr>
<tr>
<td>Allocation of nurses and patients</td>
<td>- - - - 1 - 1 2 - -</td>
<td></td>
</tr>
<tr>
<td>Verbal work reports from nurses</td>
<td>- - - - - - - - - -</td>
<td></td>
</tr>
<tr>
<td>Degree of management score</td>
<td>1 1 2 2 2 2 3 2 3 4 1 1</td>
<td></td>
</tr>
<tr>
<td>(Possible score = 8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

POINTS 2 = completed activity
1 = incomplete activity
- = no activity
TABLE 9  DEGREE TO WHICH MANAGEMENT CYCLE ACTIVITIES PERFORMED, BY HOSPITAL, BY SISTER

<table>
<thead>
<tr>
<th>SISTER</th>
<th>HOSPITAL C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Nursing round of patients</td>
<td>2</td>
</tr>
<tr>
<td>Verbal work prescription to nurses</td>
<td>-</td>
</tr>
<tr>
<td>Allocation of nurses and patients</td>
<td>1</td>
</tr>
<tr>
<td>Verbal work reports from nurses</td>
<td>-</td>
</tr>
<tr>
<td>Degree of management score</td>
<td>3</td>
</tr>
</tbody>
</table>

(Possible score = 8)

POINTS
2 = completed activity
1 = incomplete activity
- = no activity
### Table 9: Degree to Which Management Cycle Activities Performed, by Hospital, by Sister

<table>
<thead>
<tr>
<th>Sister</th>
<th>32</th>
<th>33</th>
<th>34</th>
<th>35</th>
<th>36</th>
<th>37</th>
<th>38</th>
<th>39</th>
<th>25</th>
<th>26</th>
<th>27</th>
<th>28</th>
<th>29</th>
<th>30</th>
<th>31</th>
<th>20</th>
<th>21</th>
<th>22</th>
<th>23</th>
<th>24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing round of patients</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal work prescription to nurses</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocation of nurses and patients</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>*</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal work reports from nurses</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of management score</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>*</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>+</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Possible score = 8)

* report not attended by observer
+ round completed before 07:30 hours

**Points**
- 2 = completed activity
- 1 = incomplete activity
- = no activity
<table>
<thead>
<tr>
<th>SISTER</th>
<th>HOSPITAL E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing round of patients</td>
<td>2 2 2 2 1 1 1 1 1 1 1 2 2</td>
</tr>
<tr>
<td>Verbal work prescription to nurses</td>
<td>2 2 2 1 1 1 1 1 * 1 * 1 1</td>
</tr>
<tr>
<td>Allocation of nurses and patients</td>
<td>2 2 2 1 1 2 1 * 2 * 1 1</td>
</tr>
<tr>
<td>Verbal work reports from nurses</td>
<td>2 - - - - - - - - - - 1</td>
</tr>
</tbody>
</table>

Degree of management score
(Possible score = 8)

|                        | 8 6 6 4 3 4 2 1* 4 * 4 5 |

* report not attended by observer

**POINTS**
2 = completed activity
1 = incomplete activity
- = no activity
The classification and findings in relation to each of the management cycle activities is presented below:

(1) **Nursing round of patients**

The nursing round of the patients is sub-divided into three categories: (i) completely performed; (ii) incompletely performed; and (iii) not performed. The three categories of a nursing round of patients were based on the observation that there were important distinctions in the quality of the performance of the activity. The majority of the sisters who performed the activity completely gave each patient a clear opportunity to talk. For example, these sisters approached the patient rather than the foot of the bed; they looked at and addressed the patient first rather than the charts or apparatus attached to the patient; they showed by their body posture and actions that they had time to listen to the patient.

It was apparent that there was an opportunity for both the individual patient and for the sister to assess and plan the care that was needed. This opportunity was not given to patients by the sisters in category ii who said a quick 'good morning!', or who were giving out medicines as well; in most of these instances the sister was accompanied by another nurse, which might have further inhibited the patient in initiating conversation with the sister.

Although the opportunities for the patient to make his needs known and for them to be assessed were limited in category ii, the ward sister did see each patient and further interaction could have taken place. This is the distinction between categories ii and iii. In category iii the ward sisters made no systematic round of the patients and a number of the patients were not seen by the ward
sister during the day; there was contact only when the sister wanted to say something specifically to the patient or the patient initiated the conversation; patients were observed trying unsuccessfully to attract the attention of the ward sister.

In the completely performed category the ward sister was observed to do a nursing round which included every patient and lasted not less than a total of sixteen minutes; this minimum time was selected arbitrarily from the observed range of nought to thirty four minutes as it allowed about one minute with each patient. (The number of beds in each ward ranged from eighteen to thirty three; the average was twenty six).

The finding was that seventeen (34%) of the fifty sisters completely performed a nursing round of the patients; the time spent by these sisters ranged from sixteen to thirty four minutes with a mean of twenty minutes.

Twenty three (46%) of the sisters did an incomplete nursing round. Twelve sisters did a quick round of between five and thirteen minutes duration with a mean of nine minutes; six of these sisters were accompanied by the night nurse. Eleven of the sisters did a complete drug round, the time taken ranging from sixteen to sixty one minutes; three of these sisters had already done a short nursing round of the patients.

Ten (20%) of the sisters were not observed to do any systematic round of the patients.
(2) **Written work prescription**

Various methods were employed by the sisters to prescribe nursing work: the written methods were (i) printed individual nursing care plans for each patient; (ii) printed nursing order/task sheets for each patient; (iii) an individual patient kardex instruction sheet; (iv) a printed or handwritten list of ward tasks. Ten wards also had (v) written standing orders of the routine tasks to be done throughout the day.

Each hospital had a distinctive main method of work prescription (Table 10).

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Individual patient nursing care plans</th>
<th>Individual patient nursing orders</th>
<th>Individual patient kardex instruction sheet</th>
<th>Ward task lists orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>Surgical wards</td>
<td>Medical wards</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>E</td>
<td></td>
<td>Medical wards</td>
<td>Surgical wards</td>
<td></td>
</tr>
</tbody>
</table>

* All hospitals used the kardex system for written patient reports*
One criterion for the measurement of the organisation of nursing on an individualised patient basis was evidence of daily prospective work prescription for each patient. The methods used in the five hospitals are now reviewed using this criterion. The findings were that in Hospital B all the wards had a nursing care plan (i) for each patient; these could be updated daily and were available to the nurses. In Hospital C the surgical wards used a structured nursing order/task list (ii) for each patient and one medical sister used a nursing care plan (i); these could be renewed daily and were placed either by the patient's bed or at the nursing station. Both these methods met the criterion of individual work prescription for each patient; the nursing care plans were introduced in Hospital B as a method of planning and prescribing individualised nursing (Grant 1975).

Two medical ward sisters at Hospital C, all nineteen sisters in Hospital D and the medical ward sisters in Hospital E used the blank kardex instruction sheet (iii) for written work prescription. The sisters in Hospital D had been encouraged by the School of Nursing to use the kardex as the sole source of written work prescription and this had replaced the previous method of task lists. The individual kardex instruction sheets could fulfil the criterion of individual patient work prescription if they were comprehensive and reviewed daily; work prescription in this form, however, was not readily available to the nurses as all the sheets were contained in the one kardex which was frequently being used by the sister; only two wards in the sample had a divided kardex.
The ward task lists (iv) used in Hospital A and by the surgical ward sisters in Hospital E did not meet the criterion of individual patient prescription as they were incomplete in the specification of patients, tasks or nurses.

While three of the methods may have fulfilled the criterion for daily work prescription relating to each patient, the observation of the use of the method was a substantial problem. It was not possible to ascertain if any of the methods had been fully used on the day of observation, and the amount of time observed to be devoted by the ward sister to written nursing orders was negligible. A number of sisters who used the kardex instruction sheets stated that they only used them occasionally or for recording a few items and it was observed that the nurses did not seem to refer to them. The impression was that the structured nursing care plans and nursing order sheets were more readily available and that this more formalised system was more likely to be used by both the sister and nurses.

(3) Verbal work prescription

Planned work prescription to the nurses and the delegation of authority to do the work was the first step in the daily management of the nurses by the ward sister. A theoretical basis for the need for precise work prescription in ward nursing is discussed on page 22.

The need for precise work prescription is also related to the achievement of patient individualisation. 'Routine' non-individualised nursing may be defined as each nurse applying a common decision and action to large numbers of patients; that is,
the decisions and actions of the nurse are not modified by the needs of individual patients. An example of non-individualised nursing, of common decision and action and the exercise of minimal discretion in relation to individual patients, was the routine stripping of beds in the morning; the beds may have been empty, or patients may have been required to get out of their beds, as the nurse completed the task of 'stripping the beds'. It was observed that this activity of routinely stripping the beds was more common where there was a lack of individual prescription for patients and nurses; the nurses had no authority, no discretion to decide not to strip beds of patients whose needs were to stay within them, or to get up for the shortest or their most convenient time.

Individualisation of patients required that the nurse exercised discretion, and took actions up to the boundaries set by the needs of the individual patient; this process was started by the ward sister delegating the authority to the nurse to work in this way, that is, to nurse patients. Thus, in the wards where the sisters precisely defined each nurse's responsibilities in terms of individual patients, there was less evidence of routine bed stripping; the nurses had the authority to decide when to make the patient's bed (the task was no longer divided between nurses into stripping and making), and a responsibility placed on them by the sister to relate bedmaking to the needs of the individual patient. Some instances were observed where the ward sister had to remind nurses, who were not used to exercising discretion in relation to individual patients, not to strip the beds routinely and not to
rush to make all the beds in the morning. Every activity of the ward nurse, and the delegated authority of the ward sister in relation to each activity, could be examined in this way. The commonly observed example above illustrates the observed need for precise work prescription in relation to individual patients and nurses, if nursing is to be organised on an individual patient basis.

Thus a measure used in the study to identify those sisters who met the criteria for the daily organisation of nursing on an individualised patient basis was planned verbal work prescription in relation to each patient and each nurse.

The criteria were:

(a) planned time near the beginning of the shift when all the nurses received work prescription for that day;
(b) evidence of each patient having been identified in relation to work prescription;
(c) evidence of each nurse being allocated work.

The early morning report of the sister to the nurses is subdivided into four categories of daily verbal work prescription;

(i) complete work prescription; (ii) incomplete work prescription;
(iii) no work prescription; (iv) not classified.

In the complete work prescription category the ward sister had a planned meeting in the early morning where each patient's prospective nursing needs were identified and translated into nursing work and each nurse was prescribed work.

In the incomplete work prescription category the sister had a planned meeting with the nurses in the early morning where an information report was given on each patient. Incomplete or no
work prescription was given. As the information was retrospective, for example, 'Mr Y... had a herniorrhaphy yesterday' the nurses, many of whom were in the early stages of training, had to deduce the nursing care required for the patients during the shift.

In the third category no early morning report was given by the sister to the nurses.

There were three wards where an early morning report was observed but not attended by the observer and these wards have not been classified.

Twenty seven of the sisters stated that they gave a daily early morning report to the nurses; twenty two of them were observed to do so. The discrepancies between statement and observation were all in Hospital D. The twelve sisters in Hospital E each gave an early morning report to the nurses; the remaining ten sisters were scattered through the other four hospitals. Nineteen of the twenty two morning report sessions were attended by the observer; ten of the reports were classified as retrospective information, and nine of the reports as prospective work prescription.

Overall, twenty eight (56%) of the sisters did not give any planned verbal work prescription; ten sisters (20%) gave incomplete work prescription and nine sisters (18%) gave complete work prescription; three sisters (6%) were not classified. In summary, nine out of the fifty sisters prescribed work in relation to every patient, and of these, six also prescribed work in relation to each nurse.
These nine sisters therefore applied a specific management technique to achieve work in relation to individual patients (p. 188). This was observed to be a planned and well understood activity between the sister and the nurses. In the six wards where each nurse was prescribed work, the nurses gathered, usually in pairs or teams, to receive their work from the sister. All of these sisters allocated a group of patients to each team or pair of nurses; every patient's nursing prescription was separately identified; each nurse had her area of work individually identified and had the opportunity to clarify any points. As part of this management process, the sisters delegated responsibility to the staff nurses or team leaders to prescribe and supervise the detailed work for their own team of nurses; in this way the nurses became largely self-regulating for the rest of the day, and it was noticeable that the organisation of the work, once it was delegated, became the responsibility of the nurses themselves. In the majority of wards, where work had not been defined, the sisters were involved throughout the day in ad hoc decisions of work organisation, as there was no way in which the nurses could be sure of their right to exercise discretion, and therefore instead of being self-regulating they had to refer to the sister.

The way the successful ward sisters achieved a self-regulating primary work group (Trist et al. p. 114), which was clear about its individual responsibilities for patients, was closely related to the planned use of formal work prescription by the ward sister at the beginning of the shift. As well as the planned time in the
day, the amount of time spent on each work prescription activity was the distinguishing feature of the nine successful sisters; in this group the maximum time spent on single work prescription activities reached between eight and twenty five minutes, and the range of total time spent on work prescription was between eleven and thirty two minutes. With the forty one sisters where the activity was unplanned, the maximum time spent on a single activity of work prescription was 0.5 of a minute to five minutes, the range of total time being between nine and twenty one minutes. These forty one sisters therefore gave numerous unplanned work prescriptions throughout the day but spent only slightly less time overall on work prescription than the nine sisters who gave planned and more effective work prescription at the beginning of the shift.

(4) Allocation of nurses

The relationship between the degree of management of the nurses and the organisation of nursing in relation to individual patients was most clearly seen in whether the ward sister allocated the nurses and, if she did, the way in which she allocated them. There were three distinct ways in which the sisters allocated the nurses. The first, termed ward allocation in this study, was the allocation of nurses to specific tasks, for example, dressings. In this system the nurse performs the task routinely or for any patients in the ward who require it; this precludes the nurse from being allocated to a geographical sub-section of the ward. Further, ward allocation precludes the allocation of nurses to patients, as the boundary to each nurse's
exercise of discretion is confined by the prescribed task and this is almost certainly smaller than any patient's total nursing needs.

In the second method, half ward allocation, the sister allocated each nurse to a geographical half of the ward, without further definition of nurses' responsibilities for either patients or tasks. However, because the nurse was confined to a section of the ward and therefore to a smaller number of patients, her nursing role in relation to each patient was likely to be larger and multi-skilled and therefore more able to meet individual patient's needs than that of the nurse allocated throughout the ward.

In the third method, patient group allocation, the nurses were allocated to a specific group of patients within which each nurse and patient were individually allocated. Here, each nurse's exercise of discretion was defined by the boundaries of the individual patient's total nursing needs; she had the responsibility and authority to meet all of the patient's nursing needs - not just the prescribed tasks of the ward allocation system.

It was apparent that the degree of managerial work on the part of the ward sister who explicitly prescribed nursing work in relation to each patient and each nurse exceeded that of the ward sister who allocated nurses either tasks or to a geographical section of the ward. The findings on the allocation of nurses are therefore presented in terms of low, medium or high degrees of management associated with ward, half ward or patient group allocation patterns.
At interview each sister was asked how she liked to organise the daily nursing work. Table II (p. 196) shows that seventeen (34%) of the sisters said they liked to allocate the nurses throughout the ward (low degree of management); twenty sisters (40%) liked to allocate the nurses to half the ward each (medium degree of management) and thirteen sisters (26%) specifically said they liked to allocate the nurses to groups of patients (high degree of management).

Table II also shows how the nurses were in fact allocated by the sister on the day of observation. Twenty one (42%) of the sisters were not observed to allocate any nurses. Two sisters (4%) allocated the nurses throughout the ward. Fourteen sisters (28%) allocated the nurses to half the ward each. Ten sisters (20%) allocated the nurses to specific groups of patients. Three sisters (6%) were not classified. A summary table of each sister's allocation pattern, staffing levels and degree of patient and nurse individualisation is given on pages 199-206.

There is strong concordance between low, medium and high degrees of management, as measured by allocation pattern (ward, half ward, patient group), and the levels of concordance or discrepancy between the sisters' stated and observed allocation pattern (Table II, p. 196).
Fifteen of the seventeen sisters (88%) who stated that they allocated nurses to the ward (low degree of management) were not observed to practise any form of allocation. The remaining two sisters (12%) in this category had stated that they allocated nurses to tasks throughout the ward and they were observed to do this.

Thirteen of the twenty sisters (65%) who stated that they allocated the nurses to half the ward (medium degree of management) were observed to do so; six sisters (30%) were not observed to allocate any nurses. One sister was not classified.

Ten of the thirteen sisters (77%) who stated that they allocated nurses to groups of patients (high degree of management) were observed to do so. One sister allocated the nurses to 'half the ward each'. Two sisters in this category were not classified.

| TABLE 11 | Degree of management measured by allocation pattern and compared with stated and observed allocation patterns, by number and percent of sisters |
|------------------|------------------|------------------|------------------|
| Stated allocation | Ward | Half ward | Patient group |
| Degree of management | Low | Medium | High |
| Number of sisters | 50 = 100% | 17 | 20 | 13 |
| Agreement between stated and observed allocation | 2 (12%) | 13 (65%) | 10 (77%) |
| No allocation observed | 15 (88%) | 6 (30%) | 1 (8%) * |
| Not classified | - | 1 (5%) | 2 (15%) |

* allocated to 'half the ward'.
In summary, the majority of the sisters showed a low degree of management of the allocation of the ward nurses; nearly half of the fifty sisters were not involved in the activity at all. Only ten (20%) of the sisters were observed to allocate individual nurses to individual patients.

Inadequate ward staffing levels have been given as a reason for not organising the nursing on an individual patient basis (p. 17). Table 12 (pp. 199-206) shows the staffing levels on the wards during the period of observation. No generalisation can be made from these figures but it is possible to examine the relationship between the hospitals, the numbers of nurses and the way in which they were organised.

Hospital C had the highest number of nurses on the ward over the observation period, the average number being seven per ward for the early shift, excluding the sister. In this hospital the majority of the nurses were organised within teams, with four of the eight sisters allocating nurses to patient groups.

Hospital A had the next highest level of nurses, averaging 6.6 per early shift, excluding the sister. In this hospital five out of the six sisters deployed the nurses on a ward basis, with no evidence of individual allocation.

Hospital E was third in the staffing levels, with an average of 5.5 nurses per early shift, excluding the sister. Nine out of the twelve sisters (two unclassified), deployed the nurses either to half the ward or to a patient group.

Hospital D was fourth in the staffing levels, with an average of five nurses per early shift, excluding the sister. In thirteen
of the nineteen wards the nurses were deployed on a ward basis with no evidence of individual allocation.

Hospital B had the lowest staffing levels averaging four nurses per early shift, excluding the sister, nearly half that of Hospital C. Two of the five sisters allocated the nurses to sections of the ward.

There is, therefore, no obvious relationship between the number of nurses available and the way the sister deployed them. For example, Table 12 (pp. 199-206) shows wards with eight nurses on duty who were not allocated any work, and wards with eight nurses where they were specifically deployed to patient groups. A sister with just three nurses on duty ensured that every patient was allocated and each nurse was individually responsible for patients, while another sister with only three nurses on duty did not allocate them.

The number of patients in the ward did not appear to affect the deployment pattern. Sisters who deployed nurses to patients included those who had wards of thirty two and thirty beds through to those who had wards of nineteen and twenty beds. Conversely, there were both large and small wards where the nurses were not deployed to patients.

A more important influence than staffing levels on the deployment of the nurses might be ward design. Hospitals A and D had open Nightingale wards and in nineteen out of the twenty five wards (one not classified) the nurses were deployed on a ward basis. Hospitals B, C and E had divided wards and here the exact opposite occurred; in nineteen of the twenty five wards (two not classified) the nurses were deployed to a section of the ward or to a patient group.
<table>
<thead>
<tr>
<th>Sister's stated allocation pattern</th>
<th>Number of nurses</th>
<th>Organisation of nurses (x)</th>
<th>Patient, nurse, task or geographical allocation</th>
<th>Defined responsibility for each nurse; each patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>7</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>5+1</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>6+2</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>7+1</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>5+1</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>4+1</td>
<td>1 trio; 1 pair</td>
<td>Half ward each</td>
<td>None</td>
</tr>
</tbody>
</table>

* + symbol represents part time nurse
(x) any discrepancy between the number and organisation of nurses is because part time nurse was not at the morning allocation report
<table>
<thead>
<tr>
<th>Sister's stated allocation pattern</th>
<th>Number of nurses</th>
<th>Organisation of nurses</th>
<th>Patient, nurse, task or geographical allocation</th>
<th>Defined responsibility for each nurse; each patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Patient groups</td>
<td>2+1</td>
<td>1 pair</td>
<td>Allocated to section of ward</td>
<td>None</td>
</tr>
<tr>
<td>Patient groups</td>
<td>5+1</td>
<td>2 pairs; 2 single</td>
<td>Allocated to 3 sections of ward</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>5</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Sister's stated allocation pattern</td>
<td>Hospital C: divided wards</td>
<td>Number of nurses</td>
<td>Organisation of nurses</td>
<td>Patient, nurse, task or geographical allocation</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------</td>
<td>------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Half ward</td>
<td></td>
<td>4±1</td>
<td>2 pairs</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>7</td>
<td>2 pairs with team leaders</td>
<td>2 patient groups</td>
<td>Each patient and nurse allocated</td>
</tr>
<tr>
<td>Patient groups</td>
<td>6</td>
<td>3 pairs with team leaders</td>
<td>3 patient groups</td>
<td>Each patient and nurse allocated; each nurse held responsible for individual patients</td>
</tr>
<tr>
<td>Half ward</td>
<td>5±1</td>
<td>2 teams with team leaders</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>7+1</td>
<td>2 teams with team leaders</td>
<td>Some tasks allocated</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>8+1</td>
<td>2 teams with team leaders</td>
<td>Each patient allocated to one of two team leaders</td>
<td>Every patient allocated</td>
</tr>
<tr>
<td>Patient groups</td>
<td>7</td>
<td>1 trio; 2 pairs</td>
<td>Some tasks allocated</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Each patient and nurse allocated; each nurse held responsible for individual patients
### ALLOCATION OF PATIENTS, NURSES, TASKS, BY SISTER, BY HOSPITAL

#### Hospital D: open wards

<table>
<thead>
<tr>
<th>Sister's stated allocation pattern</th>
<th>Number of nurses</th>
<th>Organisation of nurses</th>
<th>Patient, nurse, task or geographical allocation</th>
<th>Defined responsibility for each nurse; each patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half ward</td>
<td>4</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Patient groups</td>
<td>6</td>
<td>2 pairs; 2 single</td>
<td>1 pair allocated side of ward each; tasks</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>3+1</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Patient groups</td>
<td>5+1</td>
<td>3 pairs</td>
<td>3 patient groups</td>
<td>Each patient and nurse allocated; each nurse held responsible for individual patients</td>
</tr>
<tr>
<td>Ward</td>
<td>6</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Patient groups</td>
<td>5</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

* morning report not attended by observer
### Table 12: Allocation of Patients, Nurses, Tasks, by Sister, by Hospital

**Hospital D: Open Wards**

<table>
<thead>
<tr>
<th>Sister's stated allocation pattern</th>
<th>Number of nurses</th>
<th>Organisation of nurses</th>
<th>Patient, nurse, task or geographical allocation</th>
<th>Defined responsibility for each nurse; each patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half ward</td>
<td>3</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>6</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>6</td>
<td>2 pairs; 2 single</td>
<td>Tasks around ward</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>7</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>4</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>5</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Patient groups</td>
<td>5</td>
<td>2 pairs; 1 single</td>
<td>3 patient groups</td>
<td>Each patient and nurse allocated</td>
</tr>
<tr>
<td>Sister's stated allocation pattern</td>
<td>Number of nurses</td>
<td>Organisation of nurses</td>
<td>Patient, nurse, task or geographical allocation</td>
<td>Defined responsibility for each nurse; each patient</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Ward</td>
<td>2+1</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Half/third ward</td>
<td>6+1</td>
<td>3 pairs</td>
<td>Allocated to sections of the ward; tasks</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>5+1</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>5</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>4</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ward</td>
<td>4</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Sister's stated allocation pattern</td>
<td>Number of nurses</td>
<td>Organisation of nurses</td>
<td>Patient, nurse, task or geographical allocation</td>
<td>Defined responsibility for each nurse; each patient</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Patient groups</td>
<td>6</td>
<td>2 teams with team leaders</td>
<td>4 patient groups</td>
<td>Each patient and nurse allocated; each nurse held responsible for individual patients</td>
</tr>
<tr>
<td>Patient groups</td>
<td>6</td>
<td>2 teams with team leaders</td>
<td>2 patient groups</td>
<td>Each patient and nurse allocated</td>
</tr>
<tr>
<td>Patient groups</td>
<td>5</td>
<td>2 pairs; 1 single</td>
<td>3 sections of ward</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>7</td>
<td>2 groups</td>
<td>2 trainees allocated a patient each</td>
<td>2 patients allocated</td>
</tr>
<tr>
<td>Ward</td>
<td>6</td>
<td>2 pairs; 2 single</td>
<td>Tasks around ward; 2 trainees allocated a patient each</td>
<td>2 patients allocated</td>
</tr>
<tr>
<td>Sister's stated allocation pattern</td>
<td>Number of nurses</td>
<td>Organisation of nurses</td>
<td>Patient, nurse, task or geographical allocation</td>
<td>Defined responsibility for each nurse; each patient</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Half ward</td>
<td>3</td>
<td>1 pair; 1 single</td>
<td>2 patient groups</td>
<td>Each patient and each nurse allocated</td>
</tr>
<tr>
<td>Half ward</td>
<td>6</td>
<td>2 trios</td>
<td>Allocated to side of ward each; tasks</td>
<td>None</td>
</tr>
<tr>
<td>Patient groups</td>
<td>5</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Patient groups or half ward</td>
<td>6</td>
<td>1 pair; 4 single</td>
<td>Patient groups</td>
<td>Each patient and nurse allocated</td>
</tr>
<tr>
<td>Half ward</td>
<td>4</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Half ward</td>
<td>5+1</td>
<td>1 trio; 1 pair</td>
<td>Allocated to side of ward each; tasks</td>
<td>None</td>
</tr>
<tr>
<td>Half ward</td>
<td>5</td>
<td>1 trio; 1 pair with team leaders</td>
<td>Allocated to side of ward each; tasks</td>
<td>None</td>
</tr>
</tbody>
</table>

* morning report not attended by observer
Accountability reports

The final activity of the ward sister's daily management of the nurses was requiring them to report on their work, that is, to account for their use of the authority delegated to them at the beginning of the shift. A theoretical basis for the need for individual nurse accountability in ward nursing is given on page 22.

The prescription of work - the delegation of authority - together with the receiving of work reports - the exactment of accountability - is the mechanism through which the ward sister obtains work from the nurses, and the mechanism through which the nurses themselves achieve work.

Accountability has three major functions in ward nursing. First, it is the mechanism by which the sister retrieves the authority she has delegated to nurses at the beginning of the shift; it is the review mechanism which allows the sister to examine how the nurses have used their delegated authority and how the authority should be reallocated.

Second, accountability has a reinforcing function in the achievement of work on the part of the nurse. The exercise of discretion is accompanied by anxiety (p. 21) and the ability of the nurse to achieve work, to take action, is her ability to handle the anxiety associated with decision making. The act of accountability which requires the nurse to answer for her use of discretion, allows her to ascertain whether she has made the appropriate decisions and taken the appropriate actions. Confirmation of the successful use of discretion removes the
anxiety associated with the achievement of work and allows the nurse to move towards new work goals, to exercise wider discretion with more confidence. It is argued that the management techniques of work prescription and associated accountability are especially important in ward nursing which is 'cradled in anxiety' (Menzies 1960). Also, the ward sister has the double responsibility of achieving the daily nursing of the patients, and of achieving this mainly through nurses who are still students or pupils.

The third important function of complete work accountability in ward nursing is that each patient's care for the shift is formally evaluated against the goals set at the beginning of the shift. Thus individual nurse accountability is an important mechanism for ensuring that each patient's care is reviewed individually, and that the continuing organisation of the nursing is related to the known needs of each patient.

As with the other categories, the findings relating to the use of work accountability reports are divided into three categories, (i) complete; (ii) incomplete; (iii) none.

In category i complete work accountability, the ward sisters received verbal work reports from all the nurses on the first shift. In category ii incomplete work accountability, the nurses did not give verbal work reports, but instead either wrote the nursing kardex report or signed work lists when the work had been completed; although not part of the formal observation, the researchers attempted to observe these activities and the seven wards in which the nurses were observed to either write the nursing
kardex or sign work lists were placed in category ii. However, the limitations of written methods of work accountability, if not used in conjunction with verbal work reports, are threefold. First, the nurse does not have the opportunity to review her work and achievements with the ward sister. Second, the sister has limited information on the nursing of the patients. Third, each individual patient's nursing care is not systematically evaluated and then re-planned in the light of the report of the nurse who has been caring for him.

The findings were that five (10%) of the fifty sisters fell into category i, complete work accountability; three of these sisters received work reports from all the nurses on the first shift; two other sisters received work reports from the team leaders only, but these included a report on every patient in their team. Seven (14%) of sisters were placed in category ii, incomplete work accountability. Thirty eight (76%) of the sisters were placed in category iii where no form of work accountability was used by the sister. Thus, in summary, the majority of the sisters did not exercise any form of work accountability as part of their daily activity.

Two different methods of achieving complete work accountability were used by the sisters in category i; these are now discussed. One of the sisters set aside a time in the middle of the afternoon when each nurse reported to her separately. During this report the nurse's decisions and actions were discussed in detail; the nurse was reassured in relation to work achievement and alternative choices and methods were reviewed by
nurse and sister alike. It was apparent that the nurse knew what work she had achieved and where she might exercise wider discretion. Each patient's care was systematically reviewed and re-planned.

Two other sisters combined the handover report to the second shift with a report from each nurse from the first shift. Work accountability was combined with the giving of information, discussion and evaluation diffused among the group of nurses and the sister; this made classification of the activity difficult, but it was observed that each nurse who had given a report had her work goals set for her. Again, each patient's care was systematically reviewed and re-planned.

As the ward sister only was observed, it was not possible to observe whether some of the trainee nurses reported on their work to the staff nurses or team leaders instead of to the sister; it is thus possible that there were some formal work reports between nurses, other than to the sister. Only two sisters, when discussing methods of accountability at the interview, mentioned that the staff nurses received reports from the junior nurses; both these sisters were among the sisters in category i, complete work accountability.

It was thus found that the three ward sisters who received verbal work reports from all the nurses also used other methods of accountability. All three sisters delegated managerial authority to the staff nurses who were in charge of a nursing team and a group of patients and, as mentioned above, the staff nurses working with two of the sisters also received work reports from the
nurses. One of these sisters had a highly developed system of accountability; each nurse handed over her patients to her counterpart on the next shift, discussed her work with her team leader and reported on her patients to the sister and other nurses. The nurses on this ward also wrote the nursing reports on their patients.

The summary of this chapter has been given on page 178. The implications of the findings are now discussed.

Forty one (82%) of the fifty sisters did not organise the nursing on an individualised basis. In three out of the four management cycle activities the majority of the sisters did not undertake the activity at all. Only a minority of sisters either prescribed or formally checked the nursing work; fifty percent of the sisters were not observed to allocate work to the nurses.

The finding, therefore, was that in the majority of the wards the daily nursing of each patient was not actively managed by the sister, but was governed by a general ward and hospital routine. While the effect of this lack of management on patients was not part of the main study a 'patient's day' was recorded during the exploratory work (Chapter 4). The work of McGhee (1961), Hamilton-Smith (1972), Lelean (1973), Wright (1974), Jones (1975) and Wells (1975) all give examples of patients' experience of some aspect of their care when the nursing is not managed on an individual patient basis.

An important finding therefore was that nine sisters (18%) did manage the nursing on an individualised patient basis. The criteria for inclusion in this category were rigorous; the sister had to do a complete nursing round of the patients; she had to give prospective
nursing prescriptions for each patient; she had to formally allocate each patient to the nurses and ensure that each nurse was individually allocated a group of patients; finally, the sister had to receive accountability reports from each nurse and relating to each patient.

The precision of the management cycle was related to management theory in relation to work achievement; in particular, the need for the precise prescription of individual work boundaries, within which the individual can exercise discretion and subsequently be held accountable (p. 22). In the present research the hypothesis has been that to achieve the organisation of nursing on an individualised patient basis the nursing work has both to be prescribed and accounted for in terms of work boundaries determined by individual patient's needs; that is, each nurse must, individually, be given precise authority in relation to 'whole' patients; anything less than this, for example, splitting patient boundaries into task boundaries or 'group' rather than individual nurse work prescription, means that the nursing is not organised on an individual patient basis.

The finding, therefore, that two sisters fulfilled every criteria of the management cycle and that another seven sisters prescribed and allocated work in relation to individual patients and nurses is of importance because it demonstrates the validity of management principles and techniques in relation to nursing.

This in turn relates to the findings on the importance of the management role in ward nursing; unless the sister had a concept of her role in relation to the management of the nursing and demonstrated this by differentiating her own role from that of the ward nurses, the nursing was not managed (p. 165). Further, the finding was that the
degree of management was intimately related to the degree to which the nursing was organised on an individualised patient basis (Table 8, p. 178). There was no evidence that organisation of individualised nursing occurred by chance or through 'informal' organisation. The achievement of individualised nursing is a complex process, the framework of which is likely to be a formal and carefully planned management process, Hargreaves (1975), Clarke (1978), Crow (1977). This study has therefore sought to examine the application of recent management theory to the process of nursing.
Chapter 9

SECOND STAGE STUDY OF SISTERS WHO MANAGED THE NURSING ON AN INDIVIDUAL PATIENT BASIS
Throughout the study it had been hoped to find out more about sisters who organised the nursing on an individualised patient basis. As indicated on page 101, it had first proved necessary to develop a method of identifying these sisters from a sample that was large enough to include a range of ward sister behaviour. The resulting identification study formed the first and major stage of the study; it developed a method - although this requires further testing - which enables 'manager' and 'non-manager' sisters to be identified; the study also identified nine sisters who managed the nursing on an individualised patient basis.

The second stage of the study had two main purposes. The first was to test the consistency of the first stage findings; the second purpose was to describe in more detail the characteristics of those sisters who had met, or most nearly met, the criteria for the organisation of the nursing on an individualised patient basis.

With the permission of nursing management, the sisters were approached about inclusion in the second study; it was explained that the study would repeat the observation of the sister's activity over a number of days and would conclude with an interview with the sister. It was made clear that the sisters had been approached about inclusion in the study because their practice was likely to be helpful to other nurses; all the sisters agreed to participate in the study.

The second stage of the study consisted of seventeen days of observation of ward sister activity, involving seven ward sisters from three hospitals. The purpose of the repeated observation days was to test the consistency of the performance of the seven sisters over a
number of days. Exactly the same methods were used as in the first stage; the data were classified by completion of the management cycle activities, degree of role differentiation and a third criterion, the amount of time spent with the ward nurses.

The study was concluded with an interview of each sister. The purpose of the interview was to identify the factors which had contributed to the observed performance of the ward sister. In particular it was hoped to gain the views of the sister on her own training and experience, including her first line management course, as well as her views on the preparation and training needed for the role of ward sister. The sister was asked how she had learnt to value and practise the activities of the management cycle which she had been observed to perform. The particular work priorities and problems which the sister had identified on the checklists were also discussed. Thus the interview, which was tape recorded, was semi-structured by reference to the original interview and observation. However, free discussion on points of interest allowed issues such as the career structure of the ward sister and the necessary support for clinical innovations to be raised. The interviews, which took place in a room selected by the sister, lasted between thirty to fifty minutes.

The interviews were subsequently transcribed verbatim and analysed under the headings of training and experience; first line management training; learnt nursing management behaviour; the influence of role models; support required by the ward sister for innovation in nursing practice, and the training needs of the ward sister.
It has been indicated that the second stage of the study had two aims; the first was to test the consistency of the first stage findings; the second aim was to describe in more detail the characteristics of the manager sisters. In the limited time available it was not possible to test the consistency of the first stage findings throughout the range of manager and non-manager sisters, because the time needed to adequately sample throughout the range would have reduced the time available for the main purpose of the second stage, which was to study all the manager sisters in greater depth. A further study to test the validity of the research method in discriminating between manager and non-manager sisters is therefore still required.

There was, at the time of the design of the second stage, still a problem of classification of the first stage data (p. 124) and therefore a problem in identifying some of the manager sisters. The seven strongest managers of the nine sisters were identified by the original time-based activity analysis, but two manager sisters further down the range were only identified when the detailed classification of the management cycle and the role differentiation classification was developed.

During the analysis of the first stage data it was observed that the seven sisters came within a sub-sample of ten sisters who had spent the most time of all fifty sisters with nurses. The range of time the sisters spent with the nurses varied considerably. Seventeen (34%) of the sisters spent under a quarter of the day with one or more of the nurses (range 11-24%); twenty one of the sisters (42%) spent between a quarter and a third of the day and twelve sisters (24%) spent one third or more (range 33.3% - 49%) of their day with the nurses.
It was also found that the sub-sample of the ten sisters who spent the most time with nurses also spent above the average time for the total sample with patients. The average time spent with patients by the sample of fifty sisters was twenty percent of the day (range 3-40%); the average time spent with patients by the sub-sample of the ten sisters who had spent the most time with nurses was twenty six percent (range 19-41%). Time spent with nurses and patients was 'desired' work to which thirty three of the fifty sisters would have liked to have given more time (p. 172), as well as being the work given highest priority in the daily work priority checklist (p. 171). Thus the sub-sample of ten sisters who spent the most time with nurses and included seven of the sisters who managed the nursing on an individualised patient basis, represented 'role models' to which the sisters themselves aspired. A decision was therefore made to confine the second stage of the study to this sub-sample of ten sisters.

The sub-sample consisted of five sisters from Hospital D, four from Hospital E and one sister from Hospital C and thus represented equally sisters from non-teaching (D) and teaching hospitals (C, E). However, by the time the second stage of data collection started, five months after the original study, three of the ten sisters had moved from their wards. The final sub-sample therefore consisted of seven sisters, five of whom were identified managers. Four of the sisters came from Hospital D, two from Hospital E and one sister from Hospital C; there were four medical wards, two surgical and one orthopaedic ward. Four of the sisters were aged under thirty; two were between thirty and forty years of age and one was over forty.
In the limited time available, the plan was to observe the two sisters who had completed the management cycle for each weekday; thus another four days of observation were added to the original day. The other five sisters were observed for another two days each, the total observation of these sisters representing three of the five weekdays. The purpose of selecting different weekdays was to reduce the bias of any one day, in particular operating or consultant round days, but the different days did add to the difficulty of completing the observation in the time available; one sister was off sick for most of the observation period and was only observed for one further day. Another problem in completing the observation was the ward design of one of the two sisters who should have been observed for four days. The ward was divided into numerous sections by swing doors; the observer had to follow closely behind the sister to observe her accurately; this appeared to cause observer interference in the ward and although everyone was helpful it was decided to discontinue the observations after two days instead of four. The two extra days were transferred to the sister with the highest management score in Hospital D who also was the sister who had spent the most time of all the sisters with the nurses (49% of the day).

Findings from the observation and interview of the seven ward sisters

Tables 13 and 14 (pp. 220-221) show the role differentiation score and degree of management score for the repeat observations of the seven sisters in the sub-sample. The scoring system for Table 13 is given on page 164.
<table>
<thead>
<tr>
<th>SISTER</th>
<th>15</th>
<th>15</th>
<th>15</th>
<th>15</th>
<th>22</th>
<th>22</th>
<th>26</th>
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<th>40</th>
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<tr>
<td>Percent of total day</td>
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<tr>
<td>Works alone with patients</td>
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<td>3</td>
<td>7</td>
<td>30</td>
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<td>10</td>
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<tr>
<td>Works with nurses and patients</td>
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<td>15</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>18</td>
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<td>11</td>
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<td>13</td>
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<tr>
<td>Receives and gives nursing information</td>
<td>6</td>
<td>10</td>
<td>7</td>
<td>11</td>
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<td>8</td>
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<td>10</td>
<td>12</td>
<td>29</td>
<td>23</td>
<td>24</td>
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<tr>
<td>Manages the nursing team</td>
<td>24</td>
<td>22</td>
<td>17</td>
<td>19</td>
<td>4</td>
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<td>9</td>
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<tr>
<td>Role differentiation score</td>
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<td>1</td>
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</table>

(possible score 3)
### Table 11

**Degree to Which Management Cycle Activities Performed, by Seven Sisters**

<table>
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<tr>
<th>Sister</th>
<th>15</th>
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<tr>
<td>Nursing round of patients</td>
<td>2 2 2 2 1 1 2 2 1 1 1 1 1 2 2 2 2</td>
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<tr>
<td>Verbal work prescription</td>
<td>2 2 2 2 1 1 - - 2 2 2 2 2 2 2 2 2</td>
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<tr>
<td>Allocation of nurses and patients</td>
<td>2 2 2 2 - - - - 2 1 1 1 1 2 2 2 2</td>
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<tr>
<td>Verbal work reports from nurses</td>
<td>2 2 2 2 - - - - - - - - - - 2 2 - -</td>
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<tr>
<td>Degree of management score</td>
<td>8 8 8 8 2 2 2 2 5 4 4 4 4 8 8 6 6</td>
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</tbody>
</table>

(possible score 8)

Number of nurses on first shift, excluding sister: 6 6 7 6 5 4 5 6 3 3+1 4 1+3 4 5 5 3 4
The most notable finding was the consistency of the sisters' performance, both within the repeated days and compared with the first observation day (p. 181). The two sisters (15, 40) who completed the management cycle and obtained the highest role differentiation scores continued to do this throughout the other days they were observed. These two sisters spent an average of forty two and forty three percent, respectively, of their total time with the nurses. Indeed six of the seven sisters spent over a third of all their observed days with the nurses (range 34-43%), and therefore remained within the top range for the fifty sisters.

One sister (22) was inconsistent; her original time spent with the nurses, mainly on direct care, was thirty seven percent of the day, but on the two repeat days the average (20%) was in the lowest range for the fifty sisters. This sister's reversion to a non-differentiated role is reflected in the high amount of time spent working alone with patients (Table 13). While this sister and sister 26's staffing levels were similar to the original observation day, the staffing levels of the other two sisters in Hospital D (Sisters 30, 35) were reduced. On one of the observation days Sister 35, together with one third year student, was the only nurse on duty in a ward of twenty eight patients, although various nurses were 'lent' during the day. Sister 35, who was a consistent example of a 'direct care' sister (Table 13), had previously allocated nurses to patients, dividing the patients in the open Nightingale ward into three groups; she had abandoned allocation of nurses to patients due to the fluctuating staffing levels. However, it was observed that this sister even on the morning when there was only one
other nurse on duty, sat down with her and identified the patient priorities and division of work for that day before they started the direct care.

Although no firm conclusions can be drawn from the small number of repeated observation days, they indicated consistency in both the management and role differentiation scores and the sister's place on the management continuum; this consistency is absolute in the sisters who had the most developed nursing management patterns (15, 40, 41), but is also high in three out of the four other sisters. The implication, though this would require further study, is that it is possible to identify 'manager sisters' by observing them over a very short period of time; in particular the completion of the management cycle activities at the beginning of the shift is a guide to the way in which the sister will differentiate her overall role from that of the nurses. Perhaps observation of the management cycle activities is a criterion which could be of help to nurse managers in identifying those sisters who are able to organise the nursing in relation to individual patients.

The interview

Of the seven sisters who were interviewed five had obtained the General Certificate of Education at advanced level and were among the fourteen sisters out of the fifty who had obtained advanced levels. Six of the sisters were among the fifteen in the total sample who had taken a post-basic clinical course or had obtained the whole or part of the Diploma in Nursing. One sister was also a health visitor and another held both general and psychiatric qualifications. This sub-sample of sisters was therefore among the most highly academically and
professionally qualified of the fifty sisters. Six of the seven sisters had attended a first line management course. All the sisters were in sole charge of their wards and for five of the sisters their present job was their first ward sister appointment.

At interview each sister was asked for her views on the first line management course she had attended. Without exception, the sisters felt that the training had been inappropriate for their job as a ward sister; the most frequent comment was that the course tutors had had an industrial orientation which was not applicable to a hospital ward. As one sister said:

'+... it was not very well adapted to the hospital situation, it was very industry orientated. When one is dealing with people, you cannot plan as they say you can plan ...'

Two sisters mentioned the value of the informal discussion with others on the course.

In answer to the question on how the sisters had learnt to be ward sisters the most notable finding was the importance of 'role models'. The sisters had learnt to be ward sisters by working with and observing another sister whom they had identified as a 'good' ward sister. The most influential period appeared to be the staff nurse period. As one sister said:

'+... the sister on the ward where I staffed ... well I feel I owe it all to her; her attitude to patients and her patient care taught me a lot'.

Another sister said:

'+... I was trained by observing other ward sisters who I worked for ... I really feel I learnt my management from watching other people and not from having it in words'.
The sisters who had performed specific management cycle activities such as a nursing round of patients or receiving accountability reports were asked how they had learnt this part of their role and why they performed these activities. Again, the sisters related this behaviour to observing other ward sisters or said that they had arrived at the technique through experience; none had been formally taught to perform the management cycle activities.

A sister talking about why she did a daily nursing round of the patients said:

'Nobody ever told me I should do it, nobody told me on a management course; this is something through my own experience I felt I would like somebody to do to me so I do it to others'.

Another sister said:

'One sister I worked for as a psychiatric staff nurse was absolutely fantastic in dealing with problems ... she seemed to achieve an awful lot by going round the ward every morning and it impressed me a tremendous amount'.

The sisters also identified the nursing round as a means of assessing the patients' needs which is the reason the activity was included in the daily management cycle. One sister said:

'I think you have to assess a patient's needs in the morning and if you can deal with the problems that day your relationship is very much better'.

Another sister found the nursing round

'... very helpful and terribly important in my assessment of the patient'.

Five sisters had allocated individual nurses to individual patients; they included the two sisters who required each nurse to report back on her patients. One sister had learnt this system of accountability reports
from working abroad in a hospital where 'patient allocation' was hospital policy. She commented:

'The nurses were involved, they seemed to know what was going on and the nurses were reporting back about their patients that they had looked after; this was something completely foreign to me and I thought that this was marvellous'.

The other sister who was in charge of a thirty two bedded divided ward said that the system of allocating patients to nurses and the related accountability reports had:

'... evolved out of the situation, the size and shape of the ward and the difficulty of supervising the nurses. I do not know where I learnt it from, it just seemed to be a systematic way out of a rather chaotic situation!'.

This sister talked about the value of allocating individual patients to nurses and requiring the nurse to report on their patients:

'We explain that the purpose (of reporting back) is not a test at all it is just simply so one can sit down and chat with the nurse about her patients; it is then you get through to them with information like - 'what about this lady, has she had mouth care? Do you think it is necessary?' - and also it is to our advantage as well because as you can imagine I am not entirely aware of what is going on - all the little details. Also it makes the nurse realise that you are interested in the patients and also interested in them and I find that they cope with things better; it is not just trained staff giving orders, it is trained staff participating and getting some feedback. I want the nurse to take some responsibility and I think it is a very important part of my job not to get frustrated by the fact it (delegated responsibility) needs checking'.

Of the five sisters in the sub-sample who practised patient allocation three had said that they had learnt to practise the system as student nurses. Two of these ward sisters were in the hospital in which they had trained, a hospital which had a tradition of patient allocation. By coincidence a third sister who had trained in the same hospital, and who was therefore familiar with patient allocation, was a ward sister in
one of the other hospitals in the sample which did not have a
tradition of patient allocation; the sister continued to practise
patient allocation within this different environment. All three of
these sisters said that they practised patient allocation because
that was the way in which they had been trained from the beginning of
their own nurse training. The sister who was now working in a
different hospital said:

'Even from my first ward you were responsible for
looking after a certain number of patients. I looked
after patients who were sometimes quite ill ... but I
knew the people in charge were confident in me and I
was confident to go ahead and do it'.

The sister related this confidence to the way in which the nursing
was organised - through the completion of the management cycle:

'We were all given a report at the beginning of our
span of duty, and then we were asked to look after a
certain number of patients and special points of nursing
care would be pointed out again about particular patients
so that you really had the priorities in your own mind,
and you knew if something was not done then you were
going to be told off about it ... and before we went off
duty we always gave a quick verbal report to the nurse,
and to the next nurse who was going to look after the
patient for the next span of duty'.

Although three of the sisters practised patient allocation because
of their own training experience, the other two sisters in the sub-sample
who practised patient allocation had had to work the process out for
themselves and innovate it within a hospital which did not organise the
nursing in this way. One of the findings arising from the interviews was
that the influences that enabled the ward sisters to introduce innovatory
practice were fragile but of great importance. One sister identified a
senior nurse manager who had given her the necessary help and
encouragement to introduce patient allocation; support from the school of
nursing was a recognised factor in two hospitals; another sister saw the response from the nurses themselves as a source of encouragement. However, the overall impression gained at interview was that the sisters who tried to innovate - there were four who mentioned specific attempts - felt unsupported and isolated. One sister said:

'I think all I want is some encouragement, one does not want more staff ... I would just like maybe the support and encouragement and I think everybody needs this from the most junior nurse right through to the top'.

Another sister identified the lack of information and expertise available when she tried to implement patient allocation in her ward:

'You had to think out the whole thing for yourself; there was no written scheme, nobody coming frequently from the school, nobody else; there was no other ward sister whom you knew was doing it or nursing officer who had done it'.

This sister also felt keenly the lack of understanding of what she was trying to do and the practical difficulties this lack of understanding created:

'Nobody seemed to have any idea whether we were doing it or not doing it - nobody came to know what we were doing and yet they expect us to lend out nurses at short notice - you plan your day or you plan your work with that number of staff and then somebody is taken away and you have to do it all over again - it is a waste of time really'.

Other sisters who were actively trying to plan the daily nursing commented on the discouragement they felt when they had to lend nurses at short notice. It was apparent during the observation of the fifty sisters that where the nursing had not been planned by the sister - and this was in the majority of wards - the lending of nurses did not appear to cause too much feeling. Where the sister had given thought and effort to planning the nursing and had allocated the nurses individually
to patients, the seemingly casual borrowing of nurses and the failure to acknowledge the disruption caused to the planned nursing was a source of frustration and anger in the sisters; nothing illustrated more clearly their powerlessness in being able to manage the nursing.

The interviews were completed by asking the sisters what they felt were the training needs of ward sisters. More teaching in psychology was identified as the major need; the two sisters who had studied for the Diploma in Nursing both commented on the value of the psychology teaching in helping them to understand patients' reactions, group dynamics and enabling them to work better with people. The sister who was a health visitor felt that her health visitor training helped her to perform better as a ward sister; she had a better understanding of people as a whole; she could communicate and teach more easily. The practical teaching experience four of the sisters had gained during further training also was seen as relevant. Opportunities to visit areas of good practice and to meet and discuss with colleagues would have been welcomed.

Thus these sisters sought further opportunities for development and learning, but time and again they returned to what they had learnt from experience and in particular from working with and observing 'good' ward sisters. One sister summed up the situation thus:

'I think the way it has always been done is the way to train ward sisters. I think it is a shame that we are moving away from it slightly and there are not the senior sisters to learn from. I think one thing that does need some thought is the position and career structure of the ward sister'.

In summary, the interviews were helpful in describing the way in which the sisters had learnt to be ward sisters in more detail, and their
own views on ward sister training. In particular, the sisters identified the influence of other senior sisters who had acted as role models. The influence of these senior sisters appeared to be more important in the management training of the ward sister than their first line management training. The original intention of the Committee on Senior Nursing Staff Structure (Ministry of Health 1966) had been for first line management training to be given both 'on the job' as well as outside the hospital (p. 33); in this way the use of role models might assist in teaching the trainee ward sister the most appropriate management techniques for achieving nursing within the unstable environment of the hospital ward.
Chapter 10

SUMMARY AND CONCLUSIONS
Summary

This study has described the role of the ward sister in the management of nursing on an individualised patient basis.

The theoretical base for the study has been the work of Brown and Jaques (1965) on managerial role; in particular, the theoretical work on the need for managers to provide explicit work prescription and work accountability for individuals to achieve work in organisations.

These theories on managerial role have been tested in relation to the hypothesis that management of nursing on an individualised patient basis requires the ward sister, as the designated ward nursing manager, to prescribe nursing work and exact nursing work accountability explicitly in relation to individual patients and individual nurses. This hypothesis was tested by observing the completion of the four activities of a 'daily nursing management cycle' by each ward sister in relation to each patient and each nurse.

The finding from the main study of fifty ward sisters was that forty one (82%) of the sisters did not manage the daily nursing on an individual patient basis. The majority of the fifty sisters did not undertake three of the four activities which comprised the daily nursing management cycle. Only a negligible number of the sisters either prescribed nursing work (18%), or received accountability reports (10%) on an individual patient basis (Summary Table, p. 178).

Nine sisters (18%) did manage the nursing on an individualised patient basis. Two sisters fulfilled every criterion of the management cycle, including explicit work prescription and work accountability in relation to each nurse and each patient; another seven sisters gave
explicit work prescription in relation to every patient and nurse. The evidence was that these sisters exercised a managerial role and managerial behaviour, exactly as described by Brown (p. 22). The application of these managerial principles was associated with the management of the nursing on an individual patient basis.

It was observed that these nine sisters highly differentiated their role from that of the ward nurses. Conversely, the majority of the sisters only minimally differentiated their role; minimal role differentiation on the part of the sister was associated with non-management of the nursing.

The completion of the management cycle in relation to each patient and each nurse is the way in which the organisation of nursing on an individualised patient basis has been operationally defined for the purposes of this study. It is believed that this operational definition contributes towards the solution of the nursing problem of defining what is meant by 'individualised nursing' and how this can be achieved in daily practice. However, it is stressed that the present research is confined to the process through which individualised nursing is organised; outcomes in relation to patients of the completion of the daily nursing management cycle by the ward sister have not been studied.

While completion of the management cycle by the ward sister is defined as the organisation of nursing on an individualised patient basis, this relationship has been tested at various levels. It was found that the degree of management practised by the ward sister, as measured by the degree of completion of the management cycle activities, was proportionately related to the extent to which the nursing was organised in relation to individual patients and nurses. A high degree of
management was associated with more time devoted to the organisation of the nursing in relation to a larger number of individual patients and nurses; a low degree of management was associated with less organisation of the nursing and in relation to fewer patients and nurses. There was no evidence that organisation of individualised nursing occurred by chance or when the ward sister failed to carry out the management cycle activities. In contrast, the evidence was that the organisation of the nursing in relation to every individual patient and every individual nurse in the ward was always associated with deliberate managerial behaviour on the part of the ward sister and the use of precise managerial techniques.

This finding on the relationship between the degree of management and the extent to which the nursing was organised in relation to individual patients, contributes to recent nursing thinking on the importance of a carefully planned nursing process if individualised nursing is to be achieved. The particular contribution of the present research is that it points to the validity of recent management theory in relation to this process.

The management cycle activities of the ward sister were those which most differentiated her activity from that of the ward nurses. However, it was also observed that the ward sisters who managed the nursing tended to differentiate all their activities from those of the ward nurses. A classification of all the ward sister's activity on the basis of role differentiation was developed to describe the degree of role differentiation observed. Role differentiation is a further guide to ward behaviour associated with the organisation of nursing on an individualised patient basis. Organisation of the nursing in relation
to individual patients was not observed to occur when the ward sister behaved like the ward nurses and occupied a virtually non-differentiated role in the nursing team.

The study includes an attempt to identify the characteristics of some of the sisters who managed the nursing on an individual patient basis. The finding was that these sisters were among the most highly qualified, academically and professionally, of the total sample. The management of individualised nursing through completion of the management cycle activities and high role differentiation remained the consistent characteristics of these sisters' behaviour throughout repeated observation. At interview, all these sisters identified role models (other senior sisters) as the source of their learned behaviour, rather than formal management training.

As a framework to the management cycle, an attempt was made to examine the ward sister's role in relation to the organisation within which she was placed. The finding was that the ward sister, although designated a first line manager, did not have the minimal managerial authority deemed necessary to exercise a managerial role (p. 145). There was evidence, however, that the ward sister role was of critical organisational importance both in relation to the management of nursing and in co-ordination and delivery of other hospital services to the patient.

Finally, drawing from theories on the effect of organisational environment on work (p. 7), there was evidence that the particular organisational environments within which the five different hospitals were placed, influenced the work of the ward sister. These environmental factors appeared to be as important an influence on the way
in which the ward sister worked as traditional influences such as the supply of nurses. The effect of an unstable environment on work organisation, particularly at ward level, has received little attention in nursing. This study showed that the ability of the ward sister to achieve a form of nursing organisation which was flexible enough to cope with the unstable ward environment, was one of the characteristics of the sisters who managed the nursing in relation to individual patients and individual nurses.
Discussion

The most important finding in the present study was that the degree to which the ward sister managed the nursing was strongly associated with the degree to which the nursing was organised on an individual patient basis. The discussion therefore centres on the nature of the ward sister's managerial role and how this might be developed.

A number of variables, interacting over a period of time, have affected the present nature of the ward sister's role. Perhaps the most important of these has been the increasing 'openness' of the ward and hospital (p. 59); originally the ward and hospital were almost 'closed' systems, with only infrequent visits by medical staff and others. As early as 1953 Goddard noted the interruption and disorganisation caused to the ward sister's nursing work as she became more involved in co-ordinating the work of others. This strain between nursing and 'other' work has become a major feature of the ward sister's role.

In 1966, faced with evidence of the difficulty of the ward sister's task, the Committee on Senior Nursing Staff Structure (Ministry of Health 1966), suggested that the solution to the problem was to reduce the size of the ward sister's nursing management role. The overall effect of the Committee's recommendation was to reduce the nursing control and authority of the ward sister, while the complexity and size of the job remained the same. The Committee appeared to ignore organisational theory available at that time that an organic management system with control located in more autonomous and professional roles at various points throughout the organisation, rather than the concentration of control and expertise at the top of a
bureaucratic organisation, was the more appropriate form of organisation to cope with an open system. Thus possible opportunities for the ward sister role to be expanded into a more autonomous role to match the increasing complexity of her task were left unexplored.

Even more important, there was evidence from a variety of sources (p. 24) that the way to deal with the particular difficulties of the first line manager/supervisor role was to enlarge, not reduce, the managerial content of the role; without minimal managerial authority the manager cannot manage. It is therefore likely that the lack of proper analysis and empirical work on the nature of the ward sister's organisational role, and the Committee's restructuring of the nursing hierarchy in a way which explicitly aimed to reduce the ward sister's managerial role, further jeopardised the already weakened management of nursing at ward level.

It is suggested that the findings of the present study in which eighty two percent of the ward sisters did not manage the nursing reflects the size and complexity of this management task, the lack of minimal authority to manage the nursing properly and, linked to this, virtually no perception of the importance of their managerial role. None of the fifty sisters had the minimal authority deemed necessary by Brown (p. 24); they had no control over the supply, selection or deselection of the ward nurses. The size and composition of the ward team varied daily; efforts made by the sister to plan the nursing in relation to individual patients and nurses were disrupted because she had no control over the borrowing of the nurses on a daily or part-day basis.
However, it was clearly evident from the study that the ward sister's job remains a strategic and robust organisational role. Although the ward sister had little formal authority in relation to the nursing and hospital organisation, her extant role critically influenced the delivery of nursing and other services to the patient. Mauksch (p. 33) suggests that the reason for this is that the management of the patient is a 'negotiated order' out of the representations and negotiations of the different actors involved in the care of the patient, and that this negotiated order 'is not the direct translation of a managerial process'.

The ward sister remains the key nurse in negotiating the care of the patient because she is the only person in the nursing structure who actually and symbolically represents the continuity of care to the patient. She is also the only nurse who has direct managerial responsibilities for both patients and nurses. It is this combination of continuity in a patient area together with direct authority in relation to patients and nurses which makes the role unique and so important in nursing. The ward sister (or her representative) remains at the centre of the negotiated order of the care of the patient, whereas other nurses, such as the nursing officer or a specialist clinical nurse such as a stoma therapist, move throughout the hospital and are, therefore, peripheral to the negotiated order of patient care which takes place at the individual patient's bedside.

Developments in clinical nursing roles will have to take into account the importance of the daily negotiated order of the care of the patient and the continuity of nursing role that this implies. The present ward sister role is the only role in nursing which provides
structural continuity; the role strain of 'always being there' is well recognised in nursing and is crystallised in the strain the ward sister experiences between nursing and other work. But the evidence is that this role continuity is of crucial importance both in the delivery of nursing and other services to the patient. Further, the evidence is that this task of delivering nursing and other care to the patients has been made more difficult by the diminished authority and lack of appropriate investment in the ward sister role over many years.

The strongest conclusion to be drawn from the study is that, whatever the difficulties, the ward sister's nursing managerial role should be strengthened and enhanced. Other developments such as clinical nurse specialist roles are to be welcomed but, precisely because of their organisational structure, they can in no way compensate patients for the lack of nursing that results from neglect of the ward sister role.

The problem of the requisite structure and size of the ward sister's role is a substantial one; it is one which in turn affects the whole nursing structure. Recent work, mainly by nurses themselves, in applying organisational and sociological theory to nursing (p. 35) has increased understanding of the relationship between the clinical and managerial aspects of nursing roles.

In view of the recent discussion on the development of clinical nurse specialists (Royal College of Nursing 1975), it would seem that there is fundamentally no conflict between the developing autonomous clinical nursing specialist roles and that of the ward sister. The two roles are organisationally different and probably complementary; the
ward sister role represents the continuity of nursing and social organisation to the patient; the clinical nurse specialist role, represents the specialist 'free movement' role which brings special resources to the patient.

The difficulty is more likely to be in creating the necessary space for a more autonomous and powerful management of nursing role within the present hierarchical nursing management structure. This difficulty is likely to have been increased by the introduction of the line management role of the nursing officer so close to that of the ward sister. The evidence from other disciplines working in unstable environments (p. 14), is that the emergence of more autonomous roles at the bottom of the management structure exerts an upward pressure on management. Senior management in turn adopts a 'service giving' relationship which allows an increase in managerial authority at the work face; this increased authority actually within the daily work situation allows more appropriate management of the workforce in response to the constantly changing work demands. However, these developments can be a painful process; there was some evidence from the present study of conflict between some of the sisters who were among the most effective managers and middle management. On the other hand, there was also evidence of supportive relationships between the two.

Although the conclusion is that there will have to be a larger organisational role at ward level if the nursing is to be managed in terms of individual patients, the development of this more autonomous professional role is dependent on the capacity of the individual to fill it. The discussion up until now has centred on the structure of the
ward sister's role; this final section therefore considers the use of the present research in relation to ward sister performance, the implications for the future selection and training of ward sisters and the implications for future research.

Although the patient and his relatives are so vulnerable, and so dependent on the ability of the ward sister to ensure that the patient is properly nursed, little attention has been given to the selection criteria or measures of ward sister performance since the research conducted by the Wood Committee in 1947. The purpose of the present study has been to try and identify some of the characteristics and behaviour of sisters who achieved the organisation of nursing on an individualised patient basis; the study therefore includes an attempt to identify performance criteria which it is known are desired by nurses themselves.

While it is stressed that the study is exploratory and that the instruments used require validation, it is believed that observation of the completion of the management cycle activities, although only tested on sixty seven 'ward sister days', is a helpful and simple measure for assessing ward sister performance.

The performance of the four activities which comprise the daily management cycle can easily be observed empirically by anyone watching the ward sister at her daily work. Further, the degree to which the ward sister completes even the activities of work prescription and work allocation at the beginning of the shift, is a guide to the rest of her management performance. Thus, the sister who actively plans and organises the nursing at the beginning of the day is likely to undertake other activities which she is in the best position to perform, including
communicating with both patients and nurses, working with and supervising nurses in the care of patients and helping them evaluate their performance. The sister who does not assess or organise the nursing at the beginning of the shift is likely to spend the day working alone on unplanned, fragmented activity much of which could be done by others in the team, including auxiliaries and clerical assistants. At the end of the day, in spite of much activity, it will not be known whether the patients' needs have been met. This, sadly, was the most frequent pattern of ward sister activity in this study.

The instruments used in the study provide a method of identifying manager and non-manager ward sisters and thus have a number of applications. The management cycle criteria can be used by nurse managers and educators as well as by the sisters themselves to identify more precisely differences in managerial performance. These criteria are a guide to the activities the sister will have to learn how to perform if she is going to be able to manage the nursing. The method can also help identify those sisters who are already managing the nursing and who could therefore act as role models to trainee sisters. One of the findings from the present study was that the manager sisters learnt how to manage the nursing from working with and observing other senior sisters and not from their formal management training; this may have important implications for the way that ward sisters should be trained in the future and underlines the need to maintain good ward sister practice. In every hospital included in the study there were sisters from whom other sisters could have learnt much; perhaps one way to improve ward sister practice quite dramatically, and without
considerable extra resources, is for nurses to identify their own ward sister role models and to actively use them to help in the training of future ward sisters. It is also one way in which the role of these special sisters could be enlarged.

There have been developments in the formal management training of ward sisters (Armfield and Jenkin 1977), but the sisters in the study found the industrial management principles that they were taught were inappropriate in helping them to deal with the unpredictable ward situation; in turn the teachers found that the ward sisters did not perceive themselves as having a managerial role. Knowledge about appropriate forms of management for unpredictable situations (p. 7) could be utilised for ward sister management training. Williams (1969), noted the need to train ward sisters in social skills and the need to help them understand the way in which organisations behave. Consideration might be given to designated training wards for ward sisters in which the opportunity to work with role models and learn to manage the nursing in its operational environment could be combined with theoretical work.

Whatever form training might take there remain the implications for the initial selection of the ward sister. It is apparent that the sister will not be able to sustain an enlarged role or undertake post-basic training for the role unless she has the innate capacity to do this. An important - though not generalisable - finding from this study was that the nine sisters who organised the nursing on an individual patient basis were among the most highly qualified, academically and professionally, of the fifty sisters. The implication throughout the study was that the job of the ward sister required
considerable conceptual ability, the ability to make complex decisions and to pursue priorities as well as social, clinical and managerial skills.

Little is known about the capacities required to be a ward sister, and this is one of the many areas that requires further research. There are a number of possibilities for future research arising out of the present study. The measures for identifying manager/non-manager ward sisters require further testing as the present study has been limited, but once validated, the easy identification of manager or non-manager sisters opens up the possibility of comparative studies involving a variety of outcomes. The present study has been limited to the process through which individualised nursing is organised. It has not measured any outcomes, for example, how the patient experiences 'managed' or 'non-managed' nursing; how the nurse is able to nurse; what she learns; what work satisfaction she experiences.

It would be helpful to replicate studies, especially those using quality of patient care measures, to compare the outcomes under manager and non-manager sisters. The indication is - although this requires testing - that the ward sister who manages the nursing on an individualised patient basis is more likely to ensure appropriate nursing; for example, that each patient will be starved pre-operatively for an optimal time (Hamilton-Smith 1972); that each patient's bowel function will be appropriately managed (Wright 1974); that each patient will receive the information they require to assist in their post-operative recovery and reduction of pain (Boore 1976, Hayward 1975).
Another need is for manpower studies. It would be helpful to know what comparative use manager/non-manager sisters make of nursing resources; the way in which they deploy different grades of staff and utilise ward clerks.

There is also the need to know more about the characteristics and behaviour of the different ward sisters themselves so that the profession can make more informed choices and decisions in the selection and training of future ward sisters.

The evidence from the present study is that the role of the ward sister is a complex and senior nursing role, one that is unique in nursing and of vital importance to the proper nursing of patients; it is a role that the profession should not neglect.

The task of selecting and training ward sisters is a difficult one. However, the profession has perhaps never been in a better position to develop the ward sister’s role. The Committee on Senior Nursing Staff Structure (Ministry of Health 1966) ensured that nurses can determine their own policies; recruitment of better qualified candidates, developments in nursing education, the expansion of higher education and research in nursing and experimentation with different kinds of clinical nursing roles are all part of the process of developing the ward sister role. Most important of all, the profession is now actively seeking ways in its teaching and practice through which it can realise the ideal of individualised nursing. There are ward sisters who are already achieving this ideal in their daily nursing work; this study has tried to identify how they accomplish this complex task and how we might learn from them.
<table>
<thead>
<tr>
<th>Area being explored</th>
<th>Discussion with sister</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The ward</td>
<td>Facts about the ward</td>
</tr>
<tr>
<td>2. The background of the sister</td>
<td>Facts about the ward sister</td>
</tr>
<tr>
<td>3. Changes in the ward; organisational instability; 'control' factor</td>
<td>Changes that have affected her work; the patients; the doctors; nurse training policy</td>
</tr>
<tr>
<td>4. Work role</td>
<td>Questions to sister</td>
</tr>
<tr>
<td>5. Work priorities</td>
<td>How would you describe your job as a ward sister?</td>
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<tr>
<td>6. Resources and constraints; 'control' factor</td>
<td>What are the most important daily jobs for you to do?</td>
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<td></td>
<td>What would you be unhappy about if you had to leave it out?</td>
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<tr>
<td>7. Work organisation</td>
<td>Can you run the ward as you like? What stops you?</td>
</tr>
<tr>
<td>8. Work prescription</td>
<td>How do you organise the nursing work? Describe a typical day</td>
</tr>
<tr>
<td>9. Work allocation; deployment pattern</td>
<td>How do the nurses know what to do?</td>
</tr>
<tr>
<td>10. Patient needs</td>
<td>How do the nurses work?</td>
</tr>
<tr>
<td>11. Work accountability</td>
<td>How are the patients' special and daily needs met?</td>
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<tr>
<td>12. The nurses; work/training; 'control' factor</td>
<td>How do you find out what work has been done? How do you check the nurses' work?</td>
</tr>
<tr>
<td>13. Areas of importance to the ward sister</td>
<td>How do you feel about the nurses you are allocated?</td>
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</table>

**The daily nursing management cycle**

<table>
<thead>
<tr>
<th>Area being explored</th>
<th>Discussion with sister</th>
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<tr>
<td>7. Work organisation</td>
<td>How do you organise the nursing work? Describe a typical day</td>
</tr>
<tr>
<td>8. Work prescription</td>
<td>How do the nurses know what to do?</td>
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<td>9. Work allocation; deployment pattern</td>
<td>How do the nurses work?</td>
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<td>10. Patient needs</td>
<td>How are the patients' special and daily needs met?</td>
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<td>11. Work accountability</td>
<td>How do you find out what work has been done? How do you check the nurses' work?</td>
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<tr>
<td>12. The nurses; work/training; 'control' factor</td>
<td>How do you feel about the nurses you are allocated?</td>
</tr>
<tr>
<td>13. Areas of importance to the ward sister</td>
<td>Have you any comments?</td>
</tr>
</tbody>
</table>
Annexe 2 Checklist of Work Problems

A ward sister's work always has a number of problems which make the job more difficult, or stops you from doing it as you would like. Please read through the list and for each item tick whether it is a problem, or is not a problem for you.

<table>
<thead>
<tr>
<th>In your job as a ward sister is this a problem?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Getting extra help when the ward is very busy</td>
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<tr>
<td>2. Doctors not giving patients enough explanation</td>
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<td>3. Being unable to complete one job at a time</td>
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<td>4. Admissions arriving in the ward before their beds are ready</td>
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<td>5. The design of the ward</td>
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<tr>
<td>6. Student/pupil nurses allocated for too short a time</td>
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<td>7. Getting conflicting orders from different doctors</td>
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<td>8. Not enough nurses who can supervise or teach</td>
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<tr>
<td>9. The number of patients who are transferred to or from the ward</td>
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<td>10. Getting patients notes or x-rays</td>
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<td>11. The feeling that you have no one really to turn to for help</td>
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<td>12. Having to lend nurses to other wards</td>
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<tr>
<td>13. The number of dependent/handicapped patients</td>
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<td>14. Having to have extra beds in the ward</td>
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<td>15. Interruptions from the doctors</td>
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<td>16. Arranging the off duty to give adequate ward cover</td>
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<td>17. Getting ward furniture/equipment repaired or replaced</td>
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<td>18. Trained staff moving frequently</td>
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<td>19. The number of tests the doctors order</td>
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<td>20. Interruptions from the telephone</td>
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<tr>
<td>21. Getting the ward cleaned properly</td>
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<tr>
<td>22. Nurses going off sick for the odd day or so</td>
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<tr>
<td>23. The number of separate medical rounds in the day</td>
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<tr>
<td>24. Interruptions from the nurses</td>
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<tr>
<td>25. Patients being discharged at too short a notice</td>
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<tr>
<td>26. Being given, or having to keep, unsatisfactory staff nurses</td>
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<tr>
<td>27. Getting doctors to keep to the hospital drug rules</td>
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<tr>
<td>28. People always coming to the ward sister</td>
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<tr>
<td>29. Patients who should really be in other wards</td>
<td></td>
<td></td>
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<tr>
<td>30. Getting enough linen</td>
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</tbody>
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Other problems (please specify)
Annexe 3  Checklist of Daily Work Priorities

1. A ward sister/charge nurse has a great number of different jobs to do each day. Please read through the list and tick the jobs you feel are the important ones for you to do. Then please read through the list of jobs you have ticked and place an extra tick against the jobs you feel are the most important ones for you to do.

The important daily jobs for me to do are

1. Supervise the patient's meals
2. Accompany the consultant on his round
3. Ask the nurses to report on their work
4. Write up the nursing kardex
5. Give some nursing care to a patient
6. See that the medical tests are carried out
7. Check that the student/pupil nurses are managing their work
8. Accompany the nursing officer on her round
9. Do a ward round of the patients
10. Get x-rays and test results for the ward round
11. Give the nurses a report on the patients
12. Attend a unit meeting

Are there other tasks you would do each day? If so, please list below:

2. Ward sisters/charge nurses sometimes feel they have not enough time for some parts of their work. Are there some aspects of your work that as a ward sister/charge nurse you would like to give more time to?
Annexe 4  Semi-structured interview sheet

Date    Hospital    Sister    Ward

Please outline typical day/how nursing is organised (1st shift)
How do the nurses know what to do?
What work do the different nurses do?
How do they work?
How do you find out what work has been done?
Annexe 5   Questionnaire on the resources of the ward sister

Date ___   Hospital ___   Sister ___   Ward ___

How long, on average, do the nurses stay on the ward?
   Trained staff _______ months
   Students _______ weeks
   Pupils _______ weeks
   Auxiliaries _______ months

Ward change lists are received in advance
   One month or more 1; 2-3 weeks 2;
   1 week 3; less than one week 4

Any influence over selection of trained staff?
   Yes 1; a little 2; no 3
   Auxiliaries?
   Yes 1; a little 2; no 3

The hours part time nurses work?
   Yes 1; a little 2; no 3

Are extra beds put up in the ward?
   Frequently 1; occasionally 2; never 3

Are there day cases?
   Yes 1; no 2

How often does the N.O. come to the ward?
   More than daily 1; daily 2;
   less than daily 3

How often are unit meetings held?
   +1/12 1; 3/52 2; 2/52 3; 1/52 4
   How often do you attend?
   All 1; most 2; occasionally 3

Do you act up?
   Frequently 1; occasionally 2; never 3
   Does N.O. act down?
   Yes 1; no 2

Other nursing meetings?

Do you serve on any hospital committees?

Are you a G.N.C. assessor?
   Yes 1; no 2

Are G.N.C. assessments done in the ward?
   Yes 1; no 2

How often does the clinical teacher come to the ward?
   Day per month
   none 99
Annexe 6

**BACKGROUND INFORMATION**

1. Which, if any, of these United Kingdom qualifications did you obtain at school or college? Please give the number of subjects obtained.
   - CSE: 6-8
   - 'O' level, or School Certificate: 9-11
   - 'A' level, or Higher School Certificate: 12-14
   - Degree: 15-17
   - Other (specify): 18-20
   - None: 21-23

**NURSE TRAINING**

2. Training for the Register
   - General: 24
   - Sick children: 25
   - Mental illness: 26
   - Sub-normality or deficiency: 27
   - Fever: 28

3. Training for the Roll
   - General: 29
   - Mental illness: 30
   - Sub-normality or deficiency: 31

4. Training as a Midwife
   - Part I: 32
   - Part II: 33
   - One year or Integrated Course: 34

5. Community Training
   - Health Visitor Certificate: 35
   - District Nurse Certificate: 36
   - SEN Certificate in District Nursing: 37
6. Other Post-Certificate Training

<table>
<thead>
<tr>
<th>Multidisciplinary</th>
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<tbody>
<tr>
<td>First line</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Middle line</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Senior</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Nurses only</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>First line</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Middle line</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Senior</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Other administrative course (specify)</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Nurses only</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Clinical course</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Course leading to registration as a clinical teacher, nurse tutor</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Any other training (please describe)</td>
<td>50</td>
<td></td>
</tr>
</tbody>
</table>

7. How many years have you been in active nursing, including training?
- Under 7 years: 51
- 7-15 years: 52
- Over 15 years: 53

8. Which year did you start nurse training?
- Under 30: 54
- 30-40: 55
- Over 40: 56

9. Is your age
- Under 30: 57
- 30-40: 58
- Over 40: 59

10. In your present job are you
- Charge/sister in sole charge: 60
- Senior charge/sister: 61
- One of two of same grade: 62

11. How long have you been in your present job?
- Under 30: 63
- 30-40: 64
- Over 40: 65

12. Had you been a charge/sister before this present job?
- Yes: 66

13. If yes, for how long?
- Under 30: 67
- 30-40: 68
- Over 40: 69

14. Do you expect to stay in nursing?
- Yes: 70

15. If yes, what are your future plans?
1. The same job: 71
2. A similar job:
3. Further clinical training course:
4. Community nursing:
5. Clinical teacher/tutor:
6. Nursing officer:
7. Nursing administration:
8. Others (please specify)
## Annexe 7  Ward Sister Activity Code List

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Primary (basic) care of patients</td>
</tr>
<tr>
<td>020</td>
<td>Distribution/supervision of food</td>
</tr>
<tr>
<td>025</td>
<td>Talking to patients</td>
</tr>
<tr>
<td>100</td>
<td>Technical care of patients</td>
</tr>
<tr>
<td>113</td>
<td>Medicines</td>
</tr>
<tr>
<td>300</td>
<td>Personal time</td>
</tr>
<tr>
<td>400</td>
<td>Unskilled work</td>
</tr>
<tr>
<td>600</td>
<td>Walking</td>
</tr>
<tr>
<td>201</td>
<td>Written reports, kardenx</td>
</tr>
<tr>
<td>238</td>
<td>Written work prescription</td>
</tr>
<tr>
<td>239</td>
<td>Verbal work prescription</td>
</tr>
<tr>
<td>240</td>
<td>Information report to/from nurses</td>
</tr>
<tr>
<td>242</td>
<td>Asking/receiving oral work report from nurses</td>
</tr>
<tr>
<td>202</td>
<td>Teaching, other than by daily example</td>
</tr>
<tr>
<td>209</td>
<td>Talking with nurses</td>
</tr>
<tr>
<td>215</td>
<td>Talking with domestic</td>
</tr>
<tr>
<td>212</td>
<td>Visits of consultants to patients</td>
</tr>
<tr>
<td>213</td>
<td>Visits of all other medical personnel</td>
</tr>
<tr>
<td>214</td>
<td>Visits of all other hospital staff</td>
</tr>
<tr>
<td>226</td>
<td>Attention to relatives and friends of patients</td>
</tr>
<tr>
<td>211</td>
<td>Visits/interaction with unit nursing officer</td>
</tr>
<tr>
<td>214</td>
<td>Visits of all other senior nursing staff, excluding nursing officer</td>
</tr>
<tr>
<td>245</td>
<td>Attending unit meetings</td>
</tr>
<tr>
<td>208</td>
<td>Ward round of patients</td>
</tr>
<tr>
<td>243</td>
<td>Observation of patients</td>
</tr>
<tr>
<td>219</td>
<td>Charting</td>
</tr>
<tr>
<td>236</td>
<td>In office, activity unidentified</td>
</tr>
<tr>
<td>237</td>
<td>General administration</td>
</tr>
<tr>
<td>210</td>
<td>Receiving/making telephone calls</td>
</tr>
<tr>
<td>299</td>
<td>Talking with ward clerk</td>
</tr>
<tr>
<td>232</td>
<td>Looking for people or equipment</td>
</tr>
<tr>
<td>233</td>
<td>Attention to study team</td>
</tr>
<tr>
<td>223</td>
<td>Absence from ward on official duties</td>
</tr>
<tr>
<td>207</td>
<td>Official meal break</td>
</tr>
<tr>
<td>999</td>
<td>No recording</td>
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</tbody>
</table>
Annexe 8  Ward Sister Continuous Observation Code List

<table>
<thead>
<tr>
<th>Group</th>
<th>Nurses on Duty</th>
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</thead>
<tbody>
<tr>
<td>Number of people if more than 4</td>
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<tr>
<td>All = 99</td>
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**Initiated by**

<table>
<thead>
<tr>
<th>Nurse</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>2</td>
</tr>
<tr>
<td>Self</td>
<td>3</td>
</tr>
<tr>
<td>Patient</td>
<td>4</td>
</tr>
<tr>
<td>Doctor</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>Team Leader</td>
<td>8</td>
</tr>
<tr>
<td>Ward Plan</td>
<td></td>
</tr>
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</table>

**Interrupted by**

<table>
<thead>
<tr>
<th>Ward nurse</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>2</td>
</tr>
<tr>
<td>Patient</td>
<td>4</td>
</tr>
<tr>
<td>Doctors</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
<tr>
<td>Ward Clerk</td>
<td>9</td>
</tr>
</tbody>
</table>

**Nurse Grades**

<table>
<thead>
<tr>
<th>Sister</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse</td>
<td>8</td>
</tr>
<tr>
<td>SEN</td>
<td>7</td>
</tr>
<tr>
<td>Third year student</td>
<td>6</td>
</tr>
<tr>
<td>Second year student</td>
<td>5</td>
</tr>
<tr>
<td>First year student</td>
<td>4</td>
</tr>
<tr>
<td>Second year pupil</td>
<td>3</td>
</tr>
<tr>
<td>First year pupil</td>
<td>2</td>
</tr>
<tr>
<td>Auxiliary</td>
<td>1</td>
</tr>
<tr>
<td>Night nurse</td>
<td>001</td>
</tr>
<tr>
<td>Clinical teacher</td>
<td>666</td>
</tr>
<tr>
<td>Ward clerk</td>
<td>099</td>
</tr>
</tbody>
</table>

**Where**

| Office (duty room)          | 1 |
| Nurses' Station             | 2 |
| Bed areas                   | 3 |
| Centre of ward              | 4 |
| Ancillary rooms             | 5 |
| Off ward                    | 6 |
WARD SISTER CONTINUOUS OBSERVATION SHEET

Hospital:  
Ward:  

<table>
<thead>
<tr>
<th>Col.</th>
<th>1</th>
<th>2-3</th>
<th>4-5</th>
<th>6-8</th>
<th>9</th>
<th>10</th>
<th>11-13</th>
<th>14-15</th>
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</thead>
<tbody>
<tr>
<td>Form</td>
<td>Hosp</td>
<td>Spec</td>
<td>Ward No.</td>
<td>Sex</td>
<td>Day</td>
<td>Nurse No.</td>
<td>Pat No.</td>
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<table>
<thead>
<tr>
<th>Col.</th>
<th>16-17</th>
<th>18</th>
<th>19-22</th>
<th>23-26</th>
<th>27-28</th>
<th>29-31</th>
<th>32-34</th>
<th>35-37</th>
<th>38-40</th>
<th>41</th>
<th>45</th>
<th>51</th>
<th>57</th>
<th>58-60</th>
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<tbody>
<tr>
<td>No.</td>
<td>Int.</td>
<td>Time</td>
<td>Nurse numbers</td>
<td>No. of</td>
<td>Start</td>
<td>Finish</td>
<td>Group</td>
<td>Individual</td>
<td>Pats.</td>
<td>Init.</td>
<td>Where</td>
<td>Act</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is a table that lists various columns and rows for a continuous observation sheet used by a ward sister in hospitals. The columns include various time slots and specific details for each entry, allowing for detailed tracking of observations and activities.
Annexe 10  Ward sister activity analysis sheet

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>SISTER</th>
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<tbody>
<tr>
<td>TIME</td>
<td>NURSE NUMBERS</td>
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<td></td>
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</table>
## Ward sister activity summary sheet

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>TIME</th>
<th>TIME WITH NURSES</th>
<th>SISTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>025</td>
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<td></td>
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<tr>
<td>100</td>
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<td>113</td>
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<td>299</td>
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<td></td>
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<tr>
<td>300</td>
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<td></td>
</tr>
<tr>
<td>400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>600</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Ward Nursing Study

As promised, I enclose a brief summary of the day's work you kindly let us observe. The major items in your own work were:

**TIME (in minutes)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct care to patients</td>
<td></td>
</tr>
<tr>
<td>Day round and talking to patients</td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td></td>
</tr>
<tr>
<td>Supervision of meals</td>
<td></td>
</tr>
<tr>
<td>Giving, receiving reports from the nurses</td>
<td></td>
</tr>
<tr>
<td>Talking to nurses separately</td>
<td></td>
</tr>
<tr>
<td>Time with doctors</td>
<td></td>
</tr>
<tr>
<td>Time on telephone</td>
<td></td>
</tr>
<tr>
<td>Written reports, charts</td>
<td></td>
</tr>
<tr>
<td>General administration</td>
<td></td>
</tr>
<tr>
<td>(Any unusual item, for example, teaching nurses)</td>
<td></td>
</tr>
</tbody>
</table>

_____% of your total day was spent in direct contact with the ward nurses.

You were interrupted _____ times in _______ hours and ______ minutes on the ward including:

- Telephone
- Doctors
- Ward nurses
- "Others" from outside the ward but excluding doctors

The full report on the study of the fifty wards will come to the hospital later in the year, but we will gladly give you more information on your work and the ward if you would like it.

Thank you very much for all your help and time (then personalised, for example, we much enjoyed our day in the ward; it was of great value to be able to include _____ Ward in the study).

With best wishes,

Yours sincerely,

Susan Pembrey
REFERENCES

Abel-Smith, B. (1960) *A history of the nursing profession.* Heinemann, p. 190


Argyris, C. (1964) *Integrating the individual and the organisation.* Wiley

Armfield, J. and Jenkin, B. (1977) *Developing health service managers,* *Nursing Times occasional paper,* 72, 133-136

Ashton, K. (1977) *Home truths for hospital nurses.* *Nursing Times,* 73, 642-643


Auld, M.G. (1976) *Objective thinking at the top.* *Nursing Mirror,* 142, 15, 49-51

Baldwin, S.M. (1976) *Made to measure care.* *Nursing Times,* 72, 468-469

Banton, M. (1965) *Roles: an introduction to the study of social relations.* Tavistock


Bendall, E. (1976) *Learning for reality.* *Journal Advanced Nursing,* 1, 1, 3-9


Central Health Services Council (1961) *The pattern of the in-patients' day*. H.M.S.O. London

Central Health Services Council (1966) *The post-certificate training and education of nurses: a report of the Standing Nursing Advisory Committee (Chairman, M.B. Powell)*. H.M.S.O. London

Central Health Services Council (1976) *The organisation of the in-patients' day*. H.M.S.O. London


Collingwood, M.P. (1975) *The nursing care plan as a basis for an information system based upon individualised patient care*. *Nursing Times occasional paper*, 71, 21-22


Crossley, J.R. (1973) *Nursing and midwifery resources*. *Nursing Times occasional paper*, 62, 5-7


Davies, J. (1972) A study of hospital management training in its organisational context. Centre for Business Research, Manchester Business School

Department of Health for Scotland Scottish Health Services Council (1955) Report by the Standing Nursing and Midwifery Advisory Committee on the Job analysis of the work of nurses in hospital wards. H.M.S.O. Edinburgh


Goddard, H.A. (1953) see Nuffield Provincial Hospitals Trust (1953)
Goddard, H.A. (1963) see Leeds Regional Hospital Board (1963)
Jenkinson, V.M. (1958) Group or team nursing. Nursing Times, January 17th, 62-64; January 24th, 92-93

Jones, E.S. (1977) A patient allocation trial. Nursing Times, 73, 390-392


Kahn, R.L. et al. (1964) Organisational stress: studies in role conflict and ambiguity. Wiley


Leeds Regional Hospital Board (1963) Work measurement as a basis for calculating nursing establishments: an analytical study. (Goddard, H.A.)


Matthews, A. (1972) Total patient care in the ward. *Nursing Mirror*, 134, 6, 29-31


Miller, E.J. and Gwynne, G. V. (1972) *A life apart*. Tavistock


National Nursing Staff Committee (1970) Report on staff appraisal in the hospital nursing service. National Nursing Staff Committee

Nightingale, F. (1914) *Florence Nightingale to her nurses.* A selection from Miss Nightingale's addresses to probationers and nurses of the Nightingale School at St Thomas' Hospital. Macmillan

Nuffield Provincial Hospitals Trust (1953) *The work of nurses in hospital wards: report of a job analysis* (Goddard, H.A.) Nuffield Provincial Hospitals Trust

Nursing Mirror editorial (1977) *Investing in the future.* Nursing Mirror, 144, 18, 33

Nursing Times (1976) *Coping with the quadriplegic patient.* Nursing Times, 72, 303-304

Nursing Times editorial (1958) *The ward sister's exacting task.* Nursing Times, February 7th, 143

Nursing Times editorial (1970) *Are ward sisters managers?* Nursing Times, 66, 929

Nursing Times editorial (1972) *The darlings of the nursing world.* Nursing Times, 68, 1369

Nursing Times editorial (1977) *Purses for courses.* Nursing Times, 73, 591

Oppenheim, A.N. (1966) *Questionnaire design and attitude measurement.* Heinemann


Pembrey, S. (1975) *From work routines to patient assignment: an experiment in ward organisation.* Nursing Times, 71, 1768-1772


Prices and Incomes National Board (1968) *Report No.60 Pay for nurses and midwives in the National Health Service.* H.M.S.O. London


Rowbottom, R. et al. (1973) Hospital organisation. Heinemann

Royal College of Nursing and National Council of Nurses of the United Kingdom (1964) A reform of nursing education. First report of a special committee on nurse education (Chairman, H. Platt). The Royal College of Nursing and National Council of Nurses of the United Kingdom, London

Royal College of Nursing and National Council of Nurses of the United Kingdom (1974) The state of nursing. The Royal College of Nursing submission to the Secretary of State for Social Services. Royal College of Nursing, London

Royal College of Nursing (1975) New horizons in clinical nursing. Royal College of Nursing, London

Salmon Committee (1966) see Ministry of Health (1966)

Scottish Home and Health Department (1967) Scottish Health Service Study No.3. Nurses' work in hospitals in the N.E. region of Scotland. Scottish Home and Health Department

Scottish National Nursing and Midwifery Consultative Committee (1976) The process of nursing. *Nursing Mirror*, 143, 1, 55-57


Titmuss, R.M. (1966) The hospital and its patients in
Deck, E.S. and Folta, J.R. (eds) A sociological framework for
patient care. Wiley

Treece, E.W. and Treece, J.W. (1973) Elements of research in nursing.
C.V. Mosby Co

Organizational choice : capabilities of groups at the coalface
under changing technologies. Tavistock

Turner, V. (1977) How the nurse can help preserve a patient's
individuality. Nursing Mirror, 114, 3, 60-64; 114, 4, 59-62


Free Press

Webster, L. (1967) A critical look at Salmon : Salmon and the
ward sister/staff nurse. Nursing Times, 62, 1039

Wells, T. (1975) Towards understanding nurses' problems in the
University of Manchester

A comparative study of two medical units in a general hospital, in
each of which a different method of nursing was practised.
Department of Health for Scotland

Williams, D. (1969) The administrative contribution of the nursing
sister. Public Administration, Autumn, 307-328

Williams, K. (1974) Ideologies of nursing : their meanings and
implications. Nursing Times occasional paper, 70, 32

Wilson, J.R. (1971) Nursing troubles. Spectator, August 21st


The study of nursing care. Series 1 No.4, Royal College of
Nursing, London