The NZNO Charge Nurse Survey 2010

Dr Léonie Walker

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Ph: 04 499 9533, Fax: 04 382 9993
Email: publications@nzno.org.nz
Web: www.nzno.org.nz

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PO Box 2128, Wellington

Tel 04 499 9533

Fax 04 382 9993

Written by Dr L Léonie Walker

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Executive Summary

28% of the 500 charge nurse members of NZNO completed an on-line survey exploring all aspects of their role. A sound basis has been established to guide a more in depth exploration of the important role of charge nurse, and recommendations related to the preparation for role, support, workload (especially concurrent clinical caseload), and authority have been made to ensure that charge nurses continue to deliver and improve patient care and to improve the morale, job satisfaction and retention of this vital group of staff.

Background to project

NZNO has approximately 500 Charge Nurse members, (exact titles differ between different employers and settings) Anecdotally, this is a group who experiencing considerable pressures, trying to balance their clinical responsibilities with their budgetary ones, and especially in the current climate, NZNO has conducted a survey of its charge nurse members, focussing on role definition, preparation and support. A particular emphasis was placed on Safe Staffing: and the survey was designed to allow comparisons both with the NZNO 2008 Employment Survey (to examine changes in perception since then) and with the SSHWPU survey of their three pilot sites (to allow for comparisons with non-pilot sites and to allow some triangulation of results in the SSHWPU evaluation.)

Introduction

Charge nurses are the front line managers of the largest staff group in the health service, the role combining managerial responsibility for both the delivery of care and for those who deliver that care. (RCN, 2009) The importance of the role has long been acknowledged, and the impact of the clinical and managerial leadership on quality of care underlined in study after study, yet apart from evaluation of leadership education programmes such as those provided by the RCN, until recently, the charge nurse role has received comparatively little research attention in the nursing literature when compared with other nursing leadership positions. (Cunningham & Kitson, 2000a; Cunningham & Kitson, 2000b) In New Zealand, seminal work in the 80's (Kinross, 1981) the preparation and role of the charge nurse was re-examined in 2004 by Williams in a nursing master's thesis.

More recently, in the UK, the role of the Ward sister / charge nurse has received much more attention(Ward sister role under scrutiny.2009). This was driven in part by the changes brought in by the Agenda for Change restructuring, and by the campaigns by bodies such as the RCN and the Nursing Standard ('Ward leaders should be empowered to improve standards'.2009; Give power back to the ward sister.2009)for the role to be re-invested with the authority and support to be able to manage wards effectively and deliver quality patient care and a contented workforce.(Griffiths, 2009)

Many of the newer developments in the NHS (for example "Modern matron", "Releasing Time to care") also require ward management to be invested in a charge nurse able to institute the changes(Waters, 2009a; Waters, 2009b) In particular, authority over budgets, and cutting of red-tape associated with relatively minor procurement decisions (Do ward sisters and charge nurses have the authority to do their job?2010; Patients suffer as sisters lose control of ward budgets.2010) were cited as crucial both for job satisfaction and patient benefit. Preparation for role(Foster, 2000), separation of clinical patient load and adequate training to ensure absence of role conflict have been found to be vital to the development of these nurse leaders.(Gray, 2009)

Method

A detailed survey was developed in conjunction with senior nurses and professional nursing advisors within NZNO, and piloted by 2 other charge nurse members of NZNO. The questions relating to SSHWPU were agreed with the researcher and project lead of the SSHWPU. Invitations were sent out to appropriate members either by e-mail, or by post (in the absence of e-mail addresses) Two

reminders were given. The survey was hosted on a secure web site, and ran for one month.

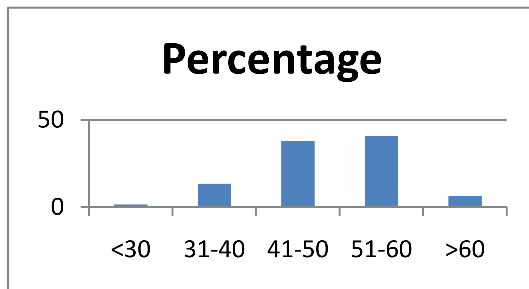
Results

538 Invitations were sent out. A 28% return rate was generated within the cut off time. A number were returned stating change of employment / role made them no longer eligible to take part, or with a wrong address. 138 valid responses were received from nurses still employed as Charge nurses (or equivalent titles)

Demographics

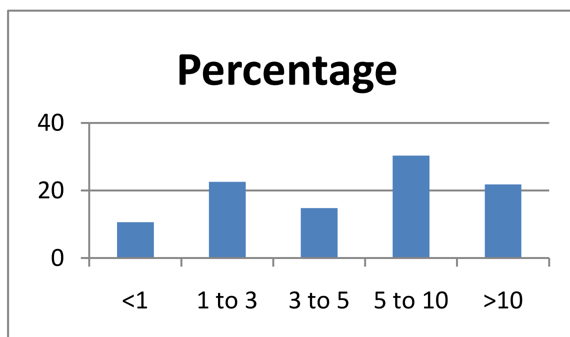
93% of respondents were female. This is the same as reported for total registered nurses in New Zealand http://www.moh.govt.nz/moh.nsf/pagesmh/6795/$File/current-state-nursing.pdf

The age profile (see below) is also similar, where 70% of nurse managers are reported as being over 45 years old.



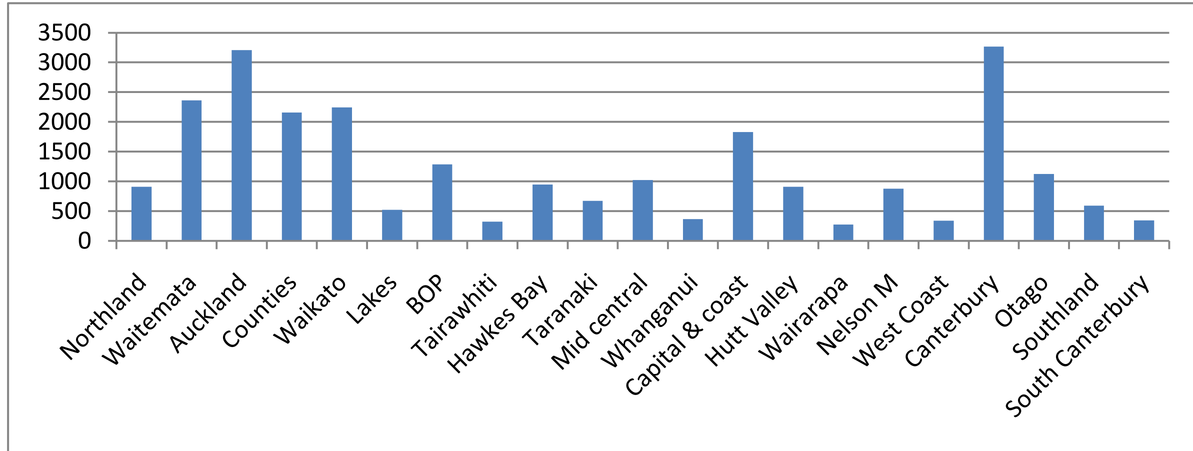
There was a wide range of job title. 44% were charge nurse managers, 28% clinical nurse managers. Of the 25% "Other" permutations on the words: clinical, charge, nurse, manager, leader, associate, specialist, or including a particular service or speciality area were described.

Years worked in current role are shown below.

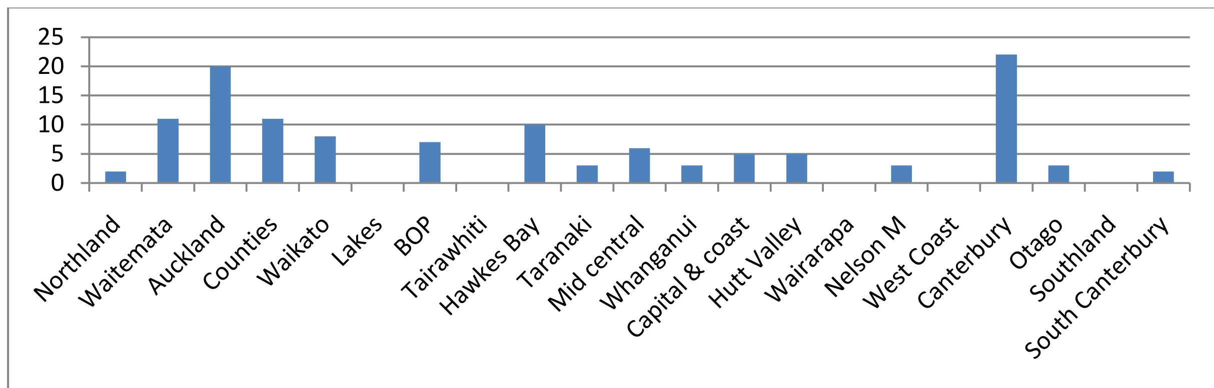


Employer by DHB

a) HWIP workforce data



b) respondents



It can be seen that the smaller DHBs are not represented, but that the numbers from all other DHBs are approximately in the same percentages. No one DHB returned more than 30 responses, and many of the others had fewer than 5 respondents, making comparisons of later items problematic.

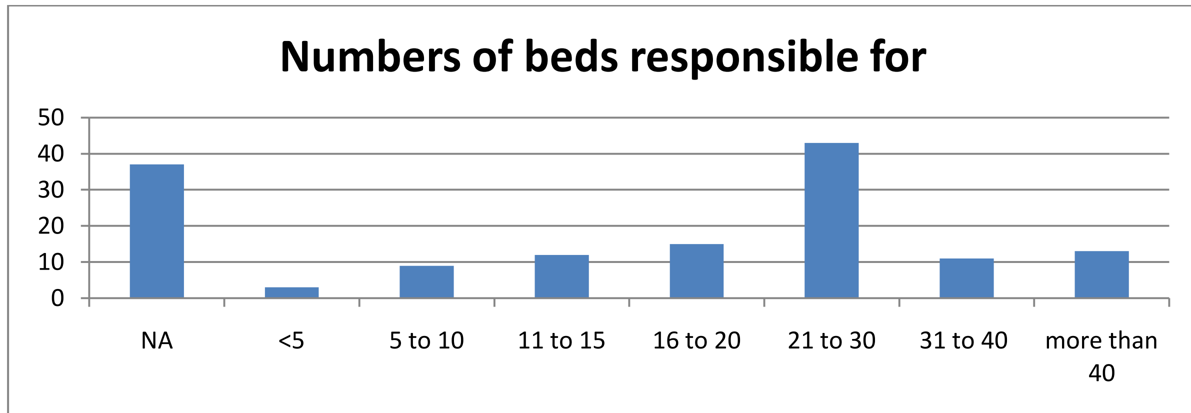
Key indicators throughout the report have been analysed by DHB. To preserve anonymity, on each graph, data for the measure has presented in increasing or decreasing order, rather than the order the DHBs were presented on the survey or alphabetically. The mean result for **all** DHBs combined is always shown using a purple bar. For the public report, one of the consistently high scoring DHBs, and one consistently lower scoring DHB were chosen, and their results are consistently shown using the same coloured bar (green and red respectively) throughout. Confidential individual reports may be prepared for individual Directors of Nursing in which their own DHB will be identified.

Facility type

70% work in inpatient facilities, 19% in outpatient facilities, 11% in the community, and a small number work across two or more facility types.

Bed numbers

For those working in the community or outpatient, this question was not applicable. The modal number of beds in the areas the respondents were responsible for was 21-30. (Numbers of respondents are shown)



Management responsibilities:

The mean number of Full time Equivalent staff each was responsible for was 23 (this ranged from 6% managing fewer than 5 staff, to 7% who managed 50 plus staff) , and the average head count making up this FTE was 28. Further examination of the meanings ascribed to the phrase “responsible for” is necessary. The complexities of line management, day to day oversight, professional oversight, degrees of authority over etc, are difficult to explore in survey format.

Safe Staffing

60.4 percent of respondents considered that overall, there were enough nursing staff to meet patient needs. However, of the 43 comments provided in relation to this question, there were some very common themes:

- Skill mix, in addition to total numbers is often more of an issue than numbers alone
- Acuity of patients is rarely computed into staffing requirements
- Fluctuations in both patient numbers and staff absence can create staffing problems
- Charge nurses often have a clinical role on top of their management role
- There were several comments indicating that workload and stress is not sustainable, either for themselves or for their staff.

One reported being overstaffed, and two reported being able to bring casual / pool nurses in whenever needed.

Staff management responsibilities

Type of staff	Mean number responsible for
Registered nurses	19
Enrolled nurses	4
Clinical nurse specialists	3
Clinical nurse educators	2 or fewer
Associate charge nurses	2 or fewer
Ward clerks	3
HCA / Care giver / hospital aide	6.5
SMO / RMO	7
Other	Range , see below

Other staff that respondents were responsible for included:

Technicians, Haemodialysis Technicians, Nurse Practitioner, typists, Administration/secretarial, Volunteers, pharmacist, Sterile Services Technicians, Paediatric Liaison Nurse (community based) , Physiotherapists , Diversional therapist, Clinical Educator, Pukenga Atawhai, Social Workers Researcher , Psychologist , Clinical Coordinators, Nursing students, Support workers, occupational therapists and needs assessors, Allied health team, Play specialist staff, clinical psychologists, recreation officers as well as ID team , Psychology, speech language therapy, Ranga Hauora, Anaesthetic Technicians, dental assistants and maxillofacial technician, volunteer meals on wheels drivers, Project Co-ordinator, Health Promoter, mental health workers, Booking clerks (surgical), Clinical Coaches.

It can be seen there is a wide range of other clinical, non-clinical and allied health professional staff that this group of managers is responsible for. A stated above, the phrase “responsible for” is likely to be interpreted differently by the different respondents. This aspect of the role is complex and rarely acknowledged in the literature, and may be better explored using focus group methodology. The tables below shows the actual numbers of responses in each category for the set of questions related to Safe Staffing (SS) The traffic light coding is indicative only, subjectively picking up the higher numbers of “desirable” responses and coding these green, or low numbers of “less desirable” responses being coded red, and intermediate responses being coded yellow or orange. This convention is followed throughout.

Safe Staffing (SS) Questions - frequency	Always	Usually	Sometimes	Never
Professional judgement about SS respected	23	80	29	5
Pressurised into taking more patients than you have indicated is safe	4	20	86	27
Appropriate additional staff provided on request	5	40	73	17
RN replaced by EN / HCA during shortages	4	9	58	64
When RN replaced as above, this is recorded formally	24	17	18	47

Safe Staffing Questions – Care compromised	Always	Usually	Sometimes	Never

Too few staff to provide safe care	1	7	111	15
Too few qualified staff to provide safe care	1	11	89	36
Inadequate cover from doctors	2	21	84	27
Staff working outside their scope of practice	1	2	51	81
Rostering insufficient to provide safe care	4	6	76	50
High staff sick leave	1	12	91	34
High staff turnover	0	6	55	72
Inadequate availability of equipment	6	8	84	40
Miscommunication between staff	0	15	111	9
Lack of admin support	10	15	85	26
Delays in patients being discharged	9	20	76	24
Pressure to take more patients than can safely be managed	10	29	72	21

While at first sight it might appear that there is a contradiction in the answers to questions related to pressure to take more staff, this is because in the first block of questions, the frequency of feeling pressured into taking more patients is examined, while in the second, where care is compromised, the frequency with which the pressure to take more patients than is felt safe contributes to compromised care is examined The difference between the two questions about pressure to take more patients than safe, indicates that actual care is not compromised as often as it is felt it might be. This may be due to additional effort and workload managing to keep patients safe or to misjudgement about requirements / safety margins in the system. One more senior respondent suggested than “sometimes the charge nurses feel safety is compromised, when in fact it is not” This might also be reflected in the 37 people who felt their judgement about safety was never or only sometimes respected. Differences in these perceptions between work sites with different models of care, or where workload planning tools such as Trendcare are used, or where acuity measures are included and where the workloads are adjusted for the patient requirements rather than bed numbers / occupancies would be an important area for more exploration.

Safe Staffing Questions - reporting	**Yes**	**No**
Can voice concerns about patient safety without fear of negative consequences	124	17
Has an escalation plan in place	115	23
Has reported a SS incident in last six months	48	94

Outcome of reporting a safe staffing incident

Safe Staffing Questions – reporting outcome	**Number**	**%**
Incident investigated, followed up but could happen again	26	54.2%
Incident not followed up appropriately	9	18.8%
Don’t know what action was taken	8	16.7%
Incident investigated, followed up and confident dealt with appropriately	5	10.4%

Free text comments related to Safe Staffing reporting

A wide variety of free text answers were given in response to reporting Safe Staffing incidents. These ranged from a confidence that risk and safety systems are in place and working well, and that patient safety is never, or rarely, compromised, through perceptions that budgetary constraints mean lack of suitably qualified cover, to a distrust and cynicism about Safe Staffing processes and reporting.

There is a concern for the loss of experienced staff, and a feeling that whereas at present nurses are prepared to be called back, and "go the extra mile", that this approach to management is not sustainable in the long run.

Where respondents had not reported incidents within the last six months, for 81% there had been no incidents to report, 7.5% did not have confidence action would be taken, 5% did not have time to complete a form, and the table below details the other responses, each from a different individual.

Safe Staffing explored by DHB

Overall Safe Staffing scores

The 17 staff who reported they couldn't voice their concerns about patient safety without fear of negative consequences came from only 9 DHBs. The DHB identified in red WAS one of these, the DHB identified in green was NOT one of these.

Other comments related to safe staffing

Again, there was a wide variety of free text answers given in response to the invitation to other comment further about Safe Staffing. There is a very wide range of perceptions from those who feel very adequately supported and able to backfill whenever needed, through to those who feel that decisions are based on fiscal rather than clinical judgements, and who feel therefore that patients are left at risk. There is also much evidence of professional and collegial loyalty and commitment, and filling in any gaps themselves. Three exemplar quotes are shown:

Firstly, an example of an appropriate and collaborative approach:
"If inadequate staff coverage then workloads adjusted to accommodate e.g. clinic appointments

cancelled, home visits postponed. Workloads adjusted as able which allows us to maintain safe staffing"

Secondly, an example of grudging acceptance of a less than ideal situation:
"Nurses have to get on with it but should be refusing to as the more this is allowed to happen it will become expected."

Thirdly, an example of obvious distress:
"If there are very sick patients on the ward and/or low skill mix it becomes exceptionally stressful but only the headcount of nursing staff is taken into consideration. At present we are not able to order any bureau HCA's to cover patient watch requirements as we are expected to use our own staffing matrix to 'watch' patients - this is clearly putting patients at risk and staff under increased pressure."

Responsibilities

The table below shows percentages of respondents with full, partial and no responsibility over the following aspects.

Responsibility	Full	Partial	None
Human resource management	**28.8**	**53.2**	**18**
Ward environment	**64**	**29.4**	**6.6**
Ward cleanliness	**52.2**	**40.4**	**7.4**
Patient nutrition	**49.6**	**30.7**	**19.7**
Developing and setting standards for patient care	**61**	**38.3**	**0.7**
Nursing practice / models of care	**59.5**	**39.7**	**0.7**
Business planning	**12.8**	**70.2**	**17**

The reporting by nearly one in five of no responsibility for patient nutrition may be further explored at a later date: it could be that respondents felt they could not influence the choices of food available or made, rather than that they did not feel that patient nutrition was a responsibility for them.

Budgetary responsibility
112 (78%) of respondents reported having budgetary responsibility. When this was further probed, 99 monitored their budgets, 90 managed it, and 30 were involved in setting the budgets. (Multiple answers preclude percentages) Other questions related to budgetary responsibilities are shown in the table below.

Question ---	Number of respondents answering YES
Budgetary responsibility	112
Preparation for budgetary role	17
Mentor for budget available	40
PD related to managing budgets	66

Free text answers related to the budgetary responsibilities further explain the input and limits to the budgetary responsibilities, and are shown below:

Comments related to the budgetary responsibilities
Answers ranged from those explaining the extent and limits of their involvements with budgets, to many who felt their power was fairly nominal or limited, being dictated by fiscal constraints rather than actual need. Some had good support from their DHB finance team: *“We work co-operatively with finance”* while others clearly felt out of their depth: *“I have never had formal handover or training regarding budget, but needs to manage it, don't even know what I can or can't sign off”*

Clinical Leadership:

Very high levels of responsibility for aspects of clinical leadership (as to be expected) were seen, but there were some activities which were slightly less frequently undertaken than others.

Activity	count	Activity	count
Oversight of standards of patient care	140	Consumer relations	122
Quality improvement	139	Policy development	121
Risk assessment	129	Rostering	119
Patient advocacy	129	Clinical supervision	115
Ward education	111		

Other aspects of leadership role
There was also a huge range of other activities classed as clinical leadership**.** Most came under the broad umbrella of HR functions, such as hiring, appraisals, performance management and team building, while other areas involved teaching or mentoring, committee work, clinical supervision or more strategic involvement in service design or policy development.

Preparation for role

Looking at whether respondents had received any pre-employment or orientation related training and assessment in any of the following key management skills, the results (as %) are displayed below.

Training and / or assessment	Full	Partial	None
People management skills	22.5	52.1	25.4
HR roles and procedures	19	49.3	31.7
Budgetary management skills	12.1	36.2	51.8
Clinical leadership skills	23.9	48.6	27.5
Systems management skills	17.1	47.1	35.7

In response to how the training and assessment had been provided or undertaken, the responses are shown below: (percentages not shown as multiple choices made)

Training and / or assessment	counts
In-house	113
Peer learning / learning sets	72
External to organisation	53
Formal / accredited	18

Additional detail was provided about how these skills and / or qualifications had been acquired:

Preparation for role

Of the 22 who reported having formal, accredited qualifications related to management, there were representatives from 10/21 of the DHBs. Interestingly none from the DHB (green) that scored well in all measures above had received formal accredited training, while many from the poorer scoring red labelled DHB had done formal training.

Informal
Informal preparation for role mainly involved learning on the job, with or without the support of mentors. In house Learning & development courses in leadership, recruitment & selection, coaching was also commonly mentioned.

Of those who reported formal training and or assessment, the range of courses and qualifications is shown below. They have been grouped into Management/Leadership, Other post graduate, & Other

Formal
Diploma in Management Post Graduate Diploma in Business (Health Management) Post Grad Dip Health Sciences (2 Nursing Leadership & Management papers and 2 Public Health Management papers). Post Grad Cert Management & Leadership University level 8 leadership and management in nursing, module leadership management MA in leadership (Overseas) University level 8 paper leadership and management in nursing Module leadership management
MN (CLIN) Master of Health Science (Nursing) Postgraduate Certificate in Health Science Endorsed in Mental Health. Postgraduate Diploma in Nursing.
EMA nzqi institute training Certificate of Quality in Health Care: Practical Skills. Change Management paper through CPIT auditors training – Health audit (also covered risk and quality management) DHB (HR dept) Assessment course DHB (HR dept) recruitment process

Other comments were invited related to the perceptions of preparation for role. These are shown below:

Other comments related to preparation for role
Many of these comments came from people who had come into their role at a time before such preparation was offered, and described career progressions based on experience and mentorship. The support and experience of their previous and current clinical nurse leadership was widely acknowledged. Particular programmes provided by various DHBs were also cited as being of real value. There had been a variety of preparation for role, which ranged from extremely helpful,

supportive management and/informal or formal training, to being thrown in the deep end and learning on the job. The importance of structured learning plans and mentors, links to others (especially finance / and HR) was frequently stated.

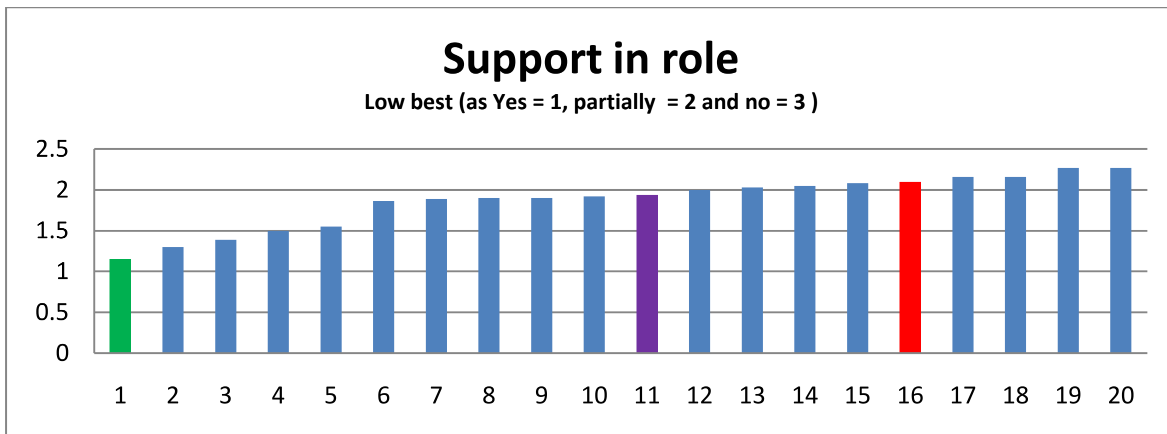
Support for role (counts from whole sample)

Support mechanisms	Yes	Partial	No
Orientation to role	43	59	40
Access to a management mentor	53	42	46
Access to a clinical mentor	45	37	54
Access to a financial mentor	44	41	54
Regular appraisals	85	36	22
Access to professional supervision	51	27	63

Support for role

This was another of the key aspects chosen for a DHB analysis. A simplistic coding of 1 for Yes, 2 for Partially and 3 for No was applied and a mean sum score across all elements calculated for each DHB and for all DHB's. The resulting graph is shown below.

Mean sum score for all six support elements, by DHB



Specifically, exploring support with issues related to performance management of staff, 99% reported receiving support with this difficult area – and the varied sources of support with performance management are shown below:

Sources of support with performance management
81/142 who answered this question mentioned HR as a source of support with performance management, and 16 mentioned their Director of Nursing. One who did not feel supported with this role reported paying for private supervision to help with this aspect of her role. 13/the 16 who mentioned their DON were also strongly enthusiastic and professionally satisfied by their jobs, and came from 9 different DHB's (one DHB had 4 respondents like this, the green DHB was one) whereas only 3 out of the 18 who did not receive support with performance management were so, these all came from different DHBs, and the red labelled DHB was one.

Professional development
This staff group are very supported with their [professional development: 94.2% had access to clinical PD opportunities, 84.9% to Management / HR PD opportunities, and 55.1% had access to financial and budgetary PD opportunities.

Priorities:

Priority	Rank
Work – life balance	1
Clinical Practice	2
Leadership opportunities	3
Take home pay	4
Professional development opportunities	5

There was a large margin by which work-life balance was selected as a top priority: this may be indicative of a section of the workforce who feel this is not currently a balance they are happy with, a stage of life phenomenon related to the average age being nearly 50, or to a feeling that salary additional to that which they are currently on is adequate. If focus groups are to be run, it would be interesting to explore this further, as it has potential implications both for the industrial side of NZNO (member's priorities) and for work force planning, as one of the striking effects of the 2004 DHB / NZNO MECA was that a significant number of nurses chose to work fewer hours. The 2008 NZNO employment survey found a near linear relationship between actual salary and satisfaction with salary except near the very top of the scales.

Salary

The mean salary for the 117 who answered this question was $80.73K per year, with the range being from $50K – $103K There were other comments, such as "not enough for what I do", " fellow MBA takes home $180K, another started on $125K" The salaries of those with formal qualifications in management ranged from 80-87K, and those with no formal management training ranged from 68-90K. (Many cited the scale, MECA step or $ per hour; these were converted for calculation of means)

Role –related morale

Questions in this block (except those marked *) were also asked in this format as a block in the 2008 NZNO Employment survey, and comparisons with those results for the nursing workforce as a whole are shown in the subsequent table.

Role related morale Questions - frequency	Always	Usually	Sometimes	Never
You are subject to unreasonable work demands	14	42	81	6
You have impossible deadlines for completion	5	28	86	23
You have inadequate resources to perform your job	10	32	77	24
You have insufficient autonomy to carry out your role effectively	11	16	69	46
You get inadequate support from colleagues	8	15	67	52
Your job is made more difficult by high staff turnover	2	4	53	81
Your workload is increased by co-worker sickness or holiday	6	18	86	33
*Clinical load is added to your management load	35	36	55	17
*Your wider organisational obligations take you out of the ward too frequently	9	25	83	22

Views –charge nurse survey 2010 versus NZNO employment survey Dec 2008 morale panel

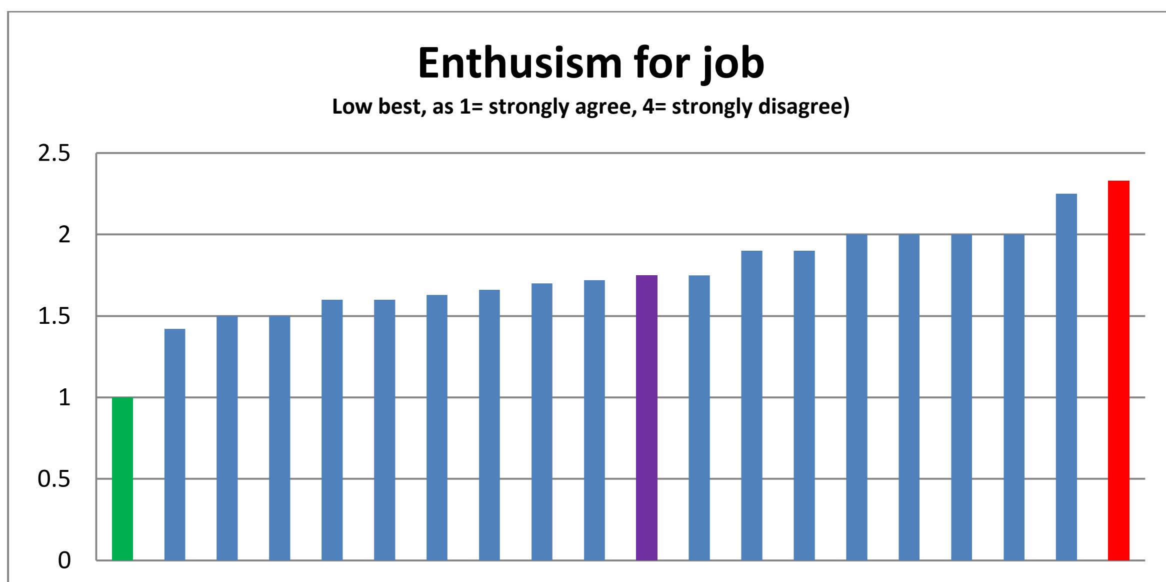
Statements / Themes	Agreement score charge nurses 2010 **Item scores (%)**	Mean score charge nurses 2010	Mean score total work force * 2008
1. Job satisfaction - **COMPOSITE**		**85%**	**80%**
Most days I am enthusiastic about my job	92.3		
I feel satisfied with my present job	80.4		
I feel my work is valued	78.3		
I feel part of a team	93.6		
I am able to practice autonomously	87.4		
My opinions about nursing are valued by my manager	81.8		
I find my role professionally very satisfying	84.3		
2. Workload - **COMPOSITE**		**54%**	**49%**
My workload is (NOT) too heavy	38		
I am (NOT) under too much pressure at work	57.1		
(NOT) too much time is spent on non-nursing duties	53.9		
There are sufficient staff to provide good care	66.9		
3.Pay - **COMPOSITE**		**50.1%**	**26%**
I am well paid considering the work I do	58.4		
Nurses are paid well compared to other professionals	41.8		
4. Quality of Care - **COMPOSITE**		**96%**	**88%**
The quality of care provided where I work is good	95.8		
5. Job security - **COMPOSITE**		**83%**	**82%**
I would find it easy to get another job with my skills	82.8		
6. Training - **COMPOSITE**		**78%**	**69%**
I am (ABLE) to take time off for training	74		
I am supported to be innovative at work	83.1		
I am able to keep up with developments to do with my job	70		
I have regular dialogue about my work with my manager	83.7		
7. Working hours - **COMPOSITE**		**65%**	**76%**
I feel able to balance home and work lives	65		
8. Bullying / Harassment - **COMPOSITE**		**54%**	**60%**
Bullying & harassment is not a problem where I work	54.2		

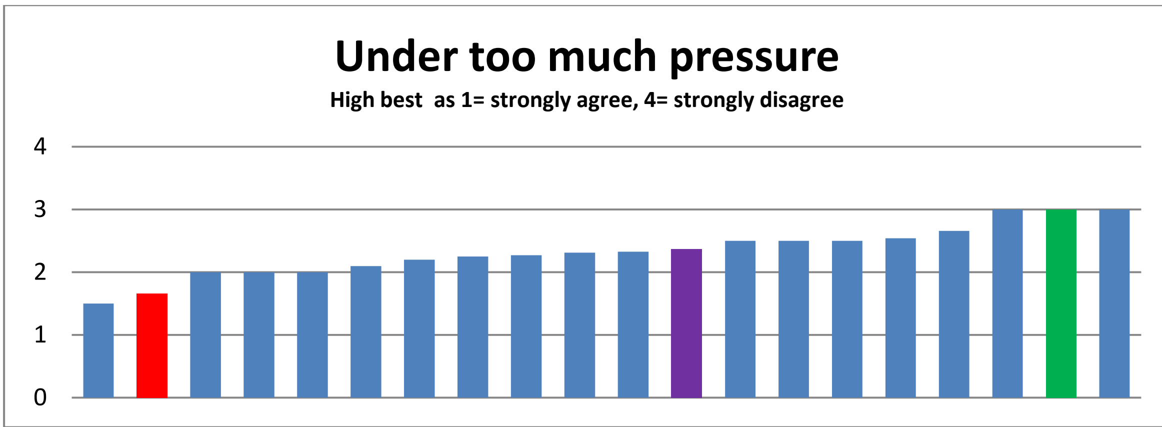
The analysis involved grouping statements into themes (highlighted) and adding the two figures for agree and strongly agree with the statement. These are then further summed and means calculated. There were some very minor differences in the actual panel of questions compared to the 2008 survey, and the best fit was selected where this was the case. Questions that were phrased negatively were inverted, and disagree / strongly disagree scores were computed this was to allow all to be presented as mean "agreement "scores. It can be very clearly seen that compared to the whole nursing workforce (late 2008) charge nurses score higher on ALL factors except work life balance. There is good agreement with findings from earlier, linked questions.

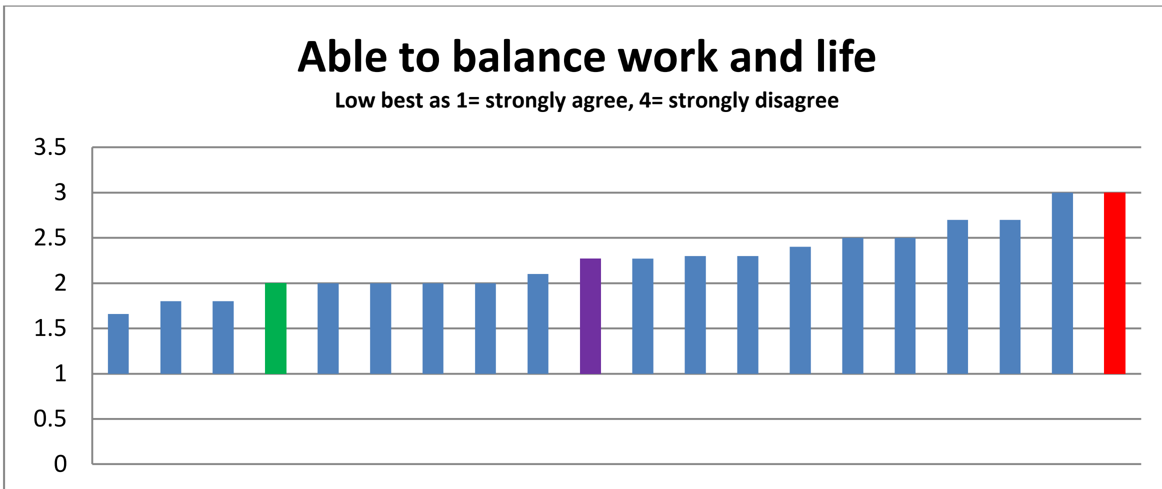
Many gave e-mail contact details, and indicated they would be prepared to take part in focus groups linked to this project.

Morale by DHB - This was also selected for analysis of differences between answers given by staff from different DHB's

In all the following graphs, purple shows mean for total sample, the red and green bars are the same DHBs throughout. Please note – these graphs merely document the averaged differences between answers for respondents from each DHB. Given the answers are Likert scale variables with only 4 options, caution should be exercises in interpretations. In some cases, the numbers involved are very small, and in all cases, it is not possible to state how *practically* significant any differences seen are. It is also not possible to separate out cause and effect from linked, contributing (confounding) variables. That said, there is evidence of patterns of some DHBs scoring well or badly on most indicators across the board. It would be useful to be able to correlate the rank order of composite "performance" scores with objective data such as vacancy rate, sickness rates and turnover, not to mention nurse-sensitive patient data.







The next set of analyses relate to the morale scores for respondents divided into 3 hierarchical groupings based on job title. This was performed independently by two colleagues. Although not an exact exercise, the 25 different titles were assigned a rank order, where 1 was a top level, 2 was middle, and 3 the least senior. This was to allow for later analyses

Table below – group assigned, by title

Title - hierarchy	group	Title - hierarchy	group
Clinical Leader	1	Associate Clinical Charge Nurse	3
Clinical Manager/ Director of Nursing	1	Associate Charge nurse	3
Charge Nurse	2	Associate Charge Nurse manager	3
Charge nurse manager	2	Associate Clinical Charge Nurse Manager	3
Clinical charge nurse	2	Associate Clinical Nurse Manager	3
Clinical Manager	2	Associate Clinical Nurse Manager	3
Clinical Nurse Leader	2	Charge Nurse Educator	3

Title - hierarchy	group	Title - hierarchy	group
Clinical Nurse manager	2	Clinical Charge Nurse Associate	3
Clinical services manager	2	Clinical Nurse Specialist	3
Inpatient Charge Nurse	2	Associate Clinical Charge Nurse	3
Nurse Manager	2	Associate Charge nurse	3
Theatre Charge Nurse	2	Associate Charge Nurse manager	3
Unit Manager	2	Associate Clinical Charge Nurse Manager	3

Analyses related to responsibilities and morale by job title / groups above are shown in the table below

Group (As above)	number	% with budget responsibility	Mean sum of all 4 items responsibility scores	Sum 4 positive morale scores	Sum 2 feel under pressure scores
			Interpretation		
			Lowest = most responsibility	lowest = most positive morale	lowest = feel under most pressure
1	2	50%	1.3	5.5	6
2	123	81%	1.6	8.04	4.1
3	12	50%	1.97	8.75	4.7

The large differences in the numbers involved mean that the differences should be interpreted with caution: however, the pooling of many items gives some confidence. There is considerable other research that has shown that the relationship between responsibility and stress is a complex one. One definition of stress is that it is responsibility without power, and it has been shown that autonomy and self-determination can more than compensate for responsibility in its impact on perceptions of work-related stress. The demonstration that the clinical leaders have the most responsibility and the highest job satisfaction despite feeling under the most pressure, and that the charge nurse group have more responsibility but less stress than the associate charge nurse group appears to bear this out. The associate charge nurse group appears to be the least positive and most pressured group. Other interpretations could be that those with most resilience and positive outlooks rise through the ranks to become leaders, or that leaders feel compelled to answer questionnaires in a positive light!

Final Comments section

The final section is the free text comments related to the “anything else you would like to add?” question, and these are presented in full. A preliminary thematic analysis is shown below. Some comments were coded in multiple themes, where they made several points.

Order	Theme	Frequency
1	Workload and Time pressures of role	17
2	High job satisfaction	15
3	Conflict between clinical & management roles, concern over clinical quality	14
4=	Concerns or disagreement about budget setting or adequacy	7
4=	A need for more support, both from union and higher management	7
6	Frustration with non-nursing tasks	6
7=	Work life balance, desire to work fewer hours / part time	4
7=	HR concerns and effects of restructures on morale etc	4
9=	Bullying culture / a role in creating a positive anti bullying culture	3
9=	Poor acknowledgement of role, including inadequate pay for responsibilities	3
9=	Well supported by higher management	3

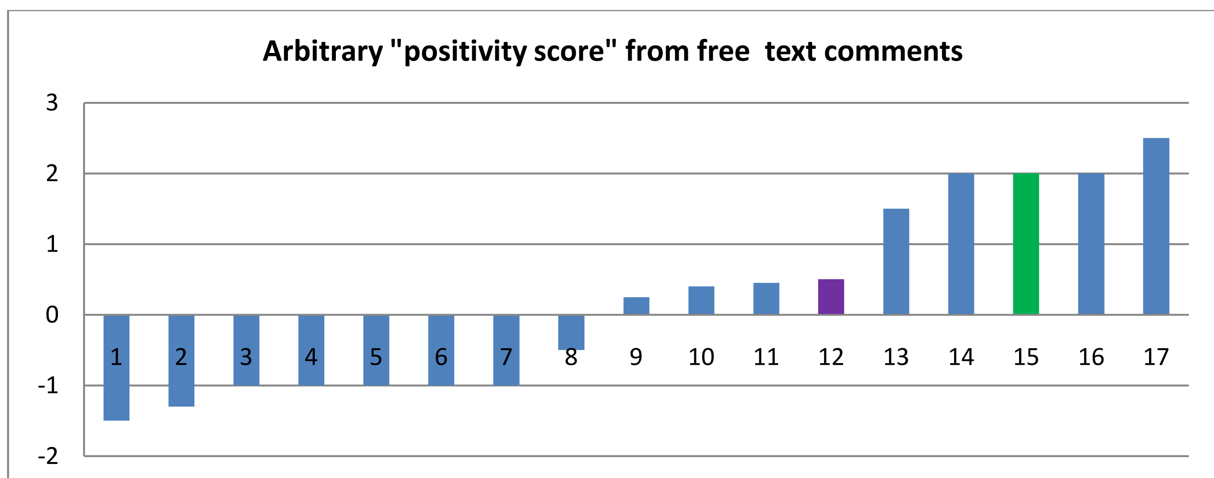
The comments were also assigned a score from +3 to -3 to denote how positively the respondents felt about their role. The coding was done independently by 2 people, and the differently coded responses discussed till consensus was reached. Exemplar quotes for each score are shown below;

Score	Exemplar quote
-3	*Role is a huge challenge - I find the fact that I feel like I am not performing in my role due to the workload that is expected of me very hard - It's very negative and draining.*
-2	*The managerial load is high and takes me away from the clinical area. It is not possible to improve the quality of patient care when away from the floor.*
-1	*While most days I am enthusiastic about my role I feel this has become less and less due to the increased workload and higher patient acuity, financial pressures, increased patient expectations, aging workforce, multi-skilling.*
0	*There are days when I love my job, where we make a real difference to patient outcomes and the whole Team is working well. The days I hate are those taken up with meetings and paperwork and the feeling that I am never achieving what I have to*
1	*Although we have been through a restructure of our department the general staff in the department feel well supported*
2	*Love that every day is so very different. From managing the varied demands of the managers role, to meeting the needs of each patient and their families to fostering a supportive, fair and dynamic nursing team who all have individual needs as well!*
3	*I have waited for 5 years to get the job I currently have. I regard it as my dream job and am very excited about the next 10 years. I look forward to make a positive contribution to nursing*

Looking at DHBs, mean positivity score is shown below – (no responses were found from the DHB previously identified by the colour red) The list, as per previous convention, is in score order.

DHB	Arbitrary "positivity" score	Number of respondents from each DHB supplying a final comment
1	-1.5	3
2	-1.5	3
3	-1	2
4	-1	2
5	-1	1
6	-1	2
7	-1	2
8	-0.5	8
9	0.25	5
10	0.4	4
MEAN	0.45	45
12	0.5	3
13	1.5	4
14	2	1
15	2	2
16	2	1
17	2.5	2

This is also shown in the graph below, (no comments from the "red" DHB were received)



While this is a subjective exercise, and based on small numbers, it again illustrates that the picture seen in the item elements in the morale question block do tally with the free text feelings about the role as expressed in the final invitation to comment, and that there are big (though not necessarily statistically or practically significant) differences between the responses from staff from the different DHBs.

Discussion

This survey has confirmed that nurses charged with responsibility for staff and wards are far from uniform in their exact roles, responsibilities, qualifications, support and rewards. It also found that there is considerable variation in the overall job satisfaction, morale and confidence in Safe Staffing processes between those employed in different DHBs and occupying different levels in the nursing hierarchy. In common with other studies, pressure, satisfaction and responsibility are not necessarily causally linked. However, autonomy, support and preparation for role are all linked to role satisfaction and perception of workload. One striking factor linked (not necessarily causally!) to positive enthusiasm and job satisfaction was to be found in the section related to where (if anywhere) support with performance management was obtained. There was a positive correlation between this and *specifically* mentioning the Director of Nursing in a free text answer – support for the role of DON in morale and job satisfaction among middle managers. The finding that a significant minority of charge nurses felt unable to report Safe Staffing incidents for fear of negative consequences is worrying on many levels. Firstly, it is indicative of a climate of mistrust linked to reduced job satisfaction, and secondly, studies have consistently shown that that in settings where staff feel able and are supported to report errors or near misses, patient safety, and their satisfaction is highest (Nursing Standard, 2008) Clinical and managerial leadership are key indicators linked to patient outcomes, and nurse workload, staffing levels and clinical leadership have been included as indicators of the quality of nursing care in the UK (Govier, 2004)
Common findings with the 2009 UK RCN report included:

- A broad and variable role, including as it does management, clinical leadership, clinical practice, education and teaching.
- Evidence of difficulty balancing the different aspects of the role
- Theoretical responsibility for many key aspects of patient care, but a lack of authority over the resources needed to assure them
- A deficit in the training and preparation for many aspects of the role, especially the budgetary responsibilities.
- Workloads and competing pressures that are undermining work life balance and may compromise job satisfaction long-term.

Recommendations from the RCN to ensure the success of ward sisters or charge nurses included the following – all endorsed by this New Zealand study.

- Managerial support and recognition.
- Human resources advice.
- Feeling valued.
- Training and education.
- Administrative support.
- Good 'work-life' balance.
- Sharing experience and knowledge.
- Succession planning.

Areas for further in depth exploration raised by this survey include:

- Consultation with Charge nurses following the release of the report to examine the levels of agreement or disagreement with the results, and to establish their priorities for improvements to the role, preparation and support.
- Changes in perceptions of this key staff group following the restructuring exercises underway in many DHBs
- Match / mismatch between formal qualifications or in house training and the knowledge and skill set required for the role
- Mechanisms and strategies to foster best practice both of the performance of the role, and the support structures required for the role
- Factors contributing to a culture of openness and confidence at all levels in the nursing leadership
- Flexible work patterns and workloads required to ensure a sustainable work life balance
- Comparisons with the NZNO Employment survey to be undertaken later in 2010, and with the evaluation of the Safe Staffing Healthy Workplace evaluation study currently underway are warranted.
- It would really be of interest to correlate the rank performance against key indicators from this survey with objective data about workforce, workload, patient outcome, quality and economic performance data for the different DHB's.

Conclusions

Notwithstanding cautions with interpretation due to small numbers and arbitrary, subjective Likert-type scales, and potential respondent self-reporting bias, a sound basis has been established to guide a more in depth exploration of the important role of charge nurse (and associated linked job titles) With the adoption in New Zealand of programmes and initiatives such as Productive Ward from the UK, it would seem appropriate to also adopt the accompanying changes introduced to support the role of the charge nurse (sister) in the UK to the preparation for role, support, workload (especially concurrent clinical caseload) authority and relative financial reward to ensure this vital group of staff. This will be essential to ensure that charge nurses continue to deliver and improve patient care, and to improve the morale, job satisfaction and retention of this vital group of staff

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