Essentials of Nursing Management

Managing People

Sheila Marson, Michael Hartlebury,
Rita Johnston and Barbara Scammell

Managing People

ESSENTIALS OF NURSING MANAGEMENT

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Preface

The health service's most valuable resource is its workforce of committed staff, many of whom have undergone years of training in one of the caring professions.

But herein lies a dilemma. For the very staff who have spent years learning to be professionally competent soon find themselves with the crucial responsibility of managing some part of that valuable resource without any kind of preparation or training at all.

Every nurse who takes responsibility for a ward or community area is, of necessity, a manager, working through other people to achieve the objectives for that ward or area and thus contributing to the overall achievement of the policy of the employing organisation. Only by securing the commitment of other staff to achieving the same aims will the nurse be effective as a manager.

As a nurse manager you should understand the objectives and plan how they can be met. You should be able to build and lead a team, recognising and using its strengths and working to diminish its weaknesses. You should encourage the personal and professional growth of the team members while working always towards your own. And you should continually evaluate the team's progress and take steps to ensure that it is dynamic, efficient and effective.

This is a tall order. The skills needed to manage a group of people to achieve a consistently high level of effective interaction are not innate; they have to be learned and can always be improved.

But the more you know of how people are likely to respond to your attempts at managing them, if you can understand your own motivation and theirs, the more you can start to adopt a more positive and effective approach.

The importance of good management at ward level must not be underestimated. Here is the greater proportion of the valuable nursing workforce, here are the nurse managers of the future, learning by example – and here, at the point of delivery, is where quality of care matters most.

This practical guide for first-line managers sets out the basic principles of managing people, the first steps on the way to acquiring a style of management which is both efficient and effective.

JB
February 1990

Notes on the authors

Sheila Marson had, up to retirement, extensive and varied experience in the field of nurse education. This experience included an in-depth study of the teaching role of the ward sister.

Michael Hartlebury trained as a nurse in Sheffield and attained the Certificate in Clinical Nurse Studies (Behavioural Therapy) at Dundee. Having spent 15 years working for Sheffield Health Authority, he is now a self-employed management consultant to various Health Authorities and private health care companies.

Rita Johnston is a lecturer and director of the distance learning master's degree in training and development, in the Centre for Continuing Vocational Education in the University of Sheffield.

Barbara Scammell, formerly a school teacher, then nursing officer in a variety of local, regional and national posts, is now a training consultant.

Chapter 1 The science and function of management
by Barbara Scammell

Starting points

While it could reasonably be postulated that management is management, regardless of where and by whom it is practised, it would be misguided to suppose that its objectives would be precisely the same if practised by an industrialist as they would be when nurse managers are the practitioners. Many nurses in the past have found it unacceptable to be offered management objectives developed in the industrial field which they are then expected to translate into health-service terms. Such a point of view is understandable and is probably supported by managers who are asked to make a similar comparison between differing professions, for example between industry and teaching. It is, however, perfectly possible to adapt the theory and functions of management so that they are congruent with the ideas, ideals, customs and practices of non-industrial organisations, and it would be foolish to disregard the expertise and the lessons that industrial management has to offer.

The objectives of this chapter are:

- to look at management as a concept;
- to consider *nurse* management, and how this fits into this concept;
- to consider the hierarchy of the NHS, and how nurse management fits into it.

Before considering the wider concepts of management as accepted by academics and practised in industry, the civil service, local government and in many other organisations, it will be helpful to establish what concepts already exist in *your* mind. This will allow you to recognise the knowledge base from which you start. To do this, a short questionnaire is offered. It encapsulates the topics to be discussed in this chapter.

The nature of management

This exercise can be worked in a group, in pairs, or alone. The answer to the questions should be spontaneous, not researched.

1 What do you understand by the word 'management'? (Try to compose a definition that *you* are happy with.)

2 What are the main functions of management? (One way of identifying these is to write down all the things that a manager does, and then group them under common headings.)

3 What do nurses manage:
- at ward or community nursing level?
- at unit level?
- at District level?

4 Who do nurses manage at each of these levels?

5 Describe the structure of the NHS.

6 Where do nurse managers fit into this structure?

7 The organisational structure within which most nurses work is described as a hierarchy. What other organisational structures do you know of?

8 What do you think makes a 'good' manager?

9 What are a nurse manager's functions when working with:
- individuals?
- people in teams?

10 It is said that the essence of good management is good leadership. How would you define leadership?

11 List what you think are:
- the qualities of a good leader;
- the functions of leadership.

12 What styles of leadership are you aware of?

The second exercise is aimed at looking at how you, as a manager, function at present.

Being a manager

1 What are the three *main* objectives of your work?

2 Consider each objective critically, and ask yourself the following questions:
- Have I achieved this objective?
- If I have *not* done so, what has prevented it?
- How could I overcome these obstacles?
- If I feel that I *have* achieved each objective, would
  – my peers
  – my subordinates
  agree that I have done so?
- How might I find this out?

Defining management

Here are some thoughts culled from a variety of sources. Management is:

1 The technique, practice or science of managing or controlling.
2 The skilful or resourceful use of materials, time, etc.
3 Getting things done through other people.

Drucker (1977) gave this description of management:

Drucker's definition of management

'Management is tasks. Management is a discipline. But management is also people. Every achievement of management is the achievement of a manager. Every failure is the failure of a manager. People manage, rather than "forces" or "facts". The vision, dedication and integrity of managers determines whether there is management or mismanagement. . . .

'It is "managers" who perform. But it is "management" that determines what is needed and what has to be achieved.

'Management is work. Indeed it is the specific work of a modern society, the work that distinguishes our society from earlier ones. For management is the work which is specific to modern organization and makes modern organization perform. As work, management has its own skills, its own tools, its own techniques. . . .

'But management is also different work from any other. Unlike the work of the physician, the stonemason or the lawyer, management must always be done in an organization – that is, within a web of human relations. The manager is therefore always an example. What he does is important. But equally important is who he is – far more important than it is with respect to the physician, stonemason or even lawyer. Only the teacher has the same twofold dimension, the dimension of skill and performance and the dimension of personality, example and integrity.'

Pause for reflection

Before going further, discuss this extract. Do you agree with its hypothesis?

There is a danger of getting lost in a forest of theories and ideas when reading the plethora of books written about management. This chapter is designed to act as an introduction to a more detailed discussion of some of the theories: as such, it is intended to clarify rather than mystify. While it is interesting to have an intellectual discussion on the 'art versus science' aspects of management, for example, the conclusions of such a debate are purely academic and will not take us much further in a search for ways of improving personal management skills and of becoming more effective as a manager. Moreover, the schools of thought that exist in the theoretical dialogues tend to

confuse and divert the student from considering what her style and stance should be.

We cannot, however, disregard some of the debates which arise. For example, one school maintains that managers are influenced most by the need for pragmatism and empiricism rather than by planned decision-making. Another theory analyses management approaches as dependent on interpersonal and group behaviour, and the manager as the collector, processor and disseminator of information, working through people. Alternatively the approaches can be seen as using systems and mathematical models, or through the use of social and technical forces working in concert.

Nurse management

How do these theories apply in the area of nurse management?

If we make the assumption that styles of management are heavily dependent on the personality of the manager, we should none the less be able to determine some common approaches, and this might be done by considering management in these four ways:

1 *From the bottom up:*
   - What do you, as the nurse manager, actually *do*? What are your functions? Are they common to all nurse managers? If not, which *are* common to all?
   - How do these functions influence your management style?

2 *From the top down:*
   - You must work within the constraints of local *and* national policies.
   - You will be influenced by the expectations society has of the service that you offer.

3 *Within certain boundaries:*
   - of authority;
   - of accountability;
   - of responsibility.

4 *According to the outcomes of your work:*
   These will depend on your ability to motivate, control and work with your workforce.

First, here are some definitions.

Authority

The power or right to control, judge or prohibit the actions of others. Thus an Authority, as a body, has these powers of authority, which are delegated to others in the organisation.

Accountability

The word 'account' indicates a very specific action whereby the manager must explain in detail how things have been done, money spent, or resources used. This accounting for your actions is a very personal function of management, and suggests that you need to maintain records of work which will be available for examination, and to report to senior management at regular intervals concerning the satisfactory accomplishment of this work.

Responsibility

This is a wider and less specific function. It indicates that, as manager, you control and use resources within the agreed objectives of the organisation, but it also suggests that you take the credit or blame for things done well or done badly.

As the NHS moves into a new era of competitiveness, nurse managers at every level will need to be clear as to their accountability in the new areas of *quality control* and *resource management*. Both of these subjects will be discussed at greater length later in this book.

In another book in this series, *Communication Skills*, it is suggested that the functions of management are these:

- planning;
- organising;
- staffing;
- leading;
- controlling;
- co-ordinating.

(Good communication skills related to each function are discussed in that book.) In this chapter we are more concerned with looking at the theory and practice of management, but the two aspects are indivisible in practice and should be considered together.

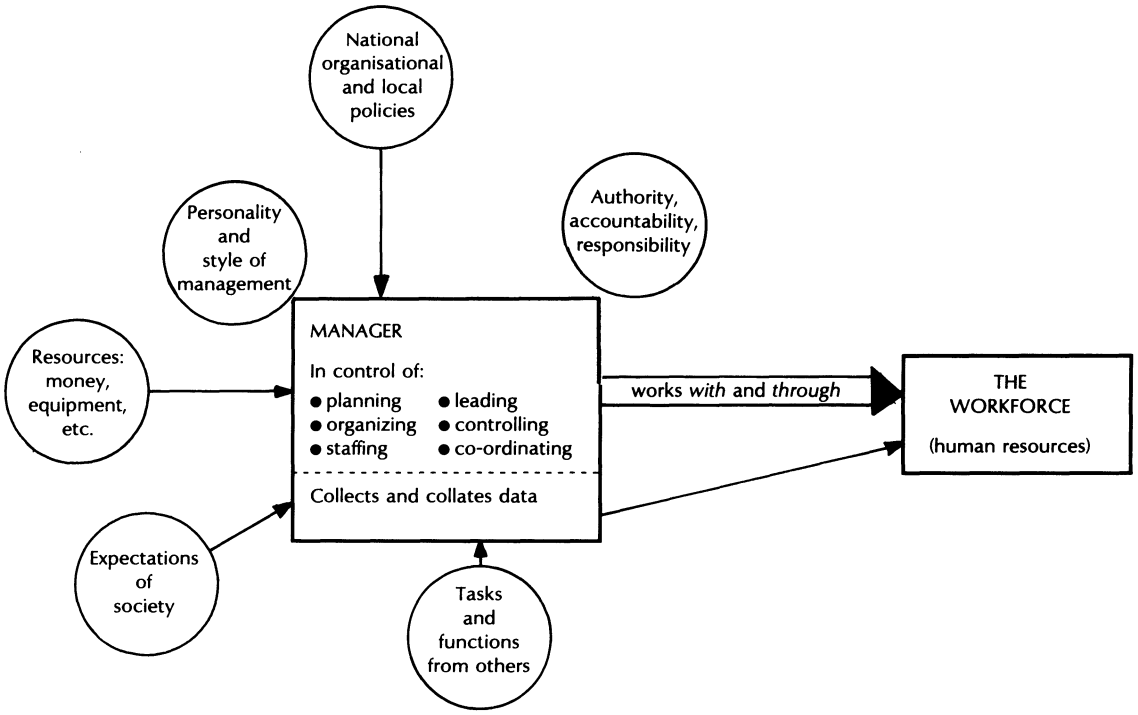


Figure 1.1 How the manager works

Management planning

An efficient and effective manager will always take time to plan work – not just planning work in the long term, but also planning how best to carry out simple procedures in the short term.

Consider the person taking part in a test of initiative in which the **objective** is to reach some high point, a tor, in the middle of Dartmoor in winter. She would not, if sensible, set off in thin shoes and inadequate clothing, telling no one of her destination, and without food, water, a map, or a compass.

'Management planning' has the following characteristics:

1 It considers the *objective* (the 'tor'): how attainable it is, and how difficult it will be to reach it in view of the existing conditions within the organisation and the obstacles that may be encountered.
2 It considers the resources available, money, time, equipment, etc. (These equate to the walking boots, the sensible clothing and the food and water taken by the moor walker.)
3 It considers the human resources available to you, the manager:
   - Who will help you to reach your goal, or be delegated to carry out your plan on your behalf?
   - Who will support you in the enterprise, acting as your back-up to argue your case to senior management? This must be someone who has trust in your ability to carry out the task, will give advice and encouragement when they are needed, and will ensure that occasional and inevitable failures are looked at objectively and *reasons* (not excuses) for the failure found. Failures should be looked on as a way of learning, not as deserving punitive retribution. (These supporters are analogous to the back-up teams of the walker, who keep track of her, are ready to rescue her if necessary, and will offer praise for success and consolation in failure.)
4 It considers the route by which you will travel, by planning how to use the resources and in what sequence, and recognises the steps that must be taken to achieve the goal. (This is analogous to the use of map and compass by the walker.)
5 Finally, as manager you must ask yourself whether your objectives and your plan are feasible, and whether you have the personal resources to undertake the exercise. (The moor walker, for example, might ask herself why it was necessary to choose winter for her walk, and seek to determine whether she has something to prove by travelling at that time of year, and whether she has the personal resources and the strength of body and mind to carry out the walk.)

It is clearly a waste of time to attempt an exercise that is doomed to failure from the outset, but only careful thought and planning will reveal when this is the case.

Thus far I have used the analogy of a long, difficult and hazardous journey, but even walking to the end of the road to post a letter requires *some* planning – it is not usually undertaken on the spur of the moment in night clothes and bare feet! Translated into management terms, *no management action, however small, should be embarked on without some thought and without a plan.*

Management organising

Having assembled the necessary elements – human resources, technology and equipment, adequate funding and good management – and established a plan of procedure that will facilitate the possibility of a favourable outcome, you move to your second function, that of organising your resources.

Organising entails assembling the elements of the plan in the proper sequence. Thus, if you were building a church you would not have the helicopter hovering, with the cross for the top of the spire suspended beneath it, before you had put on the roof!

Planning, as is discussed elsewhere in this series, deals with such matters as decision-making, problem-solving, developing and implementing strategies and policies, and using research. The management skills involved deal with:

- using teams and groups, and working through meetings and committees;
- delegation, and how it should be carried out.

Organisational structures: the Government and the NHS

The structures through which and within which nurse managers work need to be understood. Sadly, few nurses seem to have more than a hazy idea of the structure of the health service, its relationships with Government and its funding agents. It is not possible to give here more than a brief account of the organisation of the NHS, but it is important that, at least to some extent, the superstructure through which we work should be understood and some of the issues clarified.

The Government of the United Kingdom is divided into three parts:

- the *legislature*, working through the Houses of Commons and Lords to make the laws;
- the *judiciary*, functioning through the courts to enforce the law;
- the *executive*, the Crown, the Government of the day and the Civil Service, who devise new laws and interpret them to the electorate.

It is with the executive that we are concerned here.

The Department of Health

The Secretary of State and the Ministers of Health are appointed by the Prime Minister to whom they are accountable.

The Secretary of State is an elected Member of Parliament. He or she:

- informs the Prime Minister and Cabinet colleagues of the main developments in the work of the Department;
- fights his or her corner in Cabinet and with the Treasury to ensure that the budget received is adequate for the needs of the NHS within the constraints of the national budget and the needs of other Departments;
- formulates policy, in consultation with his or her Department, and pilots it through Parliament in the form of new legislation;
- represents the NHS in Parliament, answers questions about its work and policies, and takes part in debates and other work common to a Member of Parliament;
- contributes to Cabinet discussion on all matters;
- works with and through the civil service Department – in the case of the NHS, the Department of Health.

Permanent Secretaries are civil servants. They:

- head their Departments, and are responsible for the efficient management of these Departments;

- act as accounting officers to keep their Departments' spending within bounds;
- ensure that confidential information is safeguarded;
- ensure that the relevant Secretary of State receives the best possible advice from the Department, and act as his or her chief adviser.

The Permanent Secretary of the Department of Health:

- assists in the development of government policy in the field of health matters, and advises the Secretary of State and Ministers of the trends in health care that will influence the formulation of policy;
- works with the professional officers within the Department from whom he or she receives advice on professional matters, and whom he or she informs about changes in policy.

There are a number of nurses who work as civil servants within the Department of Health. The main functions of these Departmental Professional Officers are:

- to collect and collate information pertaining to their profession, so that accurate information and advice can be offered to Ministers;
- to ensure that their profession is aware of changes in government policy, advice on health matters and other professional interests;
- to advise their professions on good practices in all aspects of health care;
- to liaise with the training and other professional bodies to exchange information and ensure the maintenance of economy, efficiency and effectiveness;
- to assist in the formulation of appropriate legislation.

Civil servants are entitled to their own private views about party politics, but, while working within the Department, they are the servants of the Government in power and, as such, they act in accordance with its policies and interests. Their personal political stances are respected, and they have a duty to keep their preferences to themselves and to act and speak in a neutral manner.

The Regional Health Authorities

The second tier of management in the NHS is that of the fourteen Regions in England; Wales, Scotland and Ireland have their own management boards, which are accountable directly to the Secretary of State for Health.

Each Region has:

- a Management Board with a Chairman and members;
- Regional Officers, some of whom are administrators and some of whom are professional officers, responsible for advising the Board and the Regional Manager on professional matters;
- a number of functions related to the co-ordination of the Districts, to their formulation of policy, to the assembly and presentation to the Department of District budgets, and to the financing of the Districts by allocation of funds from the Department of Health.

The District Health Authority

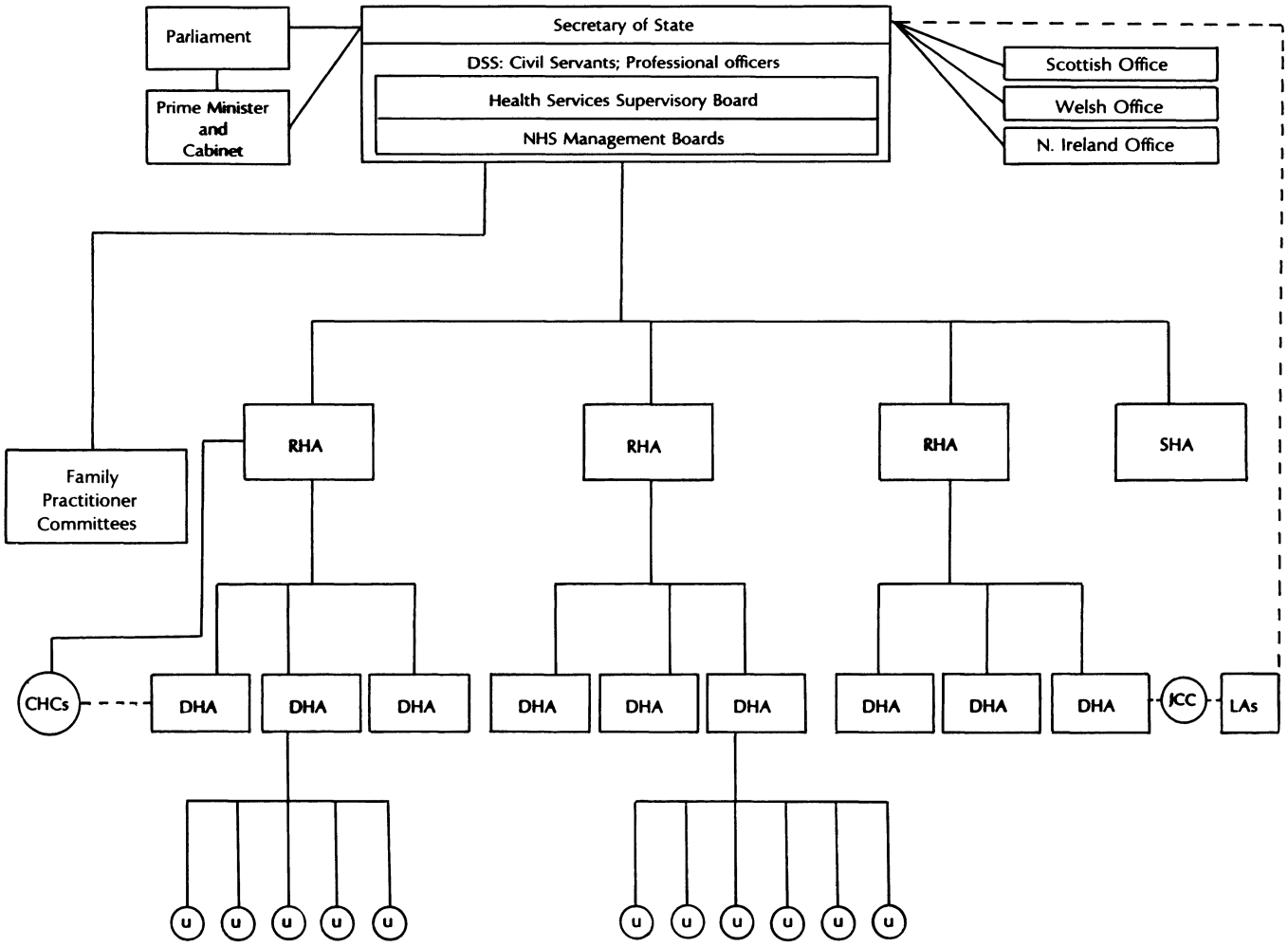
As with the Regional Health Authority, the District is managed by a District Health Authority (DHA) or Board, led by a chairman and managers, and working through the District Management Team (DMT).

The DMT, in accord with the change from functional to general management, is led by a District General Manager (DGM), who is accountable to the DHA and supported by professional team members accountable for the work of their professional colleagues in the District.

Each District, depending on its size, is divided into a number of units, each headed by a Unit General Manager (UGM).

Only a very brief account of the structure of these organisations, and of the functions of those working in them, has been attempted here. It is essential that as a nurse manager, particularly if you are at unit level, you familiarise yourself with the structures.

It is not possible to offer a generic model that would apply to all Districts in the country as each District works within a structure specific to its needs. For example, in some Districts all the Unit General Managers (UGMs) are included



KEY

RHA	Regional Health Authority (14)
DHA	District Health Authority (190)
CHC	Community Health Council
JCC	Joint Consultative Committee
LA	Local Authority
SHA	Special Health Authority (14)
U	Unit management teams (about 650)

(Special Health Authorities were set up to administer the London Postgraduate Teaching Hospitals and other specific services, e.g. the NHS Training Authority. Joint Consultative Committees act as liaison committees between DHAs and the Local Authorities.)

Figure 1.2 The structure of the NHS

in the District Management Team (DMT), while in others they are excluded but represented by the District General Manager (DGM). This has implications for their accountability, for example: when included in the DMT they are publicly accountable as part of the team.

(A bibliography has been included at the end of this chapter, and you are advised to read as widely as possible.)

Relevant reports

There are three reports with especial importance for health service workers, and you are advised to study these in detail.

The NHS Management Inquiry (The Griffiths Inquiry, 1983)

This inquiry was set up to look at the organisation, structure and management of the NHS. Its main recommendations were these:

- A Health Supervisory Board and an NHS Management Board should be set up.

- There should be a change from functional management to general management.
- Control of and accountability for budgets should be delegated to units.
- Personnel services and property management should be improved.
- Annual cost-improvement programmes should be introduced.

The NHS/DHSS Steering Group on Health Services Information (The Körner Group)

Six reports were produced by this group, dealing with:

- asset accounting;
- activity and workload measures for clinical and other services;
- manpower information;
- financial information, including specialty costing.

'Neighbourhood nursing – a focus for care': report of the Community Nursing Review (The Cumberlege Report, 1986)

The main recommendations were these:

- The establishment of 'neighbourhood patches' with associated neighbourhood nursing services (NNSs), for the purpose of planning, organising and providing related primary care services.
- The co-ordination of the NNS with Community Psychiatric Nurses, Community Midwives, and Community Mental Handicap Nurses.
- Adoption of the nurse practitioner into primary health care, and the issue by DHSS of a limited list of drugs that they could prescribe.
- Common training to be introduced by the UKCC and the ENB for first-level nurses wishing to work outside hospital.

These three reports, perhaps more than any others of recent years, have brought profound changes and challenges to nurse management. *All* nurse managers should make themselves aware of their recommendations, of how far these have been implemented in their own Districts, and of the results of such implementation. Two Command White Papers, *Working for patients* and *Caring for people* will, in the future, lead to even greater changes and it is vital that they are read and discussed by all NHS managers.

There is great scope for career development in the area of management, both nursing and general, for those nurses who are prepared to devote time and effort to the study of management theory and technique, but if nurses are to be considered for senior nursing posts in the future they will need to demonstrate considerable ability in management and an understanding of budgeting, economy, and the development of systems that will improve efficiency and effectiveness.

Below are some further definitions, and related exercises.

Economy — The careful management of resources to avoid unnecessary expenditure or waste.

Who takes the decisions?

1 The crux of the definition above is the use of the word 'unnecessary'.
- Who in your organisation decides what is 'unnecessary'?
- What criteria are used to make this decision?

2 Discuss these questions with colleagues.
- How far do you as a nurse manager make these decisions?
- When they are made for you, who makes them?
- If such decisions are imposed on you, how can you make your reactions to them known?
- How are difficult decisions made, particularly those involving difficult choices or ethical questions?

Effective Productive of, or capable of producing, a specified result.

Measuring effectiveness

This definition presupposes some kind of measurement to determine whether or not one is effective.

Consider *one area* of your work and the effect you are aiming for in it (e.g. a contented and productive workforce). How could you *measure* whether or not you have been effective in this area?

Efficient Functioning or producing effectively, with the least waste of effort; competent.

Assessing efficiency

Such functioning entails co-ordinating and using resources effectively and economically, and ensuring a high standard of work.

1 Consider your workload. Taking each of its elements, do you:

- establish objectives?
- decide on the resources to be used?
- plan the sequential use of resources?
- cost out the plan in terms of
  - money?
  - time?
  - effort?
- implement the plan if it seems feasible?
- evaluate the results?

2 What measures do you take to evaluate your efficiency?

Management staffing

Chapter 5 of another book in this series, *Communication Skills*, discusses at some length the skills of interviewing, assessment and appraisal (SD and PR), interviewing and appointments, and induction of staff. Chapter 2 of *this* book deals with team-building, a subject also covered from a slightly different point of view in *Communication Skills*, Chapter 4. For further consideration of management staffing, you are encouraged to consult that book.

Management leadership

Chapter 3 of this book discusses leadership.

The present climate of management in the NHS forces managers to ask quite tough questions about economy, efficiency and effectiveness. As all managers work through people, it is necessary to consider how one relates productivity and a concern for people.

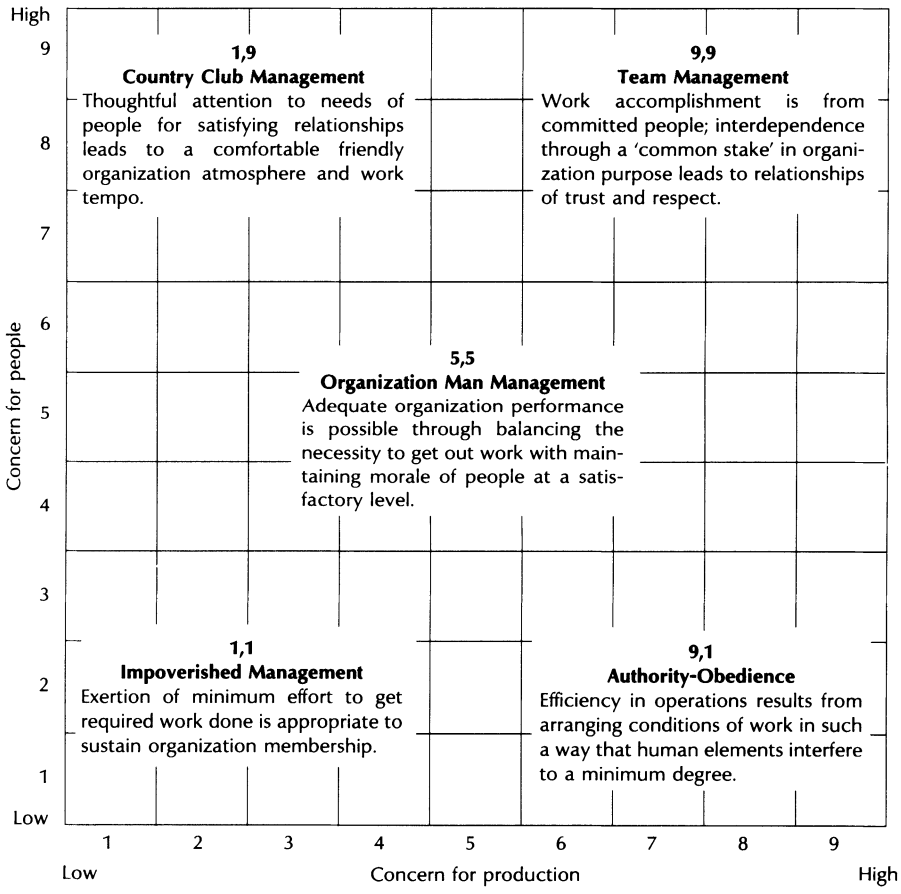
In industry 'productivity' is something that is easily understood: the need for effective and increasing production is readily accepted. Productivity in nursing terms involves the swift and efficient throughput of patients and clients who are made well or helped to come to terms with disability and/or possible death. It also deals with the care of and advice to relatives when they have loved ones needing medical treatment, and with effective preventive health care and education that can be seen to benefit the community.

How these matters are dealt with has much to do with the management style of the manager, working through people and showing a concern for 'production' and a concern for those who constitute the workforce. Blake and Mouton (1985) demonstrated this through a system which they called the managerial grid. Their book, *The Managerial Grid III*, should be studied to understand the implications of the Grid and to learn one way of analysing one's managerial style.

It should be noted here that, as with so many management systems and theories, this is only *one* way of considering management styles. What is important is that you as a nurse manager should be aware of *your* management style, how it affects and motivates or discourages others, and how, if necessary, you can modify it.

Blake and Mouton assert that the way a manager links concern for people with concern for productivity defines his use of power. Thus, as demonstrated by the Grid:

- 1,1: the manager indicates the least possible concern for both which will keep everyone quiet;
- 1,9: the manager puts a contented and happy workforce above every other consideration;
- 9,1: the manager pays little or no attention to the needs of the workforce, but places great emphasis on productivity (this is the province of the autocratic manager);
- 9,9: the manager indicates a high concern for **people and productivity**, and is the condition to be aimed for, and that most rarely attained: this manager will produce the highest quality of work through a committed workforce;
- 5,5: the manager is where most of us fit: the 'average' manager who is adequate – just!



Key
1 = minimum concern
5 = intermediate or average concern
9 = maximum concern

Figure 1.3 The Managerial Grid

Source: Blake, Robert R. and Mouton, Jane Srygley. *The Managerial Grid III: The Key to Leadership Excellence.* (Houston: Gulf Publishing Company). Copyright © 1985, page 12. Reproduced by permission.

Where do *you* fit?

Read Chapter 14 of Blake and Mouton's book, *The New Managerial Grid*. Using the method suggested, try to determine where *you* fit on the grid.

What is *your* style?

1 Another way of describing management style offers the following categories. Consider each one and decide with colleagues what you feel it means (a dictionary will give some clues).

- autocratic;
- persuasive;
- consultative;
- democratic.

2 Which category do you think *you* fall into? Perhaps you feel none of them apply to you. If so, try to define what you think *your* style is.

3 If you feel able to do so, discuss

- with subordinates
- with other colleagues

what category *they* think you fall into.

Authority, power and influence

We have already defined authority. Consider the following statements and decide whether or not you agree with them.

- Authority is the *right to limit* the choice of others.
- Power is the *ability to limit* the choice of others.
- Influence is the *ability to persuade* others to make voluntary choices.

Management control

Controlling deals with resources, human, technological and financial. Chapter 5 of this book discusses these topics and looks at overall quality control.

Management co-ordinating

Co-ordinating is the function of management that falls squarely into your role as a communicator. For further information, read *Communication Skills* in this series.

Conclusion

Ultimately, to be a successful manager, you must achieve the objectives of your organisation.

In this chapter I have outlined the structure and functions of the reorganised NHS, and drawn attention to the new emphasis on economy, efficiency and effectiveness, which should be everyone's aim. The only way of achieving these objectives is through the commitment of those whom you work with and through the workforce. To do this you must strive for:

1 *Effective leadership.* This depends not only on leadership close to home, but also on how the workforce views the organisation and its commitment to the wellbeing of those who work within it.

2 *Adequate communication.*

3 *Clear and well-defined policies.* These must be understandable to those who must operate them, and possible to identify with.

4 *Objectives.* These must be clear, attainable, and in harmony with those who work towards them. Managers are responsible for:

- setting the timescale for the attainment of objectives;
- considering with colleagues the conflicting demands that will affect the attainment of objectives;
- setting targets that will act as 'pacemakers' for the work and help to review progress along the way;
- setting priorities that have been agreed during the discussions on priority setting;
- considering the resources available to do the work, and planning their sequential use.

5 *Adequate training.* This will ensure proficiency, confidence and help with career development for those who wish to progress further in management.

The objective of training is of great importance if we are to get, as we should, a proportion of well-trained nurse managers in the senior ranks of health service management. It will be of the greatest benefit to the health service if this should happen, but it must be realised that nurses are working at their *professional* education when administrators are receiving basic management training. This means that nurses often begin their management training with a backlog of knowledge to make up. They become managers as soon as they take any responsibility for wards or community areas and, though they do not always recognise the managerial component of their work at first-line level, there is a considerable element present there. The study of management skills, techniques and theory should be begun as soon as possible, the elementary stages being worked through during basic training.

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Chapter 2 Team building: a practical approach *by Michael Hartlebury*

Setting aims and objectives for the team

'Why bother?' 'We all know why we're here: this is a waste of time!' This sort of comment may be made if you attempt to set aims and objectives for your team. Yet unless the team knows what it wants to achieve, it is unlikely to be fully effective. All teams exist for a purpose, but the way they work often suggests that this purpose is unclear.

Objectives should be:

- clear and specific, and given in terms of results to be achieved rather than 'things to do';
- 'time bound' and measurable.

Clear aims and objectives, particularly those arrived at in a democratic way, lead to:

- greater motivation;
- greater creativity and initiative;
- less conflict;
- fewer demands on management;
- less need for punishment and threats;
- better use of time and energy.

In other words, clear aims and objectives lead to a more effective team.

Before looking at how to set team objectives, let us consider the words 'effectiveness' and 'efficiency'. These two words are often confused, and people are praised and seen as good at their job because they are 'efficient'. *Efficiency* can be described as *doing things right*. In contrast, *effectiveness* involves *doing the right things*. It is quite possible to be efficient without being effective: you could be very 'efficiently' doing the wrong things well.

A good team needs to be both efficient and effective – doing the *right* things well. To achieve this, each member of the team needs to know what are the team objectives. If the benefits of setting clear objectives are to be maximised, the team members need to be involved in deciding on these objectives and on their own areas of responsibility. Each individual will then feel some sense of ownership of the team objectives and will be more likely to be committed to achieving them.

The leader and members need to agree on the results they want, how these can be measured, and some sort of timetable for review. Though it is not an easy task to get a group of individuals to agree, it is essential if the team is to be effective: it is well worth giving some time and thought to this.

Objectives should be stated in terms of the *results* to be achieved rather than in the *methods* to be used. This gives freedom to individuals to use methods that suit them. Of course, there are often well-defined limits within which they are allowed to function, usually set by the organisation. But this flexibility for individual differences is important: the team is made up of individuals who come from different backgrounds and have different experiences, expectations and needs. The effective team allows the individuals in it to give their best and to take from the team what they need. Trying to make everyone the same is unrealistic and will not increase effectiveness. Team objectives need to incorporate individual objectives and needs. The team needs to write and agree the objectives before doing anything else.

As your team starts to work at clarifying and stating your objectives, think hard about *why* before even considering *how*. The methods of achieving are irrelevant until you know what it is you want to achieve.

Once you have agreed your objectives, set a date for reviewing them. This helps to focus the team's attention on their joint purpose – the *team's* purpose.

It is easy to forget or become lazy about objectives when busy with the everyday 'doing' of routine tasks. It can be helpful to have a regular 'recap' on what they are, and to recognise that they may change with time.

Working methods and procedures

It has been said that it is important to think of *results* first and *methods* second. This often comes hard to nurses, as much of their working day is built up by routine tasks covered by procedures dictated from above. This removes a lot of problems for the team leader: most of the objectives and procedures are clear-cut. But there are other occasions which give freedom to set objectives and to decide the methods.

As when setting objectives, to get maximum commitment from team members it is usually best to find a democratic way of deciding between alternative methods. If you have been involved in making decisions, you are much more likely to act on the decisions made. To make good decisions, therefore, there needs to be a flexible and clearly stated working procedure which all team members understand and follow. You as team leader decide to what extent the members will take part. One of your main decisions will be who makes the decisions! This will vary according to the nature of the decision.

Who makes the decisions?

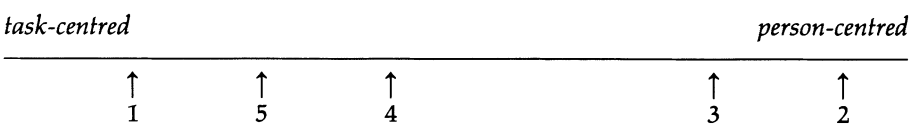
Below are five tasks about which a decision needs to be made.

1 Implementation of a revised drugs policy.
2 Selection of new curtains for the office and staff room.
3 Who is going on which meal break?
4 Allocation of tasks to nursing students.
5 Report-writing and handover procedure.

Which members of *your* team would you imagine being involved in making each of these decisions? Write down their names.

These examples probably reveal that you are using different groups of people from within the whole ward team for different decisions. If you look at the different groups involved in the decisions, you will probably notice that examples **2** and **3** involve more people: they are *person-centred*. The others are more *task-orientated* – it is essential that they are carried out, regardless of each individual's views on them. Staff may disagree with an objective, but it still has to be implemented.

It can be useful to you, as a team leader, to view these decisions on a continuum from totally person-centred activities at one extreme, through a gradual change in balance to totally task-centred activities at the other. We can place the five examples above along this continuum:



This can be a useful way of looking at how you are going to set out your procedures for decision-making. It also helps you to answer the question: 'Are decisions being taken at the right level and by the right people?'

When a decision has been made then the way it is going to be implemented, and by whom, can be planned. So that you can improve on the whole process, the outcome should be reviewed: you can then learn by experience in a planned way.

Appropriate leadership styles

Leadership is discussed in detail in Chapter 3: here we consider leadership in relation to team-building.

Within a ward or hospital setting there may be many small teams, set up to achieve various objectives, for which the ward or hospital manager may be

responsible. The nurse manager need not be the team leader for all such small teams; indeed, some teams decide not to have a permanent team leader at all. Therefore, a key issue for you as team leader, if you are to get the most out of yourself and the team members, is delegation.

Delegation

'Delegation' can be defined in a number of ways: here are two.

1 Responsibility for achieving set aims agreed by the whole team.
2 Responsibility for setting up and managing a small group of people who have been brought together to decide how to achieve clearly-defined objectives.

Delegation is an important tool: it enables you to devote your time to other issues. It also frees you so that you can oversee a number of issues at any one time without having too much time taken up by being too closely involved with any single issue. It also helps individuals to develop management skills.

Delegation should reflect the confidence you feel in your team members. An *unwillingness* to delegate to members of the team can result from:

- a lack of confidence in team members;
- a lack of time to train and develop team members;
- a fear of delegation – some managers feel they lose 'power' by delegating to others.

Used properly, delegation should enhance rather than threaten a manager's status. It should never be used simply as a way of off-loading responsibility for the team's actions.

What should be delegated?

Firstly, analyse areas of accountability. Decide what could appropriately be delegated, in principle. Secondly, consider which team members are able to cope with delegated responsibilities, and who would welcome the opportunity to develop their management experience. Finally, consider the types of training necessary for delegation to take place.

Woodcock (1979) states: 'there are often risks in delegation but although improvement and development often demand risks, they also bring high rewards. Always review the progress of delegation and be prepared to take action if things go wrong.' He concludes that, 'In observing really successful team leaders, ten characteristics of success frequently stand out.' He goes on to list these:

The successful team leader

The successful team leader should:

(a) be authentic and true to him/herself and his/her own beliefs;
(b) use delegation as an aid to achievement and development;
(c) be clear about standards he/she wishes to achieve;
(d) be willing and able to give and receive trust and loyalty;
(e) have the personal strength to maintain the integrity and position of his/her team;
(f) be receptive to people's hopes, needs and dignity;
(g) encourage personal and team development;
(h) face facts honestly and squarely;
(i) establish and maintain sound working procedures;
(j) try to make work a happy and rewarding place.

(Woodcock 1979)

Relationships within the team

If your team is going to work to maximum effect there need to be good working relationships between the members. Personal antagonisms and back-biting interfere with effective working. However, there is no point in pretending things are right if they are not: as leader, you need to be able to confront difficulties and try to sort them out. Only when problems are brought out and openly discussed is there any chance of them being resolved. If ignored too often they can fester and turn previously good working relationships sour.

out and openly discussed is there any chance of them being resolved. If ignored too often they can fester and turn previously good working relationships sour.

A healthy team is one in which members can talk openly about disagreements and problems without fear of being attacked, ridiculed or punished in some way. To help create such a team you can work at developing good communication in all directions.

Feedback

Give and encourage feedback between members. The most helpful feedback is given at the time. Discuss what has happened, *without judging it*. Concentrate on those aspects of behaviour that the person may be able to change. Be specific (not woolly), and make sure you have been understood.

It is most important to stress *positive* points. If it is necessary to give negative feedback, try to do this in a constructive, not a destructive, way.

Listening

Learn to listen so that people *know* you are listening. Encourage good listening within your team.

Guidelines for effective listening

1. Try to listen without prejudice.
2. Try to concentrate on what the speaker is saying rather than what *you* want to say.
3. Try not to allow yourself to be distracted whilst someone is speaking to you. Look at the speaker.
4. Try to stop yourself thinking of other things.
5. Try to listen to *everything* that is said – not just the bits that fit in with your own views.
6. Try to give accurate feedback by asking questions based on what has just been said.

Support

Support the team members, and encourage them to support each other and you. This means helping each other to be more effective, recognising strengths and weaknesses in each other, and accepting that you and they make mistakes.

Trust

Work towards establishing trust. This is difficult, but trust is more likely to develop if you work towards achieving the other qualities previously mentioned. Most importantly, work towards *consistency* in your dealings with others.

Co-operation

Work together. If the team is working in a co-operative manner, the team's needs will naturally come before individuals' own needs. People who trust each other will be willing to share skills and will feel happy in expressing ideas. There will be a free flow of information and members will be more likely to be committed.

Discussion

Do not feel that there should be no disagreements – these can keep the team alive and guard against complacency. It is inevitable that from time to time there will be conflict in the team: your role is to make sure that it is constructive and leads to problems being confronted and sorted out. This will sometimes be done with the whole team, and sometimes with one or a few individual members.

Reviewing team performance

The more specific and clearly the objectives are defined, the easier it will be to evaluate your team's performance. Regular reviews can help your team to function more effectively.

Benefits of regular review

1 *Decision-making* should become more efficient and democratic.
2 *Objectives* can be more clearly stated to avoid ambiguities.
3 *Meetings* can become more productive and enjoyable.
4 *'Crises'* should reduce in number and frequency.
5 *Identification of future needs*, and planning for them, should become more effective.
6 *Commitment* among team members should rise.
7 *Relationships* should improve as trust, support and openness increase.
8 *Leadership* should improve as you learn from experience and helpful feedback.

If things go really wrong, it may be helpful to ask a neutral outsider to observe your team and to provide information and advice.

Individual development

It is important to provide opportunity for individual development of team members. The benefits are twofold. From the point of view of the individual:

- she is encouraged to acquire new skills;
- there is opportunity to increase awareness of individual strengths and weaknesses;
- there is a broadening of individual perceptions and an awareness of other people's views;
- planned development leads to an increased feeling of being valued and greater self-esteem.

All of these lead to greater commitment to the team and contribute to the individual being a 'happy worker'.

For the team:

- the overall effectiveness of the team is increased as the combined skill level increases;
- with increased individual awareness, the team can become more supportive;
- with increased individual contributions to the team's objectives, there is an increased sense of ownership regarding achievement of the objectives;
- there is a consequent improvement in morale amongst staff.

Helping individuals to develop

1 Identify clearly what *you* want each individual team member to do.
2 Identify with the individual what skills she already possesses.
3 Identify, with the person and by observation, what she needs to learn.
4 Provide opportunities for the acquisition of these skills – either within the job or by sending the individual on appropriate courses.
5 Offer counsel to individuals on any problems regarding interpersonal relationships.
6 Once openness and trust have been established in your team, it may be possible to discuss individual development needs as a group. If this happens the members are more likely to support each other. However, if the team is not happy with this idea, do not force it upon them: it could be very destructive.
7 Ideally, each team member should have a written personal plan, which will need to be reviewed regularly (at least annually).

Relations with other teams

However effective your team is, it cannot survive on its own. It is part of a much larger organisation which includes other teams, some similar to yours, some entirely different. As an effective team consists of individuals working well together, so an effective organisation consists of teams working well together. In an *ineffective* organisation, teams may even work *against* each other.

Maintaining good 'external' relationships

1 *Communication:* Make sure that what you and your team are trying to do is understood by others.
2 *Understanding:* Accept that there is a need for different kinds of teams within your organisation.
3 *Mutual support:* If your team is really effective, be prepared to offer help to other leaders, but be careful not to patronise.
4 *Flexibility:* Don't make the mistake of being too rigid in setting boundaries for what your team does. There are often areas of commonality which can be shared by several teams. Flexibility often enhances job satisfaction for the individuals within a team.
5 *Acceptance of help:* Ask for help, opinions, ideas and the like from other team leaders. Be prepared to share information, and work at making it a two-way relationship; let your team know you are willing and able to do this. If your team relates well to others, you are more likely to be able to act as agents of positive change within the organisation.

Summary

A team is a purposeful and cohesive group with both a sense of identity and clearly-defined aims. Most of us find that a great deal of our work is done as part of a team: *any* work that involves other people is teamwork. Many tasks have to be done by teams of people because they are impossible to achieve by individuals working independently.

Teams differ in their size, composition, structure and aims – the ways they operate, and the ways in which they cohere. All teams are made up of individuals, and individuals bring with them their own ideas, needs and beliefs. Each individual's ideas, needs and beliefs will affect how she views the team and work within the team.

A team leader should give some thought to these two questions:

- What can each individual team member bring to the team as a whole?
- What does each individual need to get out of the team?

Not everyone is used to working as a member of a team. Some people bring to teams personal, negative attitudes which need to be countered before more positive interactions can take place. Some people may wish to achieve objectives personal to themselves, perhaps at the expense of other team members. As a team leader you need to become sensitive to many of these individual characteristics which affect individuals and groups as a whole, recognising that people approach teamwork from the basis of what they have experienced previously. You cannot achieve team cohesion by words alone – show them that you are determined to make the team work! Your personal enthusiasm needs to be obvious to all.

Strengthening the team's identity

1 Hold frequent productive and friendly meetings.
2 Work on interacting and sharing.
3 Relate to a team name – this helps you to have a common purpose.
4 Keep the composition of team as stable as possible.
5 Watch for negative interactions and conflicting loyalties to other groups.
6 Make sure there are clear roles within the team.
7 Leave scope for individual talents to grow.

The best teams combine a happy balance of skills and personalities. This is rarely possible in teams within the ward environment, where team members are usually brought together over a period of time and for various reasons outside the control of the nurse manager. Thus it is especially important that the nurse manager, as a team leader, is aware of the process of establishing and maintaining an effective working team.

Team-building activities

Although there are no team-building activities included within this chapter,

they deserve a mention. The book by Woodcock (1979) provides a wealth of resources, including forty-five practical activities that lend themselves well to the various sections covered in this chapter.

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Chapter 3 Leadership *by Rita Johnston*

In this chapter we are going to consider the role of the nurse manager as leader. We shall consider where her leadership power comes from, and how this power can be translated through influence and communications into a supporting and leading role.

The ordering of the sections in the chapter reflects the fact that it is power that comes first. This power is transferred as influence and communication, which together result in effective leadership.

The objectives of the chapter are these:

- to establish a positive attitude towards power and influence;
- to identify the different sources of power, and the different circumstances in which they are appropriate;
- to demonstrate how power can be translated into influence;
- to identify individual strengths and weaknesses in relation to influencing styles;
- to consider how verbal and non-verbal communications may be used effectively;
- to clarify the essential qualities and functions of leadership;
- to lead towards individual 'action points' to improve leadership skills.

Power

We start by considering what power is, and where it comes from. Let's look first at the *language* of power.

Your view of power

1 Quickly write down *all* the words that float into your head when you hear the word *power*.

2 Go back over your list, putting '+' against any *positive* words, such as 'strength' or 'energy'. Continue by putting '−' beside any *negative* words, such as 'corruption' and 'manipulation'; and '=' beside any *neutral* words, such as 'control' and 'authority'. (You may in fact disagree with *my* classification of these particular words. That doesn't matter: put the signs against what is positive, etc., for *you*.)

Now look again at your list. Probably it looks very mixed. Some of your associations with the word 'power' are good, some bad, some indifferent. In other words, most of us have very mixed feelings about power.

This is fair enough, since power is simply a force which can be used for good or evil. The point is that power in itself is neutral and *can* be used positively for good. So we should not be afraid of it, or shun its use.

Many people back off power for another reason. They imagine it as finite – if I take more, you must have less. In fact it may be more useful to see power as an electric circuit in a house: if I plug in a hairdryer at one socket, you can still shave using another one.

Thinking of power in terms of the electrical circuit provides another useful insight. Just as the source of some power in your house is *fixed* (it's wired in and you can only access it at certain places, the sockets), the source of some power in organisations is also fixed and can be only accessed by certain people or at certain positions. On the other hand, some power in your house is not fixed: you can take it around with you (as for instance the power in your personal calculator or transistor radio). The power is 'built in', as it were. That's true in organisations, too. Each person has built-in 'free' power which they carry round with them.

Fixed power

The *fixed power* in organisations exists in two forms. *Role power* accrues to the individual person through her position in the organisation (nursing manager, registrar, chairman of a meeting, etc.). People defer to such individuals not as themselves but as 'authorities' (e.g. 'With respect, and through the chair, . . .').

Resource power is the organisational power a person has over rewards and sanctions. It could be the power to recommend (or not) for promotions, to allocate duties, to circulate the holiday rota, etc. Even a broad smile and a 'thank you' to a subordinate can be the exercise of resource power.

Free power

Free power is the personal power that you carry round with you in the organisation simply as an individual. Again it comes in two forms.

Expertise encompasses the special skills or experience that you have built up – both professionally and personally – that are your own 'property'. No one can take them away from you, whatever role the organisation may give you.

Charisma is the personal charm or dynamism which enables you to fire others with enthusiasm or to motivate them above and beyond the tangible rewards they may get for doing something. When someone *volunteers* to do something extra to help you, this is probably an indication that, for that person, *you* have charisma. That person *wants* to identify with you, to please you.

We can therefore consider power as:

Fixed	*Role power* – e.g. being on the Nursing Procedures Committee	*Resource power* – e.g. being able to arrange the duty rota
Free	*Expertise* – e.g. having years of functional experience in accident and emergency nursing	*Charisma* – e.g. having a powerful and convincing speaking voice

How much power do *you* have?

Think for a few minutes about what power *you* have in each of these areas. The examples given above may help you think of others. You could ask yourself these questions.

Role power
- Do other people need my approval before they act?
- Do I supervise other people's work?

Resource power
- Can I offer or withhold promotion, training, perks, or important information?

Expertise
- What qualifications have I acquired?
- How difficult would it be for my organisation to replace me if I left?

Charisma
- Do I speak at meetings?
- Can I hold the attention of a group?
- Do people confide in me?

It's worth noting that most large organisations and bureaucracies approve of *fixed* power (because it reinforces or enhances the organisational structure, and therefore makes for stability), but mistrust *free* power (because internally it can make for instability, and also it can 'walk away' and be lost from the organisation). Organisations have ways of dealing with this 'unsafe' power: expertise tends to be boxed into specialist areas, or people are moved round so that the expertise doesn't threaten the organisation as a whole; charisma is discouraged by emphasising uniformity, uniforms, set procedures, and jargon.

It follows from this that it is most useful to have a balanced power base. Look back at the exercise above: in which areas were you strongest, and in which weakest? One way to check this is to consider the snakes-and-ladders power game. Try to use the ladders wherever possible, and avoid the snakes which are the forces and behaviours that take away your power. Are there action points to which you could commit yourself to redress the balance? For example, would you like to get experience in another area?

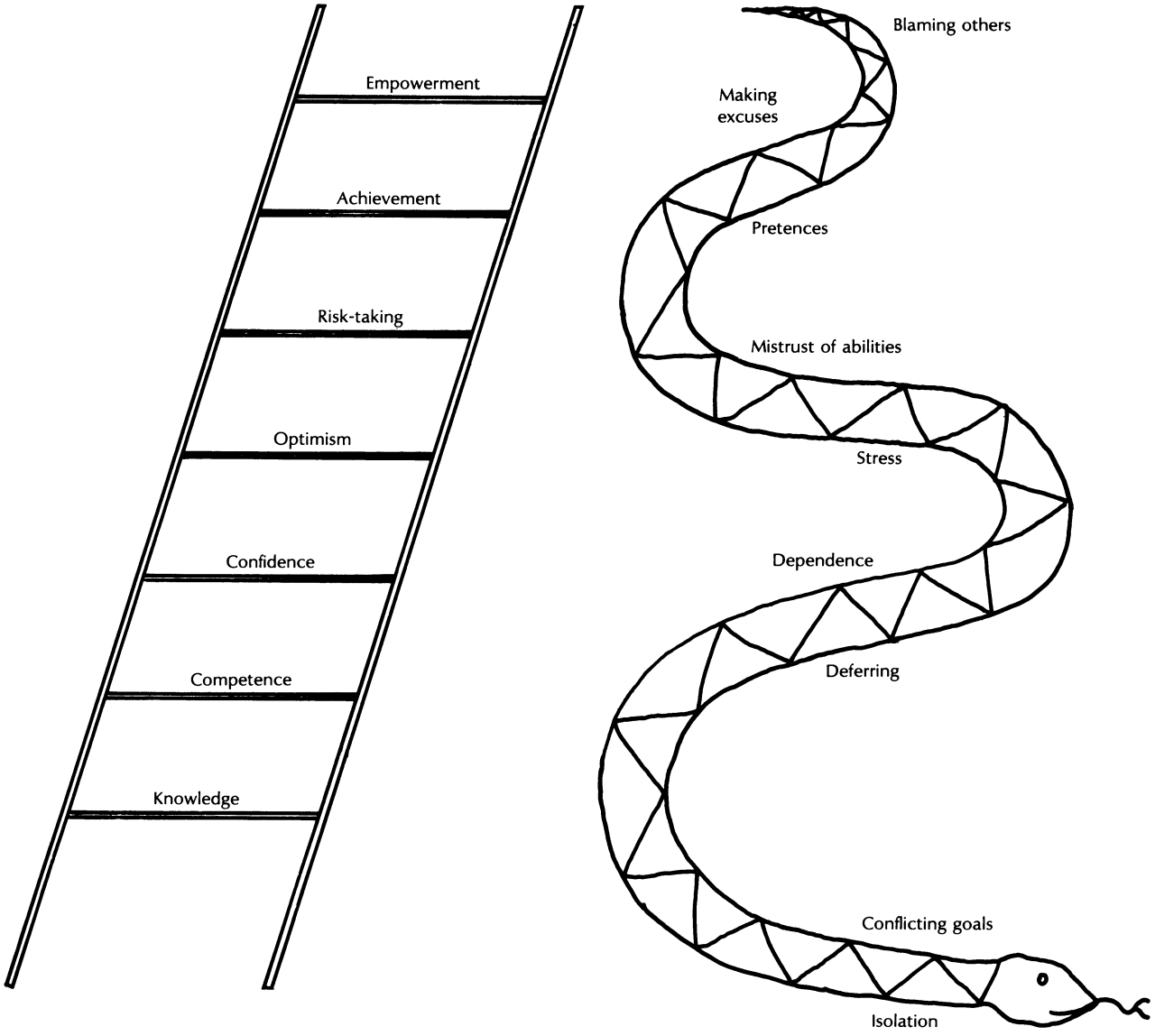


Figure 3.1 Power snakes and ladders

Influence

We have looked at the *what* of power (what it is, and what power you've got); we've also looked at where it comes from and where it lies. Now we're going to consider *how* we use it. This is a matter of our own individual style of influence.

Influence generally depends on what power you've got, what situation you're in, what people you're trying to influence, and what is the particular task in hand. We may exert influence in one or more of the following ways:

1 by offering rewards and applying pressures;
2 by building co-operation and trust;
3 by appealing to a common vision;
4 by logical argument.

You might like to check through this questionnaire to see which influencing style or styles *you* use.

Your influencing style

Tick off which behaviours are characteristic of you. Mark yourself as follows: often, 2; sometimes, 1; hardly ever, 0. Total your scores for **A**, **B**, **C** and **D**.

A 1 Telling people what standards you expect.
2 Praising people when they have achieved goals.
3 Letting people know when you think they could have performed better.
4 Offering bargains; negotiating.
5 Checking that people are doing their jobs.
6 Using status and influence to get what you want.

B 1 Asking others for their ideas and contributions.
2 Delegating.
3 Admitting your mistakes.
4 Sharing your own problems.
5 Allowing people to express their feelings.
6 Giving credit down the line.

C 1 Painting a picture of the future.
2 Appealing to ideals and emotions.
3 Building a sense of group loyalty.
4 Using exciting language, imagery and metaphor.
5 Stressing common aims and objectives.
6 Stressing differences with other groups.

D 1 Setting out your objectives clearly and logically.
2 Giving the reasons and arguments behind the task.
3 Using facts and statistics to persuade others.
4 Presenting material rationally, not emotionally.
5 Being objective and detached.
6 Taking little account of individual feelings.

Highest score **A**: You use the 'rewards and pressures' style a lot.

Highest score **B**: You operate largely on co-operation and trust.

Highest score **C**: You can influence by a 'common vision' style.

Highest score **D**: You rely on logical persuasion.

No one style is always better than another, but each may be more appropriate and effective in a given situation. For instance you would probably choose to use logical persuasion if you were arguing for an increase in resources for your ward. But perhaps you would choose a common-vision approach if you were persuading your nurses to do a little extra to cover for a colleague off sick.

Each and every influencing style can be used positively or negatively, depending on the motive of the person using it. Arguably, Adolf Hitler, rousing the German people to war, and Bob Geldof, rousing people to support Band Aid, were both using the common-vision approach!

Successful leaders try to develop a balance of influencing styles, so that they can use the right one on the right occasion with the right people.

Action points

All skills improve with practice. Do you have any action points to build up your influencing skills?

You now know your power base, and have identified your strengths and weaknesses in influencing. How do you communicate that influence?

Communication

It's impossible *not* to communicate. If you don't tell someone what's wrong with her, if you keep a nurse waiting when she wants to discuss something with you, if you constantly check your watch – in each case, you communicate a message! 'Actions speak louder than words' is a good maxim for communications. For all of us, English is at least our second language. We first learnt to

communicate our feelings, needs and demands using body language of one form or another.

Looking back over the previous sections, on power and influence, can you think of *non-verbal* ways to communicate the various types of power, and to indicate your style of influence?

Communication

Think for yourself of occasions on which you might have to operate from each of the power bases, using the appropriate influencing styles. What would be the appropriate body language and verbal signals? (Examples: You might have to use *expertise* to brief a consultant on a patient's progress. You might have to use *rewards and pressures* to discipline an auxiliary who is regularly late on duty.)

Consider these pairings:

1 Role power; co-operation and trust.
2 Resource power; rewards and pressures.
3 Expertise; logical argument.
4 Charisma; common vision.

Role power may be indicated by something like a personal parking slot, or the title 'Sister' as opposed to 'Staff Nurse'. Resource power might be indicated by the amount of space a section is given, the quality or modernity of equipment. Expertise might be indicated by carrying a stethoscope or thermometer and fob watch. Charisma was probably the most difficult to identify as it's so individual. Perhaps you have an individual smile, gesture or bearing.

People with well-trained dogs will tell you that 'He understands every word I say to him.' Of course he doesn't understand the words, but he *does* understand the communication. People are not too different in this respect. Researchers have suggested that communication is achieved 55 per cent by body language, 38 per cent by tone of voice, and 7 per cent by the actual words said.

That doesn't mean that words aren't important, far from it: it means simply that they aren't the whole story. And again, looking at the four influencing styles we can see appropriate words that seem to go with each style.

Vocabulary

Which words do *you* use a lot? Do they go with your preferred style? (For example, 'we', 'our' and 'together' might indicate common vision; 'demonstrated', 'proved' and 'analysed' would suggest logical argument.)

For optimum communication the style you choose should be related to the power base you're operating from at the time; and your non-verbal and verbal communication should match this.

If you were arguing a case for more staff, you would be using logical persuasion from your expertise power base. You might demonstrate this by words such as 'data', 'statistics', 'analyse' and 'conclude' and by sequences such as 'firstly ... secondly ... thirdly'. Non-verbal reinforcements might include counting the sequence on your fingers; you might also use a strong, slow, evenly pitched voice.

On the other hand to brief your staff on new procedures you would be using role power while influencing by co-operation and authority. You might signal this by holding the briefing in your room, but perhaps not sitting behind your desk, so as to seem non-authoritarian. You would probably give the information using good eye contact with individuals, ask for questions, check understanding and use simple, clear and unambiguous language.

Optimising communication

Think for yourself on what occasions you might have to operate from the other two power bases, using the appropriate influencing styles and appropriate body language and verbal signals.

Leadership qualities

1 Think of five people you admire as leaders. (These may be people you *admire* only *as leaders*, not necessarily as people.) Try to include at least two who are personally known to you, not just historical or very public figures.

2 Next, list the positive leadership qualities of each of the people you have named.

3 Underline any qualities that appear more than once in your lists. These are the leadership qualities you admire, and possibly those you aspire to. Remember these for later in the chapter: they may tell you something about your own favoured leadership style.

Meanwhile let us see how these qualities compare with those identified by Pedler *et al.* (1978):

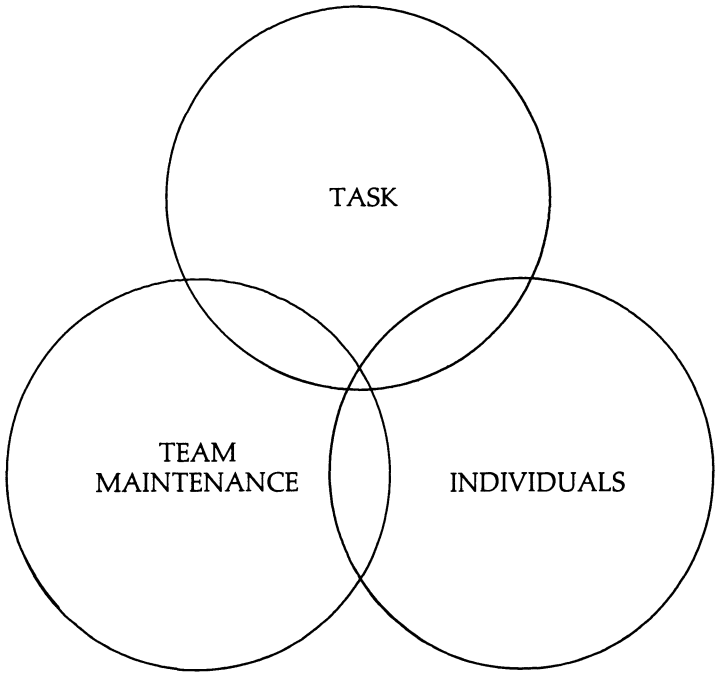
Attributes of a successful manager

1 Command of basic facts	}	Foundation
2 Relevant professional knowledge		
3 Continuing sensitivity to events	)	
4 Analytical, problem-solving, decision/judgement-making skills		
5 Social skills and abilities	}	Skills
6 Emotional resilience		
7 Pro-activity (i.e. inclination to respond purposefully to events)	)	
8 Creativity	)	
9 Mental agility		
10 Balanced learning habits and skills	}	Meta-qualities
11 Self-knowledge	)	

(Pedler *et al.* 1978)

Functional leadership

If you look again at the qualities you identified you may well find that they all relate to one of the three categories of leadership identified by Adair (1983):



According to Adair, the leader must operate in, and maintain balance between, these three areas of leadership. She or he must lead in terms of (a) the task to be achieved, (b) the maintenance of the physical, personal and morale resources of the team, and (c) the skills and growth needs of the individuals concerned.

You might like to check the qualities you listed against these three areas. Examples of task-related qualities might be 'takes decisions', 'sets clear objectives', 'takes initiatives', 'decisive'. Qualities to do with team maintenance might be 'good co-ordinator', 'delegates', 'attracts resources'. And qualities to do with supporting individuals might include 'motivator', 'good listener', 'enthusiastic'.

What is *your* style of leadership?

Go back to the qualities you identified earlier and list them again under these three headings: *Task-related, Team-related, Individual-related.*

This exercise may have given you an insight into which of the three functions seems most important to *you*.

Now think what it would be like to have a group leader without task-related skills. Even if she had team-related and individual-related skills it is unlikely that tasks would be effectively covered. And without the sense of success and achievement coming from this, the morale and commitment of staff would fall.

Next think what it would be like to work for a leader who concentrated on the task to such an extent that she neglected the needs and problems of the people in the team. Tensions and difficulties could build up to such an extent that energy would be drained from the task in hand, and effectiveness reduced.

Finally, consider a leader who allowed certain individuals to dominate and satisfy their personal agendas at the expense either of the whole team or of the task in hand. This would result in energy being used up in internal disputes and jealousies, to the detriment of effectively performing the tasks.

The chances are that the leaders you identified at the start of the chapter had positive qualities in all three areas, and maintained an effective balance between Adair's three circles.

Your own leadership qualities

1 Try to list the leadership qualities you recognise in yourself, using the three headings: task; team; individuals.
2 Which areas are *you* strongest in, and which areas do you have to work on? Have you any action points?

So you're a good leader. But why should people follow *your* leadership? We have looked at power and influence, and it is clear that these attributes of leadership, if you have them, may encourage people to follow you. In other words they may follow:

- because they are aware of your power to reward and punish;
- because they respect your authority and wish to be law-abiding;
- because they respect your specialist knowledge;
- because you have charisma and they wish to be associated with you.

There will generally be some element of all of these in your subordinates' attitudes.

However, there is another approach to leadership besides leading from the front. This is supporting from behind. A good leader will understand not just what power she has to get people to follow the desired path, but also what are the real concerns that motivate the members of the team. Before moving on to look at some theories of motivation, try the following exercise.

Motivation

1 Think back over the last year. Write down:
(a) two things you did just because you wanted to;
(b) two things you did reluctantly, because you felt you had to.

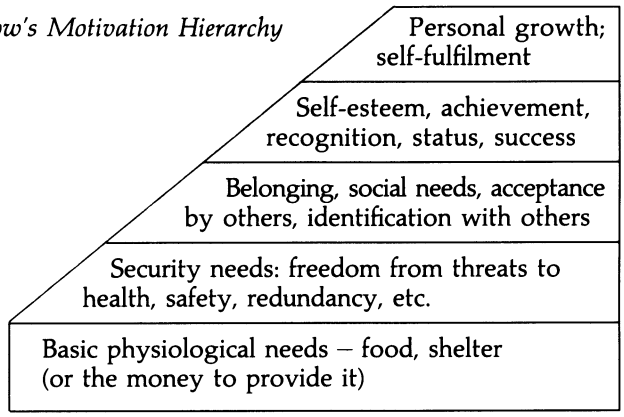
2 Now write down any reasons why you did the first two things. Next list the reasons why you did the second two things.

The chances are that for the things you did reluctantly you had reasons related to the power diagram at the beginning of the section. Perhaps you feared being disciplined if you failed to do them; or perhaps you felt you had no option, given the authority of the person who asked you to do these things. But the reasons for doing the things you did willingly probably had nothing to do with the power diagram. They were probably something to do with 'sense of achievement', 'personal growth', 'challenge', 'satisfaction' or social esteem. This is where personal *motivation* comes in.

We all do a great number of things just because we want to, not because we're asked to or expected to. What's more, if you consider how you *felt* after acting willingly rather than reluctantly, you will probably agree that you felt better, more positive and more energised after the former. That is why it is important for a leader to understand the personal motivation of her followers. If the leader can hook into and harness people's personal motivators, tasks will be done with more energy and more effectiveness than if done solely on the basis of the power diagram. What is more, people will *feel* better, so energy will be available for the task in hand instead of being frittered away in resentment and frustration.

Abraham Maslow (1954) maintained that what motivates us is the lowest human need that is currently unmet. Once the need is met to an acceptable level, it ceases to motivate us.

Maslow's Motivation Hierarchy



Someone on a very low income, for example, will be motivated by the need to provide food and shelter: such a person may be attracted to paid overtime work, or may perhaps be more easily persuaded to strike for better pay. At the second level is security: people worried about redundancies may stop co-operating with each other, and become highly competitive. And so on, to the top of the scale when a desire for opportunities for responsibility, achievement and personal growth are not just a luxury but a felt need. If the workplace does not meet these needs, such people may leave to seek fulfilment elsewhere.

The answers you gave to the exercise on motivation will have indicated your own levels of motivation. These may vary from time to time with your needs. For instance, after Christmas, when people may have overspent and incurred debts, they may be more easily persuaded into strike action in support of a plea for increased wages.

Part of your role as leader and supporter is to be aware of what forces may be motivating different members of your staff – in other words, what their needs are. One may respond positively to the offer of a training course, another may appreciate a special weekend off. Can you identify different motivating needs among your staff?

Summary

So what is leadership style all about? Well, first and foremost it is about the way you motivate people to achieve personal and organisational goals.

In working through this chapter you will have defined and strengthened your own power base, identified your preferred style of influence and learned where you may need to extend your range, consolidated your strengths in functional areas of leadership, analysed your needs for situational leadership, and thought through your own and your team's motivators. You will also have identified an appropriate style of communication.

The basis of leadership

1 Leadership is about paying attention to the tasks, the team and the individuals in your work situation.

2 To lead effectively you need to be aware of your power, and comfortable in its use.

3 Different styles of influencing may be most appropriate and effective in different situations.

4 Clear communications are reinforced by body language and by non-verbal signals.

5 As a leader you need also to be a supporter, understanding the motivation of your followers.

Leadership is a matter of:

- *Responsibility* – to decide on the goals, means and standards for which you are accountable, and to accept blame for mistakes and praise for successes.
- *Choice* – to use power and influence when, where, about what, and with whom it is appropriate. We may also choose *not* to influence, when that seems appropriate.
- *Confidence* – in the organisation's objectives, and in your own skills, power and experience to help meet those objectives.
- *Respect* – for others: your staff, and the public the organisation serves.

What next?

Look again at the five leaders you identified, and the skills you attributed to them. If your subordinates were to do this exercise and identify *you*, what skills would you like them to attribute to you? Does this lead to any further action points for you?

References

1 Adair, J. 1983. *Effective Leadership.* (Gower.)

2 Maslow, A. 1954. *Motivation and Personality.* (Harper and Row.)

3 Pedler, Burgoyne and Boydell 1978. *Self-Development for the Modern Manager.* (McGraw-Hill.)

Chapter 4 Creating a climate for learning
by Sheila Marson

The role of the ward manager carries with it an accountability for education and training. This accountability includes responsibility for meeting the training needs of all members of the nursing team – learner nurses on approved courses, and trained and auxiliary nurses; we could also add patients and their relatives, although the needs of this important group are not the subject of this chapter.

This chapter aims to help you meet the training needs of the nurse members of the team. To put it another way, the aim is to help you create the kind of environment in which learning can take place, with team members learning from experiences that just happen, from experiences you have planned, and from each other.

To achieve this aim the chapter contains a summary of current theories of learning and models of teaching. These are included to give you a rationale, a basis, from which to plan learning experiences designed to achieve the goals *you* have set.

Objectives

Training is about helping people achieve specified 'targets' or objectives, so here are some objectives for *you* to achieve with the aid of the contents of this chapter.

This chapter is designed to enable you:

- to increase your understanding of the processes of teaching and learning;
- to identify the elements of an 'enabling' learning climate, and to assess the learning climate in your own sphere of responsibility with the aid of specified criteria;
- to review the attributes of effective teachers and to assess your strengths and weaknesses as a facilitator of learning;
- to critically appraise the existing ward/department training programme and to consider ways of making this more effective;
- to appreciate the role of learning resources in training, and to consider the ways in which they could be incorporated into a training programme.

This may seem a formidable list but you will be provided with 'tools' to help you achieve these objectives. The contents of the chapter will provide the following background:

- research findings relating to teaching and learning in nursing practice;
- definitions of teaching and learning in the light of current educational theory;
- characteristics of an enabling learning climate;
- insights into 'teacher' effectiveness;
- systematic approaches to training;
- awareness of learning resources in training.

Introduction: what the research says

The Briggs report (1972) drew attention to the need for nurses to develop research awareness, so it seems appropriate to begin this chapter with a review of research findings relating to 'teaching' in clinical nursing practice.

Prior to the mid-1970s much had been written about bedside teaching, but little in the way of actual research had been carried out. However, the publication of the Briggs report stimulated a wealth of research. These studies have been well documented elsewhere (see the 'Further reading' list) so a summary of relevant findings is all that is needed by way of an introduction to this chapter. You are encouraged to read further.

Research – a summary of findings

Power of the role	The ward sister or charge nurse is identified throughout all studies – management as well as teaching – as a key figure within the organisation and the ward team. Sisters create the team climate and provide role models for their staff. The role model has a major influence on learning. (Pembrey 1978, Marson 1981.)
Confidence	Management and teaching studies highlight the conflicts many sisters have about 'teaching'. Sisters confessed to feelings of guilt about not meeting learners' expectations, about feeling inadequate, and about being unclear concerning what to teach and how to assess learning. (Runciman 1983, Bryant 1985.)
Constructs	Sisters and learners alike showed a tendency to associate the words 'teaching' and 'learning' with 'telling' and 'listening'. These two activities bore little relationship to what Rogers (1969) calls 'significant learning'. Significant learning that results in a change in attitude, perception or behaviour tends to arise from personal experience rather than didactic instruction. (Marson 1981.)
Communication	Fretwell, in her study, identified an autocratic style of leadership: this was also evident in Marson's study. (Fretwell 1979, Marson 1981.)
Competence in teaching	Good teachers were described in more than one study (Orton 1979, Ogier 1980, Marson 1981). The important factors identified cut across several of the studies. (These factors are discussed below.)

Pause for thought

Write down *your* definition of teaching and learning. Put this to one side: we will come back to it later.

Processes of teaching and learning

There is no doubt that teaching is an important part of nursing, but what do we *mean* by teaching and how do we know whether someone has learned? What part does the nurse manager play in the process?

On the whole the 'lay' person takes a simplistic view of teaching and learning. Learning is rarely seen as problematic, and teaching is seen as a process of telling, showing, praising and punishing. When children fail to learn, teachers are frequently blamed; teachers on the other hand cite a 'lack of motivation' or blame 'the system' for pupil failure.

Even if you are not a parent you will recognise a similar situation in nursing. When trainee nurses fail to meet expectations tutors may be blamed for being out of touch with the 'real world'. Trainees are said to 'lack motivation' or to 'lack self-discipline'. 'Teaching' in clinical areas is seen as a process of telling and showing. But how effective is this process in bringing about the kind of learning relevant to nursing today and in the future? What do the educational theorists say?

Contemporary learning theories

Psychologists and educationalists take a different view of learning from that of the lay person; indeed differences also exist between the various schools of education theory.

The brief summary that follows is intended to familiarise you with some of the ideas in order to help you to be more analytical in your approach to teaching and training. A reading list at the end of the chapter has books listed for further study of educational theory.

Behaviourist theory

According to Bigge (1976), 20th-century learning theories can be divided into two broadly-based categories: *behaviourist* and *cognitive* field theories.

Behaviourists see humans as biological organisms centred in their environ-

ment, and acted upon by that environment. The emphasis is on observable behaviour, and on control of the environment to bring about a desired change in behaviour. In other words behaviour is seen in terms of a response to a stimulus.

Behaviourism gave rise to a movement for change in education very evident in the sixties and seventies. The work of the influential behaviourists Skinner (1954) and Gagné (1975) has had a far-reaching effect on vocational training. Gagné gave us a definition of learning.

Gagné's definition of learning

Learning is a 'change in human disposition or capability which can be retained and which is not just ascribable to growth' (Gagné 1970).

Cognitive field theory

Cognitive field theorists see human beings as interacting *with* rather than controlled *by* their environment. The emphasis in this school of education is on the learner gaining insight, that is seeing for herself the whole conceptual pattern of what she is learning (Bruner and Anglin 1973). You will no doubt recognise this process: a concept you have been thinking about and puzzling over for some time suddenly falls into place; you *really* understand now.

To summarise, we could say that behaviourists are concerned with the *product* of learning, cognitive field theorists with the *process*. However, one theory does not cancel the other out and perhaps the definition that follows encompasses both schools of thought.

Learning – another definition

Learning could be said to be: a *process* resulting in some modification, relatively permanent, of the behaviour – that is, the way of thinking, feeling, and doing – of the learner.

Pause for reflection

You may like to return to your own definition of learning, written earlier, to compare and contrast it with the one above.

Perhaps you are asking yourself, 'Of what use to me, a nurse manager, is a knowledge of educational theory?' To think in terms of the *behavioural change* we want gives us targets to aim for in teaching and learning (behaviourist theory). In planning learning experiences the aim should be to encourage *insight* and an *awareness of the processes of learning*, in pursuit of the targets (cognitive field theory).

Humanistic approaches to education

We cannot move on from this review of educational theory without mentioning a third force for change that came to the fore in the seventies. This third force, arising out of work of people like Maslow (1968) and Rogers (1969), became known as the *humanistic* approach to education.

The work of Carl Rogers is increasingly influencing education at many levels, including nurse education. Rogers describes two kinds of learning: that which involves only the mind, and that which involves the whole person – feelings as well as cognitions. He calls the latter 'significant learning'. What Rogers is referring to is a 'gut level' type of learning which can be profound, pervasive, and permanent, particularly if it is intellectually appraised and then internalised.

> We cannot teach another person directly, we can only facilitate his learning.
>
> (Rogers 1969)

Rogers sees learning as a *self*-initiated and *self*-evaluated event. In fact he

doubts whether we can teach anyone directly, rather than simply helping them to learn. In Rogers's view the key to encouraging significant learning lies in the creation of a supportive climate: a climate that is low in personal threat, and which encourages the individual to participate in the learning process.

To sum up this section, we can see all three approaches interacting to maximise learning in clinical areas: deciding what needs to be achieved and setting targets for training (behaviourist theory); creating a supportive climate that encourages all team members to participate and learn (Rogers's humanistic approach); and encouraging insight into the processes of learning (cognitive field theory).

Rogers's words probably make an appropriate ending to this section on learning theories:

> the most socially useful learning in the modern world is the learning of the process of learning, a continuing openness to experience and incorporation into oneself of the processes of change.
>
> (Rogers 1969)

He even goes as far as to say that the survival of our culture depends on the development of individuals for whom change is the central fact of life.

The relationship between teacher and learner

You will have gathered by now that this is a much simplified account of educational theories. There is much more involved in the understanding of each, and also much more overlap between them. One thing is clear, however: the *learner* has moved to the centre of the stage. Prior to the sixties the emphasis in education was on the *teacher* teaching. Today the emphasis is on the learner learning.

Teaching

The *Oxford English Dictionary* defines teaching as:

> to show by way of information or instruction . . . to impart or convey knowledge.

Guilbert (1977) offers this definition:

> teaching involves interaction between teacher and student in order to bring about expected changes in the behaviour of the student.

Joyce and Weil, in *Models of Teaching* (1972), see what a teacher does in interactions with pupils as stemming from the teacher's general beliefs about human nature and the kind of environment that enhances human beings. Joyce and Weil think of teaching

> as a process by which teacher and student create a shared environment including a set of values and beliefs (agreements about what is important) which in turn colour their view of reality.

What nurse managers considered important to teach, in Marson's study (1981), stemmed from their values and beliefs about nursing. This would seem to link in with Joyce and Weil's theory.

Pause for reflection

You may like to consider *your* definition of teaching, written earlier. How does it compare or contrast with the three definitions listed above?

You may have noticed as you have read through the chapter so far that whenever the word 'teacher' or 'teaching' has been used in connection with the nurse manager's role, the word has been enclosed in quotation marks. This is a reflection of my own bias! Reading through the research studies cited above left me with a firm conviction that the focus should be shifted from nurse manager as 'teacher' to nurse manager as 'facilitator', that is as *enabler* of learning.

This means a shift away from the didactic (lecturing) model, the one many of us carry in our heads from our own experiences of being taught. We can illustrate this further by using a gardening analogy to clarify what is meant by the term 'facilitator'. A seed has hidden within its structure the capacity to grow. The gardener provides the right kind of environment for the seed to

grow: soil, sun, shade, nutrients, water, and support if the plant is trailing or weak. However, for the plant to grow healthily it must not be under- or over-fed, nor under- or over-watered. As with plants, so with human growth, both physical and psychological.

The art of being an effective facilitator of learning is not far removed from that of being a good nurse. Many of the qualities needed are similar, such as empathy, sensitivity, ability to listen and respond in an appropriate way. We will consider these in greater detail later, when we look at what makes a good 'teacher'.

Before we move on to look at the characteristics of a learning climate, here, as a summary, are some statements about learning and teaching, taken from various sources of educational theory (see Guilbert 1977).

Learning

Learning is a process resulting in some modification, relatively permanent, of the way of thinking, feeling, and doing of the learner.

Learning is:

- primarily controlled by the learner;
- unique and individual;
- affected by the total state of the learner;
- an evolutionary process;
- a consequence of experience;
- not directly observable.

A thought to leave you with:

Learning is both an emotional and an intellectual process.

Teaching

Teaching can be seen as the interactions that go on between teacher and student, under the teacher's responsibility, in order to bring about expected changes in the student's behaviour.

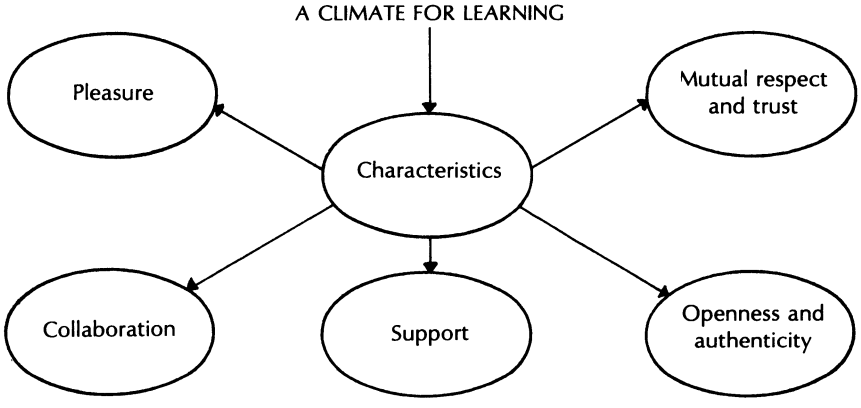
A thought to leave you with:

Teaching methods which place the student in an active situation for learning are more likely to be effective than those which do not.

Conditions for learning

The study by Orton

Helen Orton, in her study of student nurses' responses to the ward learning climate (Orton 1979), identified teamwork, consultation and an awareness of subordinates' needs as hallmarks of a good learning climate. Other studies in higher and management education show similar findings to Orton's, so what *are* the characteristics of a good learning climate?



Mutual respect and trust

We are more open to learning if we feel respected and valued as a person. If we are 'talked down' to, ignored or feel our experience is not valued, our energies are taken up with feelings rather than learning.

Openness and authenticity

When we feel free to be open and natural and able to say what we think, we are more willing to examine new ideas and risk new behaviours. The team leader sets a model of behaviour that will be followed by the team. Openness and trust beget openness and trust.

Support

We tend to learn best when we feel supported, not threatened or judged, in our efforts. When our *strengths* are valued then we are more receptive to feedback from others about our *weaknesses*. If we do not know what our weaknesses are, we are not in a position to do anything about them!

Collaboration

Putting participants into a sharing relationship from the beginning creates optimal conditions for learning. Learners should be involved in diagnosing their own needs, planning how to meet the identified needs and deciding how learning will be evaluated. Once this process has been gone through, a *contract* of learning can be drawn up that both teacher and taught will adhere to.

Pleasure

Last but not least, a *team* that operates in the kind of climate described above is an enjoyable one to work in.

The study by Pine and Horne

You will appreciate from reading Chapter 3, on leadership, that an overlap exists between the processes of team-building and the processes of creating a climate for learning. Turning back to educational theory, Pine and Horne (quoted in Guilbert 1977) have described the following as conditions that facilitate learning.

Conditions to facilitate learning: a summary

An atmosphere that:

- encourages people to be active;
- emphasises the personal nature of learning;
- accepts that difference is desirable;
- recognises people's right to make mistakes;
- tolerates imperfection;
- encourages openness of mind and trust in self;
- makes people feel respected and accepted;
- facilitates discovery;
- puts emphasis on self-evaluation in co-operation;
- permits confrontation of ideas.

The nursing profession is, by tradition, a hierarchical structure. Because of this, some of the conditions listed above may seem revolutionary, even threatening – Take, for instance, 'tolerates imperfection' and 'recognises people's right to make mistakes'. It might be said that this could never be allowed in nursing. But consider for a moment the context in which these statements are made: that is, the context of the learning process, not nursing practice. Nurses are not perfect beings and they *do* make mistakes. It is the *way* in which these mistakes and imperfections are handled that matters, not the fact that they have occurred. When feelings are aroused because of some upsetting situation, this is often a 'fertile' period in which learning can take place.

Openness – a matter of degree

The nature of nursing and the position of nurses in the total organisation makes it difficult to create a totally open (democratic) climate on individual wards and units. If we imagine a line drawn between the two poles of autocracy and democracy, individual wards and departments will vary in their position on that line, according to the nature of the work and the personalities of the team leaders:

AUTOCRATIC:
authoritarian, closed, directive

DEMOCRATIC:
open, participative, non-directive

Autocracy or democracy?

Use the following questionnaire to determine where on the line between autocracy and democracy your own ward lies or could lie. Why not use the questionnaire as a discussion trigger for your next ward meeting? You may get some surprising answers!

Ward learning climate

Consider the following statements and decide whether in your area the behaviour suggested is: D, Desirable; and P, Possible.

	D	P
1 The learners must be able: ● to set their own personal learning goals related to their work, within the constraints of nursing care in the service area ● to develop their own approaches to the achievement of these goals ● to seek criticism from teachers, trained staff and colleagues ● to collect relevant data and utilise it in finding solutions to nursing problems ● to evaluate their own performance or that of a colleague using established criteria agreed between education and service staff		

	D	P
2 The learners must be encouraged: ● to review work experiences in relation to their learning needs ● to acquire independently information that is usually transmitted by traditional lecture methods		

	D	P
3 The learners must be provided with: ● a wide variety of materials and methods from which to learn in the service area		

	D	P
4 A function of clinical experience should be to help students find solutions to nursing problems		

Adapted from a discussion paper by J. J. Guilbert, WHO, Geneva, on *Basic Issues in Curriculum Design and Implementation* (30 November 1977)

Conclusion

There is no doubt from the findings stemming from studies into teaching and management in nursing that the ward sister or charge nurse holds the key to creating the 'learning climate' in the ward or department. The next section of this chapter will look in depth at the characteristics of good 'teachers'; at what it is that makes them *special* and at what it is they *do*. Before we move on, however, try out the following activity as a preparation for the next section.

Pause for reflection

Most of us, when asked, can recall someone from our past who has influenced our development. This person (or persons) may have helped us to acquire skills previously thought unattainable; or changed our attitudes towards, or our perception of, a particular aspect of personal or professional life, and in general aided us to develop self-confidence.

Cast your mind back to your training days. Try to recall one person who had a considerable influence on your professional development. What was special about that person? Try to list all the characteristics you can recall – for example, was he or she knowledgeable, professional, sympathetic?

Put the list to one side: we will return to it later.

Effective teachers

A review of the literature on teaching reveals the following.

'Good teaching' seems to be relative. People's perceptions of a good teacher depend upon their own past experience, the culture they come from, the values, attitudes and beliefs they hold. The personality of the teacher versus the personality of the learner also colours judgement. Thus we have the traditionalists who support the teaching of tables and spelling in schools, and the progressives who value the fostering of creativity in children above other more routine activities. Both may be equally good at teaching. There appear to be, however, two major dimensions to this complex and varied activity that we call teaching, which involves such a multiplicity of human traits and abilities:

1 The first dimension concerns a teacher's mental abilities, that is her understanding of the generalities and specifics of the subject she is teaching (Ausubel 1968, Bruner and Anglin 1973, Taba 1966).
2 The second dimension involves qualities stemming from a teacher's personality, values and beliefs, from her ability to form relationships with pupils and colleagues: in other words, her ability to create a climate for learning (Rogers 1969, Flanders 1970, Joyce and Weil 1972).

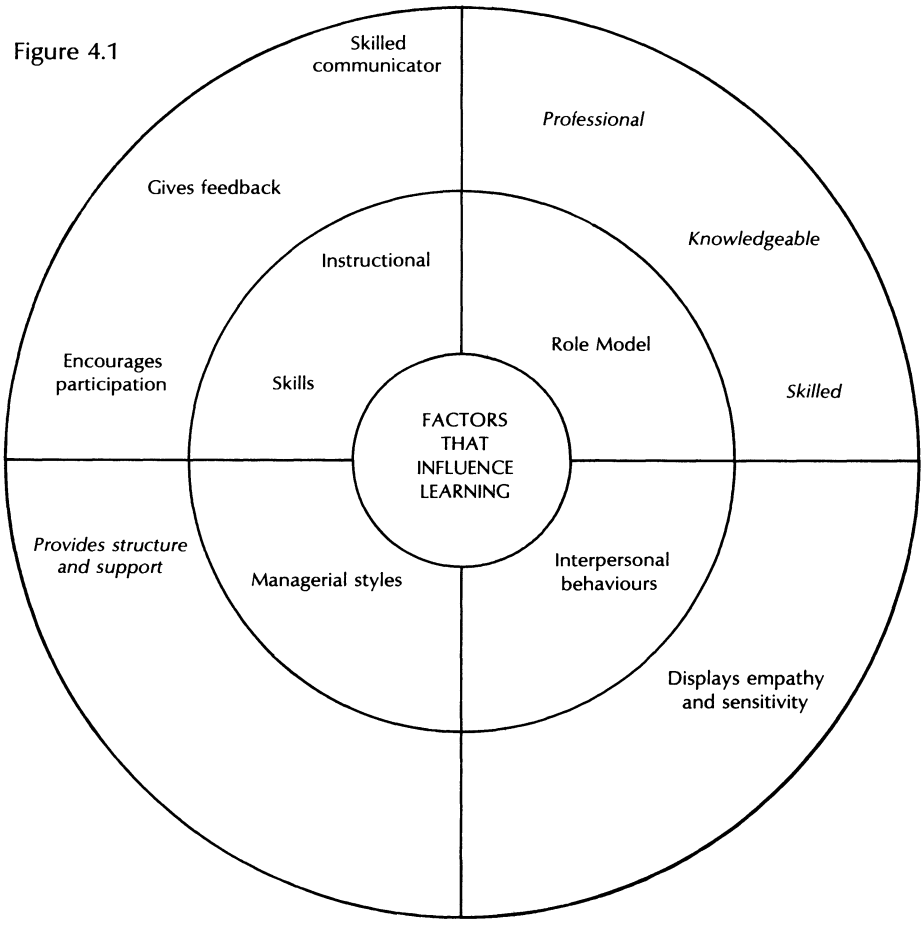
Although both dimensions operate when nursing is taught at the bedside, it is the second dimension that comes to the fore in the research studies (quoted in Chapter 1). The second dimension is also prominent in studies carried out in the United States and Canada (Shellenberger 1982).

Statements about the qualities of good 'teachers' collected from learner nurses fall into four broad areas (Marson 1981):

- the role model;
- interpersonal behaviours;
- managerial styles;
- instructional skills.

The diagram depicts these.

Figure 4.1



Activity

As we enlarge upon these four factors, have your list of characteristics nearby to see whether any of your statements come into these categories.

Role model

We tend to be influenced by those persons who possess qualities we esteem and value highly. This factor operates very strongly in relation to learner nurses. If a sister or charge nurse measures up to their picture of an *ideal* nurse, then this person can exert a great deal of influence. It is important to be aware of this factor, particularly when dealing with learner nurses: what you *are* may speak louder than what you *say*!

Phrases that may indicate that a role model is operating include 'sets a good example', 'has high standards', 'shows care and concern for patients', and 'knows her job inside out'. Do any of *your* statements relate to the professional image of the person you chose to describe?

Interpersonal skills

Qualities such as empathy and sensitivity are also rated highly. (Ogier (1980) uses the terms 'warmth' and 'consideration' in her study.)

Statements that indicate skill in managing interpersonal relationships include: 'She didn't make me feel she was the sister and I was only the pupil'; 'She could always recognise a situation where you weren't learning'; and 'You could tell her you didn't understand – you daren't do that with some people'. How many of *your* statements come in this category?

Managerial skills

Good teachers are also considered good managers; for example: 'The ward ran like clockwork' and 'He organised the work well'.

Instructional skills

Skills which could be considered as formal teaching skills were mentioned in Marson's study, but with less frequency than the other three categories. For example: 'He puts things over in an interesting way', 'She got me to work things out by myself' and 'He let me know how I was progressing'. These statements indicate that what counts in formal teaching programmes are: the encouragement of participation, the giving of feedback, and the ability to engage a learner's interest.

We could say then that good teachers are caring, competent, good communicators and skilled in managing interpersonal relationships.

Pause for reflection

Does the person you chose to describe fit this description? If not, how did that person differ?

Behaviours that facilitate learning

The profile of the good teacher we have just drawn up is very general in nature. A statistical analysis of the statements collected did reveal some specific behaviours, however. These have been converted into a checklist for use as an evaluation 'tool'.

Teaching behaviours

1 Using the checklist below, place a tick in the appropriate column according to whether the behaviour is one that you normally use (according to circumstances, of course), use sometimes, or use very rarely.

2 If you feel brave enough, ask a member of your staff also to complete the checklist in relation to you. Then compare and contrast the two sets of responses.

3 Note any behaviours rarely performed, and consider what might be the effects of increasing the use of those behaviours.

4 Note any discrepancies between your evaluation of yourself and your staff member's evaluation of you. Is your picture of you the same as his or hers of you? If not why not, and does it matter?

Teaching behaviours: checklist

Key: U, Usually; S, Sometimes; I, Infrequently	U	S	I
Do you:			
1 Take up available opportunities to teach, tell, show and work with learners?			
2 Help learners set specific objectives (goals) to be achieved from work experience?			
3 Make an effort to be friendly and approachable in your relations with learners?			
4 Ensure that other members of the ward team support learners and are aware of their needs?			
5 Ensure that learners apply their theory to the real-life situation on the ward?			
6 Make efforts to stimulate learners' interests in work experience and to draw their attention to learning opportunities?			
7 Adapt the instructions and information given to meet the individual needs of learners?			
8 Ask learners stimulating and relevant questions related to their experience on the ward?			
9 Encourage learners to ask questions and ensure that these are answered, either personally or by directing them to relevant sources?			
10 Clarify your communication with learners by testing their understanding of instructions and information given?			
11 Encourage learners to express personal feelings, ideas and opinions?			
12 Listen in a supportive and non-judgemental way to what learners have to say?			
13 Ascertain learners' feelings and capabilities before increasing responsibilities?			
14 Commend efforts and give regular feedback on learners' progress?			
15 Acknowledge and share your own feelings with learners when appropriate?			
16 Discipline in a manner that is constructive rather than destructive to a learner as a person?			
17 Manage to resolve interpersonal conflicts on the ward without anyone harbouring grudges?			

Key: R, Regularly; S, Sometimes; I, Infrequently	R	S	I
Do you:			
18 Set time aside for your own study?			
19 Meet with members of the tutorial team?			

S. N. Marson, (June 1985)

The 'good teacher' – a summary

Rogers (1969) states that one of the most important conditions which facilitates learning is:

the attitudinal quality of the interpersonal relationship between facilitator and learner.

We can assume from the research that it is also true in nursing. Trained nurses perceived by learners as good teachers are caring competent nurses and skilled team leaders. They are sensitive to the needs of others, make efforts to motivate and involve learners, and give feedback on progress when needed. They are skilled in managing interpersonal relationships, and in total act out of a personal value system of care and concern for others.

Developing your training programme

Much of what has been said up to now relates to the generalities of learning and developing a climate that maximises personal learning. There are, however, specifics that need to be taught, practical skills and background knowledge; there are also appropriate attitudes to be fostered. This section concerns the development of formal training programmes; but before moving on to specifics, we will take a brief look at the place of *reflection* in learning.

Reflection in learning

Many potential learning experiences may get lost in the pressure to 'get the work done'. Helping staff to reflect upon their experiences is probably one of the most useful ways of increasing incidental learning: learning that is not planned for, but that arises out of work experiences.

Reflection is one form of response made by an individual to an experience: a recapturing of the event, a mulling over to evaluate it. *Experience* is the *total* response of a person to a situation or event: what that person thinks, feels and does, and the conclusion she draws from the experience.

The way we respond to a new experience is determined by past experiences, which in turn have shaped the way we see the world. Thus:

- positive experiences can enhance new learning;
- negative experiences may prevent new learning.

Experience alone, however, is not the *key* to learning, so how can we help learners get the maximum benefit from an experience?

Promoting learning by reflection

First, *allow time*. This is a difficult thing to do in the pressures of today's world, but if we are to help staff develop their full potential, effort needs to be made to find time.

Second, *give attention*. Encourage the learner to return to the experience, to talk it over, to attend to any feelings that are coming out, to utilise positive feelings, and to remove obstructive or negative feelings. Encourage a re-evaluation of the experience in the light of this reflection. The aim is to help learners develop personal perceptions of attitudes and values, to enable them to interpret events in the light of greater experience, to help develop concepts and theories, and in general to consolidate their learning.

All in all, encouraging all staff, not only learners, to reflect on experiences is a useful 'tool' to have in your armoury. (For further reading on reflection, see page 45.)

Planning for learning

No training programme will be effective unless its purposes are clearly defined. New staff members joining your team, whether they are qualified or learner nurses, need to be trained specifically for the tasks they have to undertake. The starting points for any training programme then are the purposes or 'objectives' that are to be achieved.

Objectives in learning: are they necessary?

If you have learners on your ward you will need goals for them to work towards. As ward manager you are accountable for students' learning on the ward, and a list of clearly-defined learning objectives will provide clear guidelines for all staff to follow; indeed they can be used to improve standards of nursing care. The national nursing bodies require them, to validate nursing courses. Last but by no means least, well-defined objectives are a great help in assessing a learner's progress.

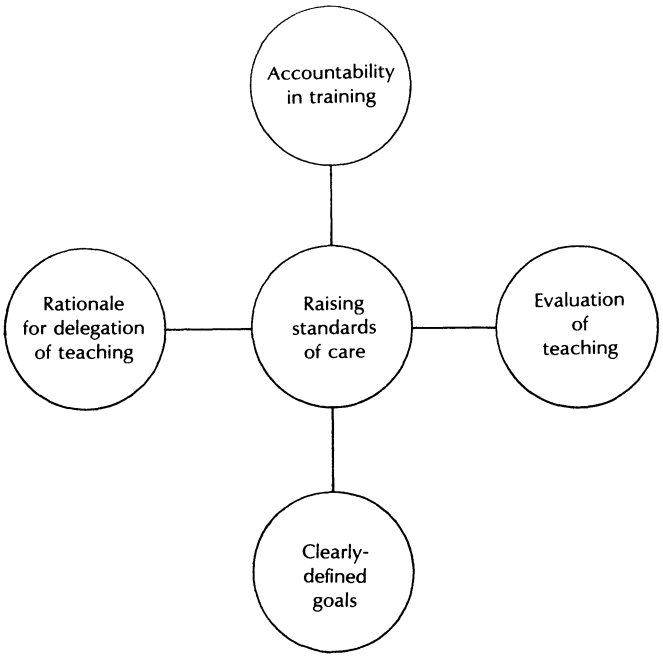


Figure 4.2 Reasons for specifying training objectives

What are objectives?

Objectives have been around in nursing since the seventies. In essence they are:

- statements about what a learner will be able to *do* as a result of a learning experience;
- targets or *goals* to aim for when learning;
- *signposts* to point the way through a complex subject;
- *guides* to the kind of *performance* expected from a learner at the end of a training programme.

Beginning to formulate objectives

As ward sister or charge nurse you will find it easy to list things which nurses do on your particular ward. You have probably done this already. Here are some examples:

- lifting and moving patients;
- caring for patients with indwelling catheters;
- making patients feel comfortable on admission;
- gaining co-operation.

These may together be referred to as a 'task list'. This list will contain a mixture of general nursing care items and other items specifically related to the ward you manage. Some may relate to the nurse as a person, such as 'be punctual' or 'be motivated to learn'.

The next step is to consider each of these statements and ask yourself: 'What do I want the nurse to be able to do?' or 'How shall I know whether the learner can do this?'

Take the first example in the list above: 'lifting and moving patients'. You might say this about it:

The learner should demonstrate her knowledge of the principles of lifting:

- by *helping* a patient move from a supine to a sitting position in bed, or by *turning* a helpless patient using the correct procedure;

and/or:

- by *instructing* another student in the mechanics of lifting;
- by *using* the principles of body mechanics for her *own* health and safety when lifting patients.

How many objectives? How specific must they be?

These are probably the most difficult questions to answer. If you are very specific about each item you will set yourself an impossible task. If you are too vague they will be of little use when assessing the learner – and yet it is very difficult to write objectives that 'cover' all the learning experiences briefly.

The only advice I can offer is to draw up a list about the same length as the list of items – that is, try to provide an objective for each item on your 'task list'. Then ask your colleagues to go through them and help you sharpen the wording in an attempt to cut out ambiguity. (You can do the same with *their* objectives.) Alternatively, do this as a group activity: each person in the group can take away a number of task items and then, after writing objectives, bring them back for general perusal. It would be useful if someone with some experience of writing objectives could act as 'referee' on these occasions to prevent too much time being given to relatively unimportant details. Also, go through this list with all of your staff: it is often the other qualified members of your team who will be guiding and supervising learners.

Organising and ordering objectives

Having produced lists of objectives you may already have seen some pattern or order emerging that relates to a problem-solving model. Most of the objectives written will relate to any one of the following steps of the nursing process, for example:

Steps	*Objectives relating to:*
1 Getting information about a patient *(Assessing)*	• Receiving patient and relatives • Establishing relationships • Collecting information on admission • Listening, awareness • Measuring and recording skills
2 Planning what to do and identifying nursing problems *(Planning nursing care)*	• Using relevant knowledge to participate in the planning of nursing care of specified patients • Knowledge of available resources • Knowledge of different nursing actions which may be considered • Understanding of consequences of different actions which may be considered
3 Doing it *(Implementing nursing care plans)*	• Competence in giving nursing care (technical skills areas) • Ability to co-operate, co-ordinate and communicate • Value of patient's dignity/privacy/safety
4 To what extent have you been successful? *(Evaluation)*	• Evaluating outcomes of care given • To what extent have problems been solved? • Have you thought of an alternative nursing solution if the problem has not been solved to the patient's satisfaction?

Objectives, in general, should be 'patient-centred' – related to patient care, knowledge about a patient, and ability to plan, carry out and evaluate nursing care.

There may, perhaps, be other learning objectives which relate to the learner herself – her approach, her position as a learner on your ward, her motivation, punctuality and ability to work in a team, or her knowledge about the general environment and resources available. An example:

The nurse will demonstrate her motivation and interest by:

- asking questions at appropriate times;
- being punctual on duty;
- appearing a pleasant and willing member of the ward team;
- offering suggestions and ideas.

If you are finding this ordering very difficult you might like to try cutting up your objectives (yes, literally!) or writing them out separately on cards. You can then decide more easily which pile they can fit on – the 'assessing patients' pile, the 'implementing' pile, the 'other' pile, etc. This exercise will also let you see what kind of balance you have in your stated objectives. For instance, have you very few in the 'evaluation' pile? Is that how it should be, or do you need to look at this gap?

This strategy has the further advantage of allowing you a pile of 'can't decide yet – come back to later'. Such a pile will help you not to get too bogged down in unproductive discussion.

Other considerations in producing objectives

There are of course many other things to take into consideration and there are many educational books written on the subject of objectives. The 'Further reading' list at the end of the chapter gives some examples of these.

You may be concerned with *levels* of objectives for different nurses and you may feel that not all your objectives are appropriate for a first-year nurse on her first ward experience. There may be some parts of the objective that you feel are more appropriate for management experience of the pre-final student. You may consider it adequate for a new learner merely to *know about* something, but consider it necessary for a more advanced learner to be able to make decisions *using* that knowledge. Thus, a first-level objective might read:

- The nurse will be able to discuss factors relating to diminished mobility in a given patient.

A more advanced objective might read:

- The nurse will be able to plan the care of a given patient with mobility problems, and to implement and evaluate the care given.

Another area of concern may be how specific or detailed to be when writing your objectives. You may have noticed that the examples I gave of objectives on page 40 were rather broad and general. Here is an example of a *specific, detailed* objective:

- During her experience on this ward the learner nurse will demonstrate her understanding of the importance of fluid balance when caring for a patient with intravenous infusion, by maintaining accurate records of all fluid intake and output for a given period.

An example of a *broad, general* type objective:

- Following her experience on this ward the learner will be able to care for a patient having a blood transfusion.

In conclusion, learn more about objective writing *by* objective writing. Learn from each other – and trust your own experience and common sense.

Learning objectives for clinical experience: checklist

Read through the objectives of your training programme and place ticks in the appropriate columns. Note any objectives that do *not* meet the criteria, and rewrite them until they do.

	Yes	No
1 *Do the objectives* provide a summary of the learning experiences possible on your ward?		
2 Are they related to different levels of student experience?		
3 Are they written in words that describe what the learner will be able to *do*?		
4 Do the objectives indicate the standards that have to be achieved?		
5 Do the objectives include • assessing • implementing • evaluating skills of the learner?		
6 Are they written in such a way that the learner will know when learning has taken place?		

From objectives to teaching

If objectives are the *ends* of training, then teaching methods are the *means* to those ends. In relation to teaching 'on the job' we are up against two almost intractable problems, time and facilities. As staffing ratios dwindle and patient throughput increases, time for formal teaching is diminishing. Space too is often at a premium. This should not deter you from developing a programme: there are other ways to achieve 'ends' than formal face-to-face teaching.

Let us take, for example, the objective: 'The learner should demonstrate her knowledge of the principles of lifting.' How will we teach this, and how will we know that the learner has learned? Here is an example. ('Key points' are discussed below.)

Objective	*What the learner should be able to do*	*Teaching methods*	*Assessment procedure*
To teach the principles of lifting	• Demonstrate lifting a patient from bed to chair. • Turn a helpless patient in bed. • Instruct a colleague. • Use principles of body mechanics when lifting.	• Demonstration. • Supervised practice. • Study of learning package on lifting.	• Observe student demonstrating the lifts. • Observe student teaching a colleague. • Note whether key points of technique are observed.

Key points are derived from what is called a 'skills analysis': the breaking down of a skill into its component parts and noting the *particularly important* steps in the procedure, which become the criteria for performance. Below are two key points taken from an analysis of building an artificial kidney. (This analysis was carried out in the early seventies.)

Procedural step	*Key points*
5 Take first membrane and immerse in bath of acetic acid.	Handles membrane carefully; checks that it is held taut. Lowers one end before whole membrane is immersed.
6 Lift membrane from bath.	Lifts membrane sideways and holds at an angle to allow surplus acid to drain away.

To break every skill objective down in this way would be very time-consuming. It is well worth doing if the skill is a critical one, that is when a patient's well-being or safety would be threatened if the task was not carried out well. If you are not satisfied with standards of care, carrying out a skills analysis can be an aid to improving standards. A key-point checklist can also be used as a training aid or *aide-mémoire*, as well as a tool for assessing performance. A word of warning here: the setting of criteria for skill performance should be a team activity. If there is agreement on standards they are more likely to be adhered to.

Assessing learning

The term 'assessment' refers to measurements and judgements of a learner's achievement of the *objectives* of a period of clinical experience. This is somewhat different from course evaluation or staff appraisals, which have a different focus. Assessment focuses on the student and progress in learning; to repeat, without clear statements of meaningful objectives, assessment is fraught with difficulties.

Why assess?

Assessment gives feedback to the student on her progress; it also gives you feedback on the success or otherwise of your 'teaching' methods. To be useful it needs to be a continuing process, giving time in which unsatisfactory nursing practice can be corrected. It does, however, require more time and efficient record-keeping than the 'one off over the hurdle' assessment at the end of a period of clinical experience.

Who should assess?

With clearly-specified objectives and criteria for performance, assessment can be delegated to other trained nurses in the team. Self- and peer-assessment also become possible. Patients may also be involved, but the assessment by a patient of an individual nurse may give rise to difficulties. Patients may be better involved in assessing the team rather than an individual.

Learning resources in the ward

As was said earlier, time and space for teaching are at a premium in clinical areas. With a little ingenuity, perhaps an area can be cleared to house learning resources. These can range from a folder containing articles from nursing journals, or card-index files with quizzes and questions for learners to answer, to more sophisticated resources such as video tapes and computer-assisted learning packages. Why not make use of such technology if you have it available on the ward?

The amount of packaged learning material suitable for nurses increases almost weekly. The English National Board's Resources and Careers Services Department in Sheffield holds a computerised data bank of learning material. Print-outs of available material on specified subjects are available on request. The Department will also give advice on the use of such materials. (Address: ENB Resources and Careers Services, Woodseats House, 764A Chesterfield Road, Sheffield S8 0SE. *Tel:* 0742 551064/5.)

Collecting and developing suitable learning materials for use on the ward will extend your teaching role beyond the constraints of time and inclination. Let's face it: after a busy day you may not be in the best frame of mind to hold a teaching session, however much it may be needed.

Continuing professional education

Before concluding this chapter we need to take a brief look at continuing professional education. The subject is treated in more depth in the book *Managing Yourself* in this series.

Today as never before in the history of nursing, there is a need to continue professional education beyond state registration. This means reading journals to keep up to date in your clinical speciality; meeting with trainers and nurse teachers for the exchange of ideas and advice on training matters; and seeking opportunities for continuing your education by going on appropriate courses and conferences, or alternatively taking one of the distance-learning courses now available. Your department of continuing education should be able to give you details of all of these. If such details are not available to you, the English National Board's Resource and Careers Services may be able to help (see above).

Conclusion

The emphasis in this chapter has been on creating a climate favourable to learning, a climate that builds up trust so that people are able to learn from day-to-day experiences and are not afraid to learn from one another. You as the ward sister or charge nurse have a major influence on that climate. The power of the role model is such that if you show that you are willing and able to learn from others, this will permeate through the team and 'learning' will become as important as the other activities that go on. Use the tools we have provided, and we wish you the best of luck.

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Chapter 5 Quality and its control
by Barbara Scammell

Throughout the series and especially in this book, we frequently refer to that function dealing with the establishment of quality standards and the control of staff who are expected to achieve and maintain standards. In this chapter we will look at:

- the need for a high quality of nursing care;
- how standards of quality are set, who sets them, and how they are achieved;
- how nurse managers work with their own profession and liaise with other professionals to ensure that everyone is aware of the standards and objectives within which they operate;
- which factors contribute to high-quality care and which may inhibit it;
- how nurses work within employment legislation and maintain good labour relations.

This chapter acts as an introduction only to the much more detailed account given by Diana Sale, in *Quality Assurance*, another book in the series.

The need for high-quality care

Peters and Austin (1985) maintain that 'quality, above all, is about *care, people, passion, consistency, eyeball contact* and *gut reaction*. Quality is not a technique, no matter how good' (italics added).

Responses to those we deal with

1 Think for a moment about two girls at different check-out tills at your local supermarket.

- The first girl very efficiently rattles off on her till the items you have bought. She takes your money, offers you the change, and pushes your purchases to the bottom of the chute. She does not look at you during these operations. Were you to say to her (for example), 'You have just served a two-headed, blue-based baboon!', your remark would no doubt elicit only a nervous giggle and a swift glance.
- The second girl, equally under pressure, looks at you, smiles at you, and may even venture some comment.

Discuss these two approaches.

2 What reaction *might* you get? Some people might say, 'But I go to the supermarket to be served quickly and efficiently, not to make social contacts. As long as the operation is done swiftly and accurately, I don't care *how* the girl at the till behaves!'

Try asking the question of different kinds of people, e.g. an elderly person, a young man, and a busy housewife with a young child.

What responses did you expect? What responses did you get?

If you found that the responses varied, it may be because different people have different perceptions and different standards of quality which they expect from those they meet in ordinary life.

If we carry this experience across to the care of patients, might we not equally find a range of responses to the sort of nursing care expected by the public? For example, there may be those who say, 'All I want is to get efficient treatment on time, with the minimum of discomfort. I don't expect to make friends with the nurse!' We need therefore to consider a whole philosophy of care, and to decide what our personal attitude to care is, and what factors affect the kind of care we give.

The nature of care

1 With a partner, or in a group, list the skills and qualities that you think contribute to care.

2 What attitudes to patients or clients do you think influence care?

3 What outside influences affect your standards of care?

4 From these three lists, try to write a definition of care that satisfies *you*.

It should be possible to define a continuum of care such as that suggested in the illustration. *A* and *E* on the continuum are least often encountered, and most well-adjusted 'carers' fall into category *D*, having achieved a balance between care for self and care for others. It is, however, surprising how often people will care enough to put themselves at risk, even of death, for another human being, and doctors and nurses, as well as parents, frequently do so. In fact most of us are capable of such sacrifices in the heat of battle, or under situations of great stress.

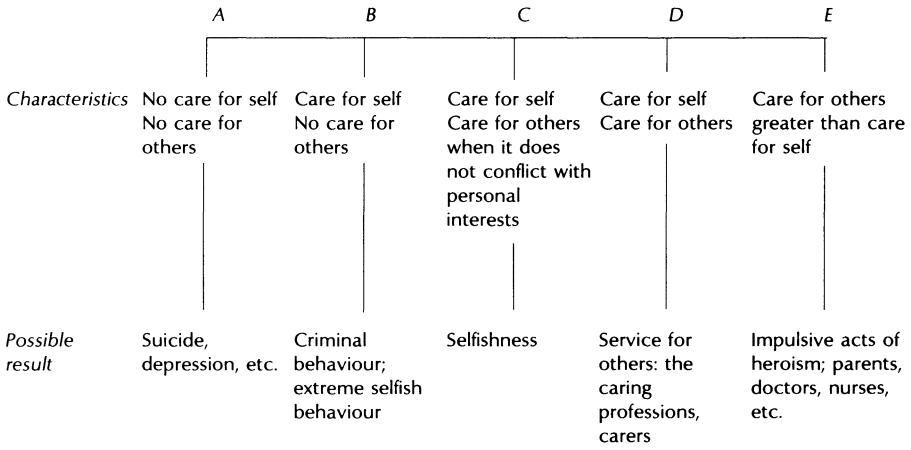

Figure 5.1 Continuum of caring

A caring and civilised society looks after the needs of those least able to care for themselves by reason of lack of physical or mental ability or because they have personalities damaged by society or upbringing. The caring professions, of which nursing is possibly the principal profession, are the main agencies through which the caring society acts, and which it trusts to give specific and specialist help, on a temporary or permanent basis, to those who cannot care for themselves.

When a person becomes a patient or client of any of the medical professions, she temporarily relinquishes her autonomy and may lose her dignity. This is a painful experience and one that demands a different dimension of care from the nursing care associated with the performance of tasks:

On the *task* side of the interaction it is possible to offer care that is technically excellent, accurate but impersonal. This is the nurse 'doing her duty'. On the *attitude* side are the influences that will encourage the nurse to consider not only the body of the patient but also her emotional and psychological needs. The formation of such attitudes will be affected by a number of factors, such as:

- how 'popular' the patient is (refer to Stockwell 1972);
- how much the nurse likes that patient (it must be acknowledged that we cannot like everyone equally);

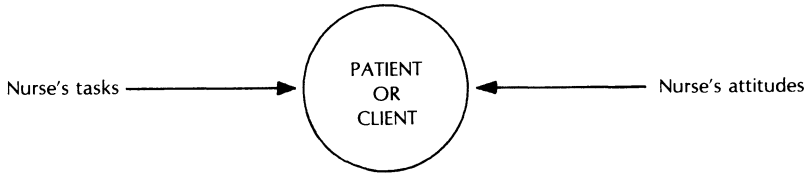

Figure 5.2 The two dimensions of care

- the personality of the nurse, which allows her to relate to others or causes her to find it difficult to do so;
- how confident she is in her ability as a nurse;
- how secure she is in her profession, and in the professionalism that will help her to overcome her natural dislike of some patients and to offer all in her care equal loving attention.

Added to the two dimensions of 'task' caring and 'attitude' caring is a third factor, the personal satisfaction the nurse gets from being wanted and needed. When asked the perennial question, 'Why do you want to be a nurse?', the almost universal response is, 'To help other people.' It is well worth asking, 'What do I *get out* of being a nurse?'

From these reflections we might extrapolate a range of definitions describing the quality of nursing care, ranging from 'We do not actually *harm* the patient' through 'We usually send the patient away having had the best treatment we can devise for him' to 'We cure or support or comfort the patient, looking at his whole being and caring for his body, mind and psyche'. It is difficult to be all things to all men, and few of us attain the perfection of the last description: most of us 'do our best'.

The question 'Why do we need a good quality of nursing care?' seems therefore to depend for its answer on the expectations of others as well as of ourselves.

- The patient or client has the right to expect standards that come somewhere near to her expectations of the treatment which she imagines that nurses offer. These expectations vary with the patient, and with what she has read, heard or experienced previously.
- The nurse manager has the right to expect standards which will be concomitant with the objectives within her sphere of accountability and responsibility.
- The organisation has the right to expect that standards will be in accordance with the objectives of the NHS.
- The professional nursing bodies have the right to expect that whatever the nurse does will conform with the Professional Code of Conduct (UKCC).

Who sets standards of care?

Within these constraints the nurse must set her own standards. These must be attainable, and the highest of which she knows herself to be capable. Though it is the *nurse* who sets her own standards, this must be done in association with her manager if both are to be committed to their achievement.

Peters and Austin added several new concepts to the usual list of epithets which contribute to the definition of quality. Somewhere in the *mélange* they talked of *passion, eyeball contact* and *gut reaction.*

- Their book was entitled *A passion for excellence,* and by 'passion' they meant an intense, burning need to be best or to do best what is required; a desire for every employee to contribute to corporate excellence.
- 'Eyeball contact' is described in another book in this series (Scammell 1990): it is mainly concerned with the first encounter, the 'shop window' communication. To look at someone when you are talking to them or doing

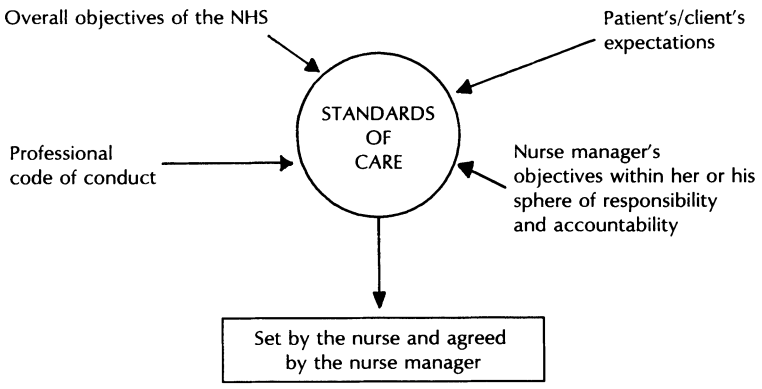

Figure 5.3 The setting of standards of nursing care

something for them is a way of acknowledging their importance. You are saying, non-verbally, 'You matter to me, you count, I care about you, you are not just a cypher, another faceless entity to be dealt with as quickly as possible.'
- 'Gut reaction' refers to the instinctive 'seat of the pants' knowledge of the true professional about what is right and proper and when something is not up to scratch. Peters and Austin maintain that it transcends technique, 'no matter how good'.

These may be the *foundations* upon which a philosophy of quality care rests, but the final statement setting the standard must be:

- written by the nurse;
- agreed by her manager;
- measurable.

The last of these, the ability to *measure* standards, is of the greatest importance. It will be impossible to decide whether a standard has been reached unless some form of measurement is built into its setting.

Informing others

Some standards of care are designed to be used at local level, and are specific to the nurse who will be working within their parameters. Others will be generic and devised for all those working at unit or District level. At national level the profession sets its own standards, which are stated in the professional Code of Conduct (UKCC), and maintained by admitting to the profession only those who are judged proficient in relevant skills and who are experienced in a wide range of basic knowledge. Government sets standards of knowledge and conduct for all its employees which are in accord with its political beliefs, objectives and bias, and for the implementation of which it can provide the funds.

Standards when set must also be communicated to a wide range of other professionals. Nurses do not work in a vacuum and the way in which they function will inevitably affect others – not only those within the nursing profession, but also those with whom the nurse comes in contact in the course of her professional work. Tutors in schools of nursing *must* be involved in contributing to the philosophy of quality of care and of the generic standards which are set at unit and District level. Doctors, working closely as they do with their nursing colleagues, need to be aware of the standards which the nurses with whom they work consider desirable. Other professionals (physiotherapists, radiographers, and so on) should also be aware of nursing standards.

One way in which this information can be communicated to others is by the establishment of quality circles.

Using quality circles

Middle and first-line managers co-operate to develop a quality circle of between five and twenty employees of all the disciplines and professions who share a common interest. The group meets regularly to consider a chosen problem related to the quality that the service provides. The reasons for, and the extent of, the problem are analysed and possible solutions, which can be tested and validated, are discussed.

Such a meeting of a combination of a number of professions makes all aware of their common responsibility for the provision of a service that will meet the standards set by NHS policy. It will also reduce inter-departmental competition and friction, and make each profession more aware of the problems of its colleagues in other professions. Because all are involved in the implementation of solutions, all are more likely to be committed to their success.

Once the basic philosophy of control of quality has been fully backed by management at all levels, there should be little need for inspection or supervision, though these will remain as a 'safety net'.

Setting standards

From what you have read, try to list the factors that you think would determine ability to establish standards of high-quality care.

(Suggested answers are given on page 53.)

Factors that inhibit high-quality care

Basically these are the converse of the factors given as answers to the exercise above. Even if only *one* of these factors is missing, the *whole* standard is threatened.

Monitoring and checking standards

We all think we know what we mean by high standards, and we may all be convinced that we operate at the highest level. We would be distressed to be told that our work was not up to scratch. Unless offered measurable *proof*, the response we might offer is to suggest that the manager was demanding impossibly high standards which could never be reached by anyone! Despite this instinctual approach to quality of care and to high standards, there can be few of us who cannot relate horror stories of neglect, uncaring attitudes, rudeness or low morale which we have experienced or been told of. Somehow one such *bad* example takes on so high a profile that other examples of *good* practice fade into insignificance.

What service do *you* offer?

Patients and clients come and go through our hands. How sure are *you* of what *your* patients or clients think of the service you offer? How might you find out?

If, as we have shown, 'gut reaction' alone cannot give us the answer and even allows us to excuse bad practices, then we must look for ways of *measuring* performance so that we can compare outcomes with objectives and define the shortfall.

To do this criteria must be set which:

- look at the resources – human, structural, technological and financial – that are available (it is useless to formulate standards that are unrealistic in terms of what we need to achieve them);
- describe in detail the actions needed to achieve the standards;
- describe in measurable terms the expected and desirable results of the actions.

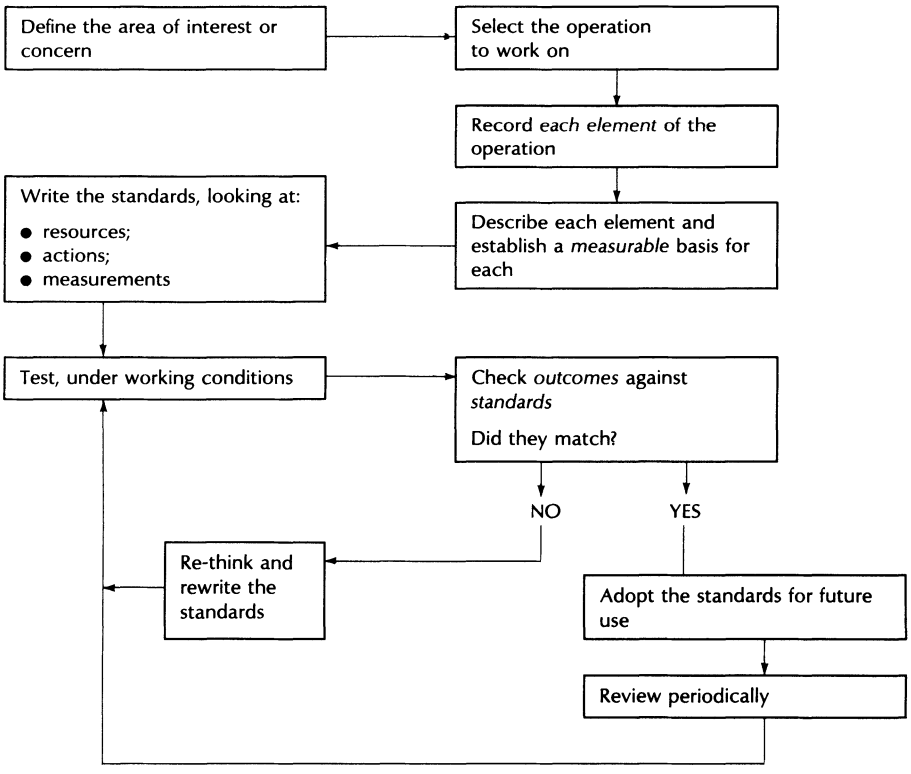

Figure 5.4 A model for setting standards

It has been acknowledged that standards must be monitored, compared with objectives, and shortfalls identified. It has also been shown that the final adoption of a standard is not the end of the exercise, but that there must be a review from time to time, and that adjustments may need to be made. These adjustments will mainly be concerned with a change in the job, with new or expanded objectives, or with changes in policy.

The most appropriate time to make such assessments and possible adjustments may be at the time of the Staff Development and Performance Review interview (SD and PR). (It must be stressed, however, that changes should be made at any time as they are needed: you, as a nurse manager, should have a continuing dialogue with your subordinates which is not dependent on a formal interview.) One of the purposes of the *formal* interview is to ensure that there is one point in every nurse's year when there is time for her to sit down with you in a calm unhurried atmosphere and review how you are working together so that your collaboration can be improved.

Working within employment legislation

You may, from time to time, encounter nurses whose standards of care regularly fail to reach the required standards. You will have to consider what action can be taken to rectify the situation. There are a number of possibilities:

- Discuss with the nurse concerned the shortfall between objectives and outcomes, and try to discover *why* this is occurring. (Be prepared to find that *you*, as the manager, are culpable in not giving enough support. Other causes may be found in the nurse's personal life and she may need help to resolve them.)
- If it appears to be necessary, rethink and rewrite standards so that they are more realistic in terms of resources, actions and measurements.
- Offer the nurse further training if it is obvious that lack of knowledge or lack of practice may be responsible for the shortfall.

Even so, you may at some time find that all attempts to help the nurse to achieve better standards have been exhausted without success. The only recourse then is to a disciplinary interview. (***Note:* This must not be confused with a *counselling* interview, nor should you describe the activity as counselling.**)

First-line managers are not generally involved in the dismissal of subordinates, but they may be asked to advise as to whether dismissal should take place. There is a need therefore for the greatest possible care to be taken in determining the difference between *capability* and *conduct*. Is the nurse culpable because she cannot do better? If so, she should be given further training or assigned to work that is within her capabilities. Or is she wilfully in default?

Nurse managers may be involved in disciplinary interviews, either conducting them personally or being present when they take place. You must therefore be aware of the correct procedures and ensure that these are always impeccably carried out. Most organisations have established procedures for such interviews; if you are unaware or uncertain of the correct procedure you should consult your personnel department or your senior manager. You must also have:

- a working knowledge of employment law;
- respect for the rights of employees, their professional bodies and their unions;
- knowledge of the procedures leading to dismissal.

It is all too easy to become antipathetic towards unions when a difficult shop steward seems to be for ever stirring up trouble, but the majority of shop stewards are anxious to do their best for their members and to help resolve any difficulties. Work *with* rather than *against* them. The results will be much more productive and working conditions more peaceful. Be aware that employees have the right to attend meetings of their unions or professional bodies within working hours, and shop stewards have the right to time off for their duties.

The main points to consider about dismissal procedure are these:

1. The employee must know what is alleged against her, and be given the opportunity to state her case.
2. She should be given the opportunity to be represented by her union or professional body.

3 If someone other than yourself is making the complaint, that person should be present so that it can be talked through by both parties concerned, with both being able to state their case.
4 Those taking part should be committed to getting to the truth and to resolving the difficulties if possible. No progress can be made if the only objective is seen as 'scoring points'.
5 Following the interview a letter should be sent to the employee describing in essence what was said and agreed. This letter is to be retained by the employee, and a copy, signed by her to say that she has *seen* it (not that she necessarily *agrees* with it) is returned to you. This copy is then placed in the nurse's records.

Justice can only be seen to be done if, when a noticeable improvement occurs following the interview and any training which may have been given, this also is noted in her record and the nurse informed that this has been done. It would be unfortunate if the need for discipline alone were to be recorded, with subsequent improvement going unmarked.

A record containing a disciplinary letter is a black mark against the person's future as a nurse. Such action must be considered very seriously in advance. Even the most recalcitrant of offenders may have it within their ability to improve; it is only just to look for and note any such improvement.

It is usual to allow three disciplinary interviews to take place before progressing to the final step which may result in dismissal. If any stage of the procedure is omitted, the entire process must be begun again.

Other employment legislation

In addition to the employment law relating to discipline and dismissal, there are other laws which the first-level nurse manager must be aware of.

Contracts of employment

You should ensure that each employee who works for you has a contract, and understands its terms. It should include:

- the job title;
- the date of commencement;
- the salary scale, and how and when salary will be paid;
- the hours of work;
- holiday entitlement and pay;
- pension rights;
- the period of notice;
- disciplinary rules and procedures;
- grievance procedures.

If a nurse has been given such a contract and understands fully all its implications she is better able to function adequately in her post.

Equal pay, sex discrimination and racial discrimination legislation

The nursing profession, originally thought of mainly as a woman's profession, does not suffer from inequalities of salary, but laws against discrimination of sex and race are of importance.

The rule says in essence that everyone must be treated equally, comparing like with like. For example, for the purposes of employment, a married woman must be treated in the same way as a married man. Specifications that would make the employment of either sex impossible are unlawful, though there are certain exceptions which are clearly laid down in the Act. Although at first-line level nurse managers are not generally responsible for advertising or appointing employees, it is wise to be aware of these Acts and their provisions, particularly as some of their philosophy applies to working conditions.

Racial discrimination could be deemed to have occurred if a white nurse were to be given opportunities for work or training for which a black nurse was not considered. Such matters are very difficult to prove but they *must* be guarded against *at every level.* Discrimination can be very subtle, and is usually well concealed except from its target.

Every effort must be taken to confront overt or covert sexual discrimination and racism and to make sure that those under your command are aware that

you will not countenance such behaviour. Standards of care can be affected by the unhappiness or disillusion caused by such discrimination.

Maternity rights

You should be aware of maternity rights and know the statutory rights to time off for antenatal care, leave of absence for the birth, and provision of a post on return. Allowances must be made for nurses who have the extra burden of pregnancy to cope with.

Health and safety at work

All employers, of which a first-level nurse manager is one by the delegation of some responsibilities, have a statutory duty to ensure, as far as is reasonably practical, the health and safety of their employees. It may well be, for example, that a nurse who scratched herself with an infected needle and contracted hepatitis would expect industrial compensation. The immediate manager would no doubt be considered accountable for failing to warn the nurse of the danger, or for taking insufficient care with training in good practices. Fire safety practice, too, is often a neglected area of safety in hospitals.

An excellent and reasonably priced book, *Guide to Employment Law* (see 'Further reading') should be referred to for detailed information. Personnel departments should be prepared to talk to first-line nurses and to help them understand the importance of employment law.

Conclusion

There are no short cuts to quality care or to its establishment and maintenance. It is, however, of the greatest importance to make sure that standards do not decline in the interests of economy; and today, perhaps more than ever before, nurses are being asked to look critically at *what* they do, *how* they do it, and what *effect* it has on those they serve.

This chapter has sought to discuss some of the philosophy of such care. Diana Sale's book in this series expands on this topic and offers details of setting, agreeing, monitoring and generally improving standards.

Suggested answers to the exercise on page 49.

1 Commitment to professional standards and continuous improvement of them.
2 Knowledge of the objectives of the NHS:
- at government level;
- within the nursing profession;
- at District and unit levels;
- at the coalface.

3 Ability to perform nursing tasks adequately at her existing level of knowledge, dexterity and seniority.
4 Awareness of personal attitudes, strengths and weaknesses.
5 Sensitivity to patients' or clients' needs and expectations.
6 The right to set her own standards and to discuss and agree them with her nurse manager.
7 The commitment of immediate superiors to support the nurse in her work, and to give her every assistance to achieve the standards which she has set for herself.
8 The provision of adequate resources, human, technological and financial, to enable the standards to be achieved.
9 The provision of ongoing training, and the time and resources to enable her to profit from its provision.
10 A desire and commitment to continue with personal development and with personal education.

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5 UKCC. *Code of Professional Conduct for the Nurse, Midwife and Health Visitor.* (United Kingdom Central Council for Nursing, Midwifery and Health Visiting. This code can be obtained from the UKCC, 23 Portland Place, London W1N 3AF; or from the RCN, 20 Cavendish Square, London W1M 0AB.)

Further reading

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