

**The Leadership Experiences of the Assistant
Directors of Nursing in the
Dublin Academic Teaching Hospitals (DATH)**

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September 2018

Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Education is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Date: 11th September 2018

Acknowledgements

I would like to thank Michael, Cora and Patsy for all their patience and support through this journey. I would like to say a special thank you to Mary Wynne and my work colleagues, Teresa, Marie and Georgina, for all the support and kindness they have shown me along the way. Thank you to my family who put up with me through all events and a very special thank you to Dr Pauline Joyce and Prof Jerry McNamara and I send him my very best wishes. A very special thank you to Dr Shivaun O'Brien for her patience and support without whom neither I nor the thesis would have survived.

I dedicate this thesis to Ronan and Mary - never forgotten.

Abstract

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Title: The Leadership Experiences of the Assistant Directors of Nursing in the Dublin Academic Teaching Hospitals

The profession of nursing has undergone significant change in the last century but more so in the last two decades since the Report of the Commission on Nursing (1998). This Report is highlighted because of its significant contribution to the advancement of the profession. It heralded radical change both in education requirements and the structure of the profession. This study took place at a time when the Department of Health was in the process of developing systems to restructure the acute hospital system in Ireland into seven hospital groups with the objective of eventually converting the groups into Hospital Trusts similar to the English system.

The aim of the study was to explore the leadership experience of the Assistant Directors of Nursing (ADON) in five of the six Dublin Academic Teaching Hospitals referred to as DATHs. Both the historical context and the current role of the nursing profession were explored including the role of the Assistant Director of Nursing.

Twenty participants were interviewed using phenomenological methodology with Giorgi's Framework being used for analysis. The role of the ADON was found to be multifaceted and is discussed in the context of the characteristics of transformational and transactional leadership. Themes identified included aspects of both these styles of leadership with a strong emphasis on Governance and patient safety.

The essential meaning structure of the phenomenon that was highlighted in the study relates to the balance the Assistant Directors must maintain between their clinical role and their management role. At the time of the study, Ireland (and the world), was in an economic crisis and this was reflected in the health service budget. This was mirrored in the experiences of the ADONs. In their managerial role, they were given directives for budget savings while in their clinical professional role they were managing the clinical environment with staff shortages and a moratorium on recruitment with resultant governance and patient safety concerns. Patient safety concerns were paramount with this group and remained so when cutbacks and workloads became more demanding.

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Chapter 1

Introduction and Context

1.1 Introduction and context

This chapter will set the context and background to the development of the nursing profession from the poor uneducated servant to the professional well-educated nurse in the health service today. The rationale for the study will be explained, the structure of the thesis, the research question and the aim of the study are documented. The role of the Assistant Directors of Nursing (ADON) in the acute hospital as well as their roles will be explored. The position of the 5 hospitals in the health service, The Dublin Academic Teaching Hospitals (DATH), which participated in the study, is also explained. The historical context and the reform of the hospital system together with the apprentice training model and its evolution to a highly educated nurse are described. The Report of the Commission on Nursing (1998) is examined and its significance for the profession particularly for the changing roles for Directors of Nursing and Assistant Directors of Nursing – known as Matron and Assistant Matron prior to this report. Policy development in more recent times and its impact on nursing and the role of the ADON will be examined.

In 2005, there was considerable restructuring and rationalisation of the health services in Ireland when the Health Service Executive was established. Following this there was the fiscal crisis with resultant budget cuts and a moratorium on recruitment of staff including nurses. There were also early retirement packages offered across the services with a number of nurses of all grades taking advantage of this opportunity. The result was a reduction on the number of personnel, including nurses, across the service.

Following on from these events, strong leadership in health care has become more important than ever and is a very relevant topic in the Irish healthcare system in recent times. The current Director General of the Health Service Executive is a strong proponent of leadership development in the health services and supports

two-day masterclasses in Leadership annually for senior and top level leaders in Healthcare. Directors of Nursing (DON) and Assistant Directors of Nursing (ADON) would be in a position to attend these masterclasses. There are a number of MSc programmes on leadership in higher level institutions with a myriad of short programme, ranging from one day seminars to eight day programmes, throughout the health sector. Undergraduate nursing degree programmes also have a leadership module. All nurses applying for a post with a management and leadership role now require, in addition to the required nursing qualifications and registration with the nursing governing body the Nursing and Midwifery Board of Ireland (NMBI), a qualification in management or leadership. All management programmes have a leadership component. Since 2016, the ADON's job description for the acute services in the HSE requires a postgraduate qualification in a management related area in health care of not less than level 8 (Appendix 1). In reality, a number of nurses will have level 9 qualifications in management and/or leadership. Leadership responsibilities are also documented in the job description for all ADONs, both Directorate Nurse Managers and ADONs in a more hospital-wide role (Appendix 2 and 3).

In my current role as Deputy Director of the National Leadership and Innovation Centre for Nursing and Midwifery, Office of the Nursing and Midwifery Services Director, HSE, I commission a number of short leadership programmes for senior leaders in nursing. In this context I encounter ADONs across the services and discussions indicate that the leadership role varies considerably while in some situations is more focused on operations management. Following discussion with a number of these programme participants and senior colleagues in the service, and in light of healthcare changes and the role of the nursing profession within the health sector, it was an opportune time to explore the role of the ADON in relation to their perception of their contribution to issues of leadership within their own hospitals and the changing healthcare environment. For the purpose of this study I focused on the leadership role of the ADON in the Dublin Academic Teaching Hospitals.

1.2 Rationale

In recent years leadership has become one of the most talked about issues in the health services. There has been a proliferation of programmes and events recognising its importance in delivering high quality, safe care. However failings in the system have often been blamed on poor leadership (The Mid Staffordshire NHS Foundation Trust Public Enquiry 2013)¹ and (HSE Midland Regional Hospital Portlaoise Perinatal Deaths (2006-date) 2014).² The development of the nursing profession has its historical roots in the concept of subservience to the medical profession and also in the administrative function of the health sector (Carney 2006) but not in leadership at that time.

Historically, the environment surrounding nursing was strict and controlled with good behavior, obedience and dedication absolute requirements. The qualities of a good nurse were restraint, discipline and obedience (Fealy 2006). Matrons, as they were known then, were generally not seen as having a leadership role but were the implementers of healthcare policy rather than active participants in the process. This concept has changed radically with leadership seen as a key component across the health service for the safe effective delivery of care (Howieson and Thiagarajah 2011).

The Dublin Academic Teaching Hospitals (DATHs) are among the largest and most prestigious hospitals in Ireland having not only a number of specialty areas, but also some national specialties and designated Centres of Excellence. The Directors of Nursing (DON) within this group are perceived as having a key role in the development of policy and planning, not only in their own hospitals, but in the wider health developments in Ireland. The ADONs in this group of hospitals would be considered as having achieved considerable status in the profession and would be at the top of their careers as ADONs. They would be perceived as

¹ The Mid Staffordshire NHS Foundation Trust Public Enquiry (2013) is generally referred to as The Francis Report and will be referred to as The Francis Report (2013) for the remainder of this study.

² The HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date) (2014) is generally referred to as The Portlaoise Report (2014) and will be referred to as The Portlaoise Report (2014) for the remainder of this study.

potential future Directors and leaders of the nursing profession and also eligible for upward and lateral promotion within the health sector.

The fiscal crisis over the last number of years indicates that now more than ever the services delivered must be accessible and appropriate for those seeking medical and nursing care. The best way to ensure this is through organisational excellence which can only be achieved by engaging in effective leadership activities and a fully integrated governance system, which includes not only the administrators, medicine and other professions, but also the nursing profession including the ADONs.

1.3 The structure of the thesis

This Chapter provides the background and context to the study. The rationale, research question, the number of participants and the Dublin Academic Hospitals are described. The historical context of nursing in Ireland is explored with an overview of its development to the present day. The apprentice model of training will be reviewed with reform of the training system up to the introduction of degree status to register as a nurse in Ireland. The Report of the Commission on Nursing will be reviewed in relation to the ADON, leading up to the current role with policy developments impacting the profession. Chapter 2 will provide an overview on the current studies on leadership including theories of transformational and transactional leadership and new paradigm leaders. Aspects of followership, power and influence and decision-making will be reviewed. Governance and organisational excellence will be reviewed as well as self-image and self-confidence. Bourdieu's theory of practice or theory of social structure will also be presented. Chapter 3 will present the methodology. The underpinnings of phenomenology will be explored as the methodology used to carry out this study. Sampling, data collection and all ethical considerations are discussed. Giorgi's framework (1985) for data analysis is also documented and how it was applied to this study. Chapter 4 will present the findings of the study with participant perceptions and relevant literature to underpin discussion. Leadership role and style, decision-making, governance issues and cultural issues

are also presented in the findings. Chapter 5 will present a synthesis of the findings of the study together with its strengths and limitations and finally recommendations.

1.3.1 The aim of the study

The aim of the study is an exploration of the leadership experience of the ADONs in order to describe the phenomenon of their leadership role in their own hospital setting.

1.3.2 Research question

The research question was ‘What is the leadership experience of the Assistant Director of Nursing (ADON) in the Dublin Academic Teaching Hospitals in the Dublin area?’

1.4 The position of the Assistant Director of Nursing

The position ADON in the acute hospital lies between the Clinical Nurse Manager 2, who is the ward or unit manager, and the Director of Nursing. An organisational chart is attached (Appendix 4) and a nursing organisational Chart (Appendix 5) demonstrate this. The Irish hospitals system comes under 4 bands from the largest to the smallest in bed numbers. The band 1 hospitals are the largest acute care hospitals in the Ireland. The Dublin Academic Teaching Hospitals are acute Band 1 Hospitals. The focus of this proposed study is to explore the leadership role of the Assistant Directors of Nursing in their own hospital setting. These ADONs have a very wide brief including clinical roles as well as management roles and are usually in charge of a number of units or departments. They have varying titles but all are at the grade of ADON. For this study, the titles of participants included ADON, Directorate Nurse Manager and Divisional Nurse Manager. There is one ADON who had just moved into a new established role called a XXX. There is no discernible difference between the role of the Divisional Nurse Manager and the general ADON. The only difference is that the hospital is divided into sections called divisions and the ADON is in charge of that division.

20 ADONs participated in this study from 5 of the 6 Dublin Academic Teaching Hospitals ((DATH). This hospital grouping is explained in 1.3 of this chapter. The 20 ADONs comprised the following:

- Directorate Nurse Managers X 8
- Divisional Nurse Managers X 2
- XXX ADON X 1 (This role was newly established at the time of the study)
- ADONs in Mental Health X 2
- ADONs with a hospital wide role X 2
- ADONS with Education Brief and clinical role X 2
- ADONs with an Out of Hours role X 3 (the hours were between 4pm and 8am the next day).

Appendix 6 outlines a table of the hospitals and the number of ADONs and their role in the hospital. A number of transcripts were sent out for the approval of the participants with the proviso that if I did not get a reply within two weeks I would assume approval and include them in the study. Two participants required further information which was sent and accepted.

1.4.1 The role of the Assistant Director of Nursing (ADON)

The role of ADON is both operations management and leadership. They provide professional and clinical leadership and ensure standards are maintained at all times. S/he has a leadership role in ensuring the quality and safety agenda is at the forefront of patient centred care and the principles of good governance are upheld through collaborative practice and maintaining the highest standards. Implementing the service plan and achieving targets while staying within budget are also part of the management role of the Hospital ADON and the Directorate Nurse Manager. Staff development, new developments and the quality care metrics are also their part of the role. Quality care metrics include National Early Warning Score (EWS), falls, wound care and risks. They have an extensive operations management role with responsibility for a number of services and departments within their area of responsibility ensuring the services function

smoothly on a daily basis. Issues such as staffing levels, relocation of staff, patients waiting on trolleys, bed shortages, complaints and meetings are all daily matters. Supporting front line staff, particularly through times of staff shortages, is also high on their agenda.

All the hospitals have a Nursing Executive Committee and All ADONs are members with the Director of Nursing as Chair. Each ADON represents her area at this committee as well as more general issues such as the moratorium on staff employment and general budgetary issues. It sits every 1-2 weeks – this varies depending on the hospital. They are also members of other committees and subcommittees throughout their respective hospitals. A limited number sit on committees outside the hospital.

1.5 Historical context

The development of the nursing profession has its historical roots in the concept of subservience to the medical profession (Fealy 2006) and also in the administrative function of the health sector (Carney 2006). Nurses carry out their role within a bureaucratic hierarchy in the hospital system which in the past was determined by medicine. In the 18th and 19th centuries, both in Europe and North America, with the advance of industrialisation, urbanisation and social change, considerable poverty followed (Fealy 2006). Ireland at this time was under British rule and was also experiencing considerable poverty.

In Ireland, encouraged by the Nightingale school, most of the Irish voluntary hospitals had nurse training schemes in operation by the end of the nineteenth century (The Report of the Commission on Nursing 1998). The first training for nurses was established in 1858 by the Adelaide Hospital. Others followed including Dr. Steevens, The Royal City of Dublin (Baggot St), The Meath Hospital and Sir Patrick Duns (Cited in The Report of the Commission on Nursing 1998).

After the 1820s Dublin had 30 hospitals where medicine flourished and was described as the 'Golden Age of Medicine' within Europe (Fealy 2006: 16). Medicine was practiced in the voluntary hospitals and so they became the locus of this Golden Age where teaching and research began to be established (Fealy 2006). In this context, the voluntary hospital became the most influential domain of the medical profession (Fealy 2006).

While medicine flourished in the voluntary hospitals, nurses, mainly uneducated and untrained, provided care and had the status of servants whose duties included domestic and household as well as care of the sick. The consequence was that nursing care was of a poor standard (Fealy 2006). These poor standards became a great cause for concern in the 1880s in Dublin mainly as it did not serve the needs of the renowned medical profession in the voluntary hospitals at this time (Fealy 2006). Nurses were seen as servants from lower classes, coarse and unreliable where medicine required '... a nurse properly trained in the care of the sick and acting under the direction of the medical man...' (Fealy 2006: 19).

1.5.1 The 'good nurse'

The concept of the 'good nurse' emerged in the 1900s and in the 1950s the 'Good Irish Nurse' was seen to be '...professional and hardworking, obedient and unquestioning....' These, as well as kindness and being considerate, were espoused as features of Irish Christian ethos (Fealy 2004: 653). By the 1960s discussions began about the contribution of the nurse to healthcare and by the 1980s the international concept of new nursing had emerged including new conceptual models and approaches to care delivery such as Primary Nursing (Fealy 2004). This challenged the medical model and promoted the autonomy of nursing as a profession. By the 1990s the concept of the good nurse was discarded and the role of the nurse seen as far more complex with knowledge, skills and competence crucial to the role. Although held in high esteem, the prevailing public concept of nursing remained as that of the implementer of the doctors' orders.

Although the catholic religious orders had considerable influence on the ideal nurse in the 20th century, the increasing diversity in the profession in the later part of the century saw this considerably diminished. Fealy (2006) argues that the idealised image of nursing did not serve nursing well and supported the reality of 'training' under the thumb of those with influence and power as opposed to promoting an educated autonomous profession.

1.5.2 The apprentice training model

The Dublin Metropolitan Technical School for Nurses was the school for Dublin supplying this apprentice method of training in the 1900s. It was eventually disbanded in 1969 as the voluntary teaching hospitals had begun to take over this function with the appointment of Nurse Tutors in their own hospitals (Fealy 2005). Until this time the majority of classes for students were taught by physicians with the environment still being that of dominance and subservience, with 50% of nursing schools in Europe having a physician as principal. As a result, nurses had no clear concept of the real meaning and fundamental nature of nursing.

In Ireland, the apprentice style of training was legalised in the 1919 Nurse Act and continued through the 20th Century. The programme was described as an "apprenticeship" model of training (An Bord Altranais 1994) and allowed for two programmes per year. This traditional style of training offered nurses very little educational opportunity (Fealy 2006). Nurses completed this highly practical and task oriented programme which shaped obedient and unquestioning nurses (Coughlan 1995: Condell 1998). This training was mainly carried out while on the job. The student nurse was paid a salary and so had a dual role of both learner and employee (An Bord Altranais 1994) with 3rd year students often acting as the senior nurse in charge. The qualities of a good nurse were restraint, discipline and obedience with the students being part of the workforce (Clark et al 1997). This traditional style of training offered nurses very little educational opportunity.

Internationally, the apprenticeship method of training nurses prevailed. In Ireland, this apprentice style of training was legalised in the 1919 by the Nurses' Act and continued into the 1990s. In this environment, the role was strictly controlled with good behaviour, obedience and dedication being absolute requirements. Apprentice type training for nurses continued through the 20th Century up to the 1990s when the model was reviewed (Condell 1998).

Following a number of reports, it was evident that this apprentice-type training was not sufficient for nursing in the future (An Bord Altranais 1994; Condell 1998). The changing needs of society, advancing technology and increasing demands of a more discerning society convinced the nursing population that this model of training was totally inadequate. Following a review of nurse training by An Bord Altranais in 1994, the nursing diploma programme was established (Condell 1998). Despite some criticisms, for the first time nurses had supernumerary status with formal support in the clinical area. It was recognised that nurses need to be knowledgeable, autonomous and critical thinkers. To achieve this, it was acknowledged that education and training should be based on scientific research principles.

The establishment of degree status for registration as a nurse varied from country to country. In Canada, university education dates back to 1919 when the first Baccalaureate programme was initiated in the University of British Columbia. In Israel, from the outset, nurse education was established at diploma level and in 1975 degree status was established. This was brought in on a phased basis unlike Ireland where radical change saw degree status implemented overnight on a national scale.

In a review in 1998, in looking at the role of the nurse from 1980 – 1997, Condell (1998) found that historically the role of the nurse was that of servant with very little Irish literature referring to the role. In the 1970s postgraduate education courses in nursing emerged in Ireland from stand alone modules up to Masters' level programmes with a number of these being well established before degree

status for nurses was launched. In the 1980s Specialist Nurses emerged in a number of different specialties but a lack of role clarity meant a lack of standardisation of competencies or education requirements (Condell 1998).

1.6 Reform

Reform of the hospital system began in London in the early 1880s and extended to the Irish Catholic hospitals in the 1890s (Fealy and Harford 2007). In Ireland, the religious orders were at the forefront in caring for the sick which grew in the 19th century together with lady-nursing. The lady-nurse was seen as coming from a better social class than the previously untrained nurse from the poorer social class. By the end of the 1800s, the educated lady-nurse from the lower middle and gentle classes replaced the uneducated nurse (Fealy 2005). These reforms, as well as the caring role, included nursing management being in charge of reform of the domestic, laundry and cooking utilities. To this day in some cases, domestic and household matters are part of the nursing brief.

Until the end of the nineteenth century, in the religious owned hospitals, most of the nursing duties had been carried out by religious nuns who had informal training within their own communities and promoted nursing as a vocation while Nightingale promoted nursing as a profession for lay women. As the other hospitals progressed training schemes for nurses, The Mater Misericordiae Hospital established its school in 1891, followed later that year by Jervis Street, with St Vincent's Hospital in 1892 (The Report of the Commission on Nursing 1998; Condell 1998). (Jervis St Hospital later moved to what is now Beaumont Hospital).

These reforms still kept nursing under the control of medicine and therefore lacking autonomy in its own right (Fealy and Harford 2007). However, despite the male dominated world of healthcare in the hospitals, there were those, such as Margaret Huxley and Annie McDonnell, who in the early and mid-19th century, advanced the professional role of the nurse in areas of caring, education and management (Fealy and Harford 2007; Tracey and Hyde 2003). Modern nursing

developed from the involvement of women such as these caring for the sick and they became the first leaders of modern Irish nursing (Fealy 2005).

1.7 The Commission on Nursing

The role of the nurse in Ireland has radically changed since the publication of the Report of The Commission on Nursing *A Blueprint for the Future* in 1998 (Department of Health 1998). Unrest among the nursing profession in relation to parity and equity with other healthcare professions lead to the setting up of the Commission on Nursing in 1997. It was set up by the Minister for Health to examine the issues of changes in both training and service requirements for nurses. An extensive report was published in 1998 (Department of Health 1998). Among the recommendations was that pre-registration nursing education be based on a four-year degree programme and fully integrated within the third level institutions. This was accepted in full and implemented. Degree status was now a requirement for registration as a nurse. The first group of nurses with degree status at registration graduated in 2005.

Career pathways were addressed including a more formal structure for the Clinical Nurse Specialist and the appointment of Advanced Nurse Practitioners. The title of Ward Sister was to be changed to Clinical Nurse Manager 2 with the Matron and Assistant Matron to be changed to Director of Nursing (DON) and Assistant Director of Nursing (ADON).

The recommendations of the Commission on Nursing (1998) were implemented and changed the face of Irish nursing. Full degree status for nurses put the profession on an equal par with other healthcare professionals. It is of note that prior to this, postgraduate programmes were in place for qualified nurses in a number of colleges including leadership and management programmes. The Faculty of Nursing, The Royal College of Surgeons, ran programmes on Leadership, Management and Research for nurses for a number of years prior to the degree programme being established.

1.7.1 Senior Nursing Management – Matrons

Issues related to the role of the senior nurse or Matron in the management of services were also identified during the consultation process (Commission on Nursing 1998). These included a lack of internal communications, lack of involvement in strategic planning and policy and strategy development. There was also a perception that there was a lack of partnership and consultation both within and between the different professions and general administration in the setting and attaining of corporate goals. The command and control structure within nursing in a hierarchical service was also a concern with micromanagement prevailing rather than the management of the nursing and midwifery function. Matrons and Assistant Matrons tended to micromanage on the wards or departments rather than promote the professional clinical leadership and management role of the nurse. Recruitment and selection to support changing service needs and greater devolution of authority within the nursing and midwifery management structure was also identified as challenging (The Report of the Commission on Nursing 1998). The commission recommended the change of title from Matron and Assistant Matron to Director of Nursing and Assistant Director of Nursing. This recommendation was accepted.

Carney (2004) in her study of the strategic role of Directors of Nursing found that organisations with flatter structures, four or less layers, included DONs in the strategic decision-making while those with five or more tended not to include the DON. The Commission Report (1998) also advocated replacing the traditional hierarchical and bureaucratic models of management with flatter structures. Emphasis was also placed on developing a strong professional leadership role with a greater focus on strategic and clinical leadership leading to a more effective and efficient service delivery rather than the command and control style that appeared to be prevalent.

1.7.2 Middle Nursing Management (Assistant Matrons)

The Report of the Commission on Nursing (1998) presented a comprehensive description of the role, or lack of a clear role, of the middle managers or Assistant

Matrons (now called ADONs) in the Irish health system. Middle management will be referred to as ADONs hereafter as recommended by the Commission Report (1998) and implemented. It found there were various titles ascribed to middle management in nursing and their roles were seen generally as more administrative than managerial with the Director of Nursing making many of the decisions relating to working arrangements, skill mix, educational requirements or career plan. The ADON was often seen in these circumstances merely as the carrier of instructions. Clarity in relation to the role of the middle manager was crucial going forward with a clear, detailed job description being essential. Where restructuring had taken place such as the directorates, role clarity, authority and accountability were better defined.

The report highlighted the development of Directorates within some hospital structures in Ireland and supported their development. The first Clinical Directorates in Ireland were established in the 1990s in St James Hospital, Cork University Hospital, Galway University hospital and Waterford regional hospital. The management structure included a team of three; A Clinical Director (a Consultant), a Nurse Manager and a Business Manager. Each directorate comprised a specialty encompassing a number of units. The Nurse Manager was managerially accountable to the Clinical Director and professionally accountable to the Director of Nursing. These directorates have helped to provide middle nursing and midwifery management with more clearly defined management and leadership roles. Within the Directorates, the Clinical Director has overall responsibility for the directorate budget with the ADON in charge of the management of clinical services. The ADON also has responsibility for the personal and professional development of nursing personnel within the Directorate. The Commission (1998) made clear that nursing should retain its strong sense of identity and that the nursing manager should be responsible for ensuring the highest standards of patient care are met.

To date, in Ireland, the Clinical Director in all cases is a medical consultant but this is not the case internationally. The Commission recommended that

consideration should be given to the appointment of nurse managers as clinical directors, where they have the necessary knowledge and skills. This has not occurred to date. Not all areas in the DATHs are under the management of Directorates. Some areas function in a more traditional way. In these areas, management and leadership of the services remain the remit of the ADONs. They will often have responsibility for a number of units, such as all surgical units or oncology units and other roles such as practice development. The continued role of nursing management in services such as housekeeping and catering services also continues in some areas (The Report of the Commission on Nursing 1998). The role of the 'Out of Hours' ADON is different to that of the Directorate Nurse Manager. They work after 4pm to 8am the next morning. This role is more traditional and that of a gatekeeper administrative role in many respects. This is very much an operational role but nonetheless very stressful as all emergencies are referred to them as well as many other functions within the hospital. These ADONs are also members of the Executive Nursing committee where they have an equal voice in all clinical and strategic issues brought to the committee.

The Commission made a number of recommendations in relation to the role of the ADON. They recommended a defined function and not just a 'gatekeeper function' with defined roles and responsibilities. They also examined areas of care delivery and quality of care and recommended greater nursing input in these areas. Involvement in awarding contracts was also advised particularly in areas such as catering, cleaning and laundry services. As these catering and cleaning services impact on safe quality care, this is a reasonable nursing management function. However their leadership role was not mentioned.

1.8 Policy development impacting nursing

Published following the programme for government in 2011, *The Strategic Framework for Role Expansion of Nurses and Midwives: Promoting Quality Patient Care* (2011) set the policy direction for nursing based on service need. Role expansion had long been debated with considerable diverse opinion expressed. Although the role of the ADON was not specifically explored in this

document, expansion of roles throughout the service to optimise safe quality care was discussed. By extension, the role of the ADON would involve greater accountability and responsibility with role expansion of others practicing within their domain.

The document, *Future Health: A Strategic Framework for Reform of the Health Service* (2012-2015) (2012) outlined the greatest reform of the health service in the history of the state. Included was reform of the hospital delivery system. It outlined the need for change in the context of budget constraints, long waiting lists, capacity deficits and an ageing population. It suggested that it was not possible to address these challenges within the confines of the existing health system (*Future Health: A Strategic Framework for Reform of the Health Service* 2012). Following on from this Report hospital groups, as a transition to independent hospital trusts, were established in 2013. This development was one of the most ambitious reform projects in the history of the health services. The aim was to reorganise the public hospitals into more efficient and accountable hospital groups. The purpose was to establish greater control of their services at a local level thereby becoming more efficient and effective in the delivery of care.

In this report, *Future Health: A Strategic Framework for Reform of the Health Service* (2012) a distinction was made between the voluntary and statutory sectors. The varying standards of care between the two sectors was highlighted as well as restricted management and leadership development required to run a world-class national hospital network. The variation in governance structures was recognised and so the best of the governance systems were to be taken from the voluntary sector and applied throughout the acute sector. Leadership and management were to have greater devolved autonomy and accountability within these groups particularly for frontline staff with command and control type structures obsolete. An integrative model with primary care was advocated. Reduced fragmentation and integration both nationally and with primary care were part of policy.

The management team of each hospital group would be comprised of at least the following key posts: Chief Executive Officer, Chief Clinical Director, Chief Academic Officer, Chief Director of Nursing, Chief Finance Officer and Chief Operations Officer. Thus the new role of Chief Director of Nursing and Midwifery for each group was established. This placed the chief DONM at the top table in relation to decision-making and strategic focus with a very strong leadership role both for the profession and also for the development of health policy and planning.

The four main functions of each group board were:

1. strategic planning
2. policymaking
3. supervision and challenge of executive management
4. accountability to stakeholders

(Future Health: A Strategic Framework for Reform of the Health Service, 2012-2015)

1.8.1 The Office of the Chief Nursing Officer

In 2013, the Department of Health elevated the post of Chief Nursing Officer (CNO) to Assistant Secretary grade. This was implemented to ensure that a nursing and midwifery perspective is brought to bear on the development of policy within the Department of Health. The Office of the CNO plays an important strategic and leadership role in the Department of Health and has direct access to the minister. She provides professional policy direction and evidence-based advice to the Minister in relation to nursing and midwifery. In 2015, the Office of the Chief Nursing Officer developed the first Strategy of the Office of the Chief Nursing Officer for 2015-2017. This was intended to support and promote development in nursing and midwifery policy around the professions into the future in a collaborative manner.

1.9 Dublin Academic Teaching Hospitals

The acute hospital sector in Ireland consists of Health Service Executive (HSE) hospitals and Voluntary hospitals. They are all funded by the HSE, provide the most comprehensive range of services with most of them being teaching hospitals.

The HSE hospitals are owned by the HSE but the Voluntary public hospitals are not. Ownership of these hospitals lay mainly with religious orders. These Voluntary hospitals are general hospitals with a number of specialist areas that function as teaching hospitals and are located mainly in Dublin and some other large centres of population. Historically, funding for these hospitals was from government and charitable foundations but the hospitals themselves controlled the funds and therefore exercised considerable influence in their management and policy development, including nursing policy (Fealy 2006). The voluntary hospitals, mainly under the care of religious orders, became the principal care institutions of the 19th century for the sick poor in the main cities in Ireland (Fealy 2005). Today, The Dublin Academic Teaching Hospitals (DATHs) are 6 voluntary hospitals in the Dublin area and are among the most prestigious in the country. They are funded by the HSE but continue to have control over how that funding is managed. 5 of these hospitals participated in this study, 1 declined.

This study was carried out in these 5 Voluntary Band 1 Dublin Hospitals. They are St James University Hospital, Tallaght Hospital, St Vincents University Hospital, The Mater Misericordia University Hospital and Beaumont Hospital. These are among the largest and most prominent hospitals in Ireland and greatly value their reputations for excellence. Prior to the setting up of the hospital groups, the DONs of these 6 hospitals had formed their own committee with a rotating chair and meet regularly for the purpose of discussing issues pertinent to the group. Although they are not all in the same recently set up hospital groups, they remain a functioning committee apart from the hospital groups.

1.10 Current role of the ADON

The role of the nurse has radically changed since 1998, with post registration and postgraduate education courses flourishing. Considerable numbers of qualified nurses have completed primary degrees, diploma and masters programmes over the last 20 years. The structure of nursing has also changed with the traditional Ward Sister becoming the Clinical Nurse Manager promoting a greater managerial and leadership role and Clinical Nurse Specialists and Advanced

Nurse Practitioners now firmly placed in the clinical setting. The extended role of the nurse is now common speak but it is not always clear to what extent this role extends in clinical practice (Nikoletti et al 2008). The role of the ADON or Directorate Nurse Manager lies between the Director of Nursing and the Clinical Nurse Manager with both a clinical and a managerial brief. They are in a position to have a strong leadership role in matters of clinical governance and quality improvement. They have roles in leadership and management, education and development and are key to improve quality, drive performance, and ensure efficiency. They now have the opportunity to ensure they have a key role in developing leadership potential and furthering the development of the profession.

1.11 Summary

Chapter I presented the rationale for the study and identified the hospitals in which it was undertaken. The aim of the study was also presented. The historical role of the nurse was reviewed with both the traditional apprentice type training model and the current education degree models discussed. The report of the Commission on Nursing was reviewed in the context of leadership development in middle and senior nurse managers. Policy development in the health service impacting on nursing and the restructuring of the acute health sector and the current role of the ADON was presented.

Chapter 2

Literature Review

Leadership

2.1 Introduction

In this chapter the theories of transformational and transactional leadership and new paradigm leadership will be examined. Issues of strategic focus, power and influence, decision making, governance and culture will be explored in the context of the nursing profession and their significance for nursing leadership in the development of an efficient and effective health service for the delivery of safe effective healthcare. Bourdieu's theory of social structure will also be explored.

2.2 Theories of leadership

Leadership is a multi-dimensional, complex phenomenon in the turbulent environment that is healthcare (Saravo 2017). It is multifaceted and is increasingly becoming a focus for achievement and success of the health care system in the current time but there is no clear definition of what leadership means. Leadership and management although related, are often used interchangeably.

Leadership is described and defined in many different ways and affected by many different factors (Lacasse 2013). Nursing, as does the healthcare system, requires engaging and aspiring role models in an economically challenged and changing environment (Scully 2013). Leadership roles are shaped by the individuals who occupy them (Sherman 2005). Traditionally, nurses were not seen as leaders but as implementers of policy decisions made at corporate and executive level. In the present day dynamic context, it is imperative that emerging and aspiring nurse leaders are identified, supported and nurtured. At a national level, the nursing profession is challenged to develop and contribute to a more demanding and discerning society (Hanley 2003) while adhering to economic constraints.

2.3 Transformational Leadership

The transformational leadership approach has resonance with a number of writers (Bass 1985; Bass and Avolio 1994; Antonakis et al 2004; Avolio et al 2009). Other theories of leadership including transactional, distributed and servant theories (Avolio et al 2009; Carney 2006; Daft 2005; Antonakis et al 2004; Bass and Avolio 1994; Bass 1985). There are also many definitions but that of Daft (2005: 5) encompasses its essence, “Leadership is an influence relationship among leaders and followers who intend real changes and outcomes that reflect their shared purposes”. This indicates the core of leadership and that is to include all players in bringing about change for a common purpose. Transformational leadership embodies these characteristics (Avolio et al 2009) therefore this leadership style, with some reference to transactional leadership, will be the main focus for this study. These theories were chosen as they are both frequently used in references to leadership in nursing. A number of characteristics common to most leadership styles will also be discussed, including the concept of influence, as it permeates all aspects of leadership (Avolio et al 2009; Carney 2006; Daft 2005; Antonakis et al 2004; Bass and Avolio 1994; Bass 1985).

The factors associated with the transformational style are frequently held as being, charismatic, inspirational, transformational and visionary (Anonson et al 2013; Avolio 2005) with some variations of these. According to Antonakis et al (2017) the new leadership approaches again equate transformational leadership with charisma or charismatic leadership. Daft (2005) also discusses the notion of charisma, inspirational leadership and influence being central to this leadership style. In addition, he examines Bass (1985) concept of self-actualisation under the headings of intellectual stimulation and individual consideration. Vision and charisma appear to be the most commonly quoted factors associated with this leadership style with the concept of inspiration and actualisation, or intellectual stimulation, being intrinsic to the whole process (Durham and Klafehn 1990; Bass 1985). The result of this complex and powerful concept of leadership style is according to Bass (1985), a relationship of mutual stimulation and elevation with the potential to drive effective and efficient organisations (Drucker 2007).

According to Pounder (2006) team work is crucial for success. She does not buy into the bureaucratic structure but promoted their shared purpose, self-direction, autonomy and innovation (Jooste 2004). In the nursing profession this relates to shared purpose in teamwork and innovation in care delivery. Self-direction and autonomy relate to clinical autonomy, particularly in the medical profession with self-direction related to continuing training and education.

Bass (1985) argues that transformational leadership is a much more complex and powerful concept which looks for potential or what is called intellectual stimulation and promotes higher needs and self-actualisation with some variations of these. According to Antonakis et al (2017) the new leadership approaches again equate transformational leadership with charisma or charismatic leadership, or what Bass (1985) calls idealised influence.

Transformational leaders motivate and energise staff to pursue mutual goals where personal values and respect are fundamental principles (Murphy 2005; Bass and Avolio 1994). Leaders as good teachers build trust and rapport and build skills and confidence in others (Pounder 2006). These leaders can have a strong influence on people through a combination of relation behaviours and human resource management (Gary 2008). The leader takes cognisance of place, people and opportunity and helps others to join in the journey (Smythe and Norton 2007) thus promoting job satisfaction and building organisational excellence. Transformational leaders are more likely to delegate and allow others the responsibility and autonomy to achieve and develop (Bass and Avolio 1994; Covey 1992). Again in the broader context, this leads to organisational excellence. Leaders as good teachers build trust and rapport and build skills and confidence in others (Pounder 2006). Transformational leaders motivate and energize staff to pursue mutual goals where personal values and respect are fundamental principles (Murphy 2005). These leaders can have a strong influence on people through a combination of relation behaviours and human resource management (Gary 2008). The leader takes cognisance of place, people and opportunity and helps others to join in the journey (Smythe and Norton 2007).

To develop and promote an effective and successful organisation, the leader needs to be aware of the external environment as well as the internal workings of the organisation itself (Carney 2006; Daft 2005). The external environments of both the business community as well as the broader social community, including the economy, are of crucial importance to the success of any organisation, particularly the health service and the nursing profession (Ginter et al 2013). This strategic focus includes the mission, vision and values of the organisation as well as strategic goals, critical success factors (CSF) or key performance indicators (KPI) and the evaluation processes (Daft 2005; Friesen and Johnson 1995; Duncan 1995). An analysis of the current state of the organisation, including its culture, is also critical to its strategic focus and forward planning (Ginter et al 2013) particularly in the current turbulent economic times.

The transformational leadership style was found to support effective clinical leadership in nursing in a UK study and identified five attributes of effective clinical leaders including creativity, highlighting, influencing, respecting and supporting (Cook and Leathard 2004). The ‘self-defining’ transformational leader of Bass and Avolio (1994) has strong internalised values and ideals. They also have the ability to make strong unpopular decisions and view the organisation in a wider context in relation to long term goals and interests.

2.3.1 The four I’s of transformational leadership

The four I’s of transformational leadership include, Idealised influence, Inspirational motivation, Intellectual stimulation and Individual consideration (Bass and Riggio 2006).

Idealised influence

This concept involves the leader as a role model where the follower sees the leader as one to be emulated (Bass and Riggio 2006). This entails modelling good behaviours and acting in accordance with the values and the objectives of the organisation. The followers have trust in the integrity of their leaders which is demonstrated by their consistent and persistent behaviours even in difficult times.

Maintaining standards in a complex and sometimes difficult environment is also a feature of this attribute.

Inspirational motivation

Leaders inspire their followers. They clearly articulate their vision for their team and the organisation. It is important that the leader does not demonstrate lack of motivation in difficult times but support the team through consistent ethical behaviours and encouragement. This is particularly true in the current economic climate where budget cuts and staff shortages are commonplace.

Intellectual stimulation

One of the greatest assets of a company is its employees (Bass and Avolio 1994; Handy 1993). The transformational leaders will promote the concept of a questioning environment and a learning organisation (Avolio et al 2009; Carney 2006). The concept of innovation and creativity are intrinsic to this. The learning organisation not only promotes innovation and creativity but also explores the organisation in the broader sense (Carney 2006). Intellectual stimulation encourages employees towards continuous quality improvement thus promoting organisational excellence (Carney 2006) which is critical for nursing leaders in promoting patient centred care. This encourages examination of new and different ways of doing things and taking intellectual risks (Bass and Avolio 1994). Reframing old challenges and trying new solutions are encouraged by the leaders without criticism or blame if they don't work out but examining the issues that arose and encouraging followers to try again.

Individual consideration

Achievement is intrinsically motivating (Handy 1993). The transformational leader recognises the necessity of promoting the potential of others and particularly leadership potential (Carney 2006) for the future success of an organisation. This is especially important for leadership in nursing in succession planning (Covey 1989). Intrinsic to this is the idea that followers take responsibility for their own development (Bass and Avolio 1994). This has long

been a principle of the nursing governing body, An Bord Altranais (2000) (now the Nursing and Midwifery Board of Ireland) and is accepted by the majority of the nursing profession. Bass and Avolio (1994) posit that this acceptance of responsibility also promotes accountability and responsibility within the workplace. This, they maintain moves the individual from being directed by external forces to self-direction. This leads to greater accountability, improved quality care and a greater contribution to the organisation (Jooste 2004). Carney (2006) and Ginter et al (2013) also identified accountability as the new critical success factor at the time. Creating a supportive environment and identifying opportunities for development are part of this concept for the leader. Personal and professional development opportunities encourage staff to strive to reach their potential and develop self-confidence.

2.4 Succession planning

Succession planning supports individual consideration and promotes leadership potential at all levels and keeps followers motivated and committed (Aquinis and Pierce 2008; Handy 1993) to the continuing development of excellence in the organisation. Transformation leaders expect high standards from their workforce and will not accept average input (Kouzes and Posner 2002). This pushes the staff to achieve more than they expect which in itself is both motivating and promotes job satisfaction (Aquinis and Pierce 2008; Handy 1993). This also raises self-expectations and promotes greater team spirit which in itself, promotes organisational excellence (Bass and Avolio 2005). In the areas of role development, considerable advances have been made which are contributing to continuous quality improvement in patient care and therefore a better health service. This is evident in the new nursing roles of the Advanced Nurse Practitioner and the Clinical Nurse Specialist in their extended roles both at clinical and leadership area.

2.5 Transactional leadership

Transformational leadership is an example of how leadership style has evolved and to emphasise this, it is sometimes contrasted with transactional leadership

where the emphasis is on operations management or caretaker leadership (Soferalli and Brown 1998). The transactional concept of leadership maintains the status quo and expects what could be termed an average input from employees, where operations management or caretaker leadership is emphasised (Huber 2006; Soferalli, and Brown1998). There is no intellectual stimulation or individual consideration (Huber 2006) so motivation is by the carrot and stick approach rather than self-actualisation. Bass (1985) would argue that this and other traditional approaches are supervision and not leadership. This approach also lacked any strategic or developmental aspect (Huber 2006) therefore rendering it incongruous with dynamic growing businesses or a dynamic health delivery service.

Transactional leadership is a contractual relationship (Bass and Reggio 2006). In healthcare this is evidenced by habitual practice. Innovation and risk-taking are not encouraged. Transactional organisations tend towards the self-interest concept and lack a team approach (Bass and Reggio 2006). This approach supports a bureaucratic hierarchical structure with little room for innovation, intellectual stimulation or individual consideration. Khan et al (2015) posits that this style can stifle innovation in healthcare and adversely affect job satisfaction. In their study, they found that the transactional leader was more inclined towards rules and regulations and tended to 'go by the book'.

On the other hand they found the transformational leader to be more human, flexible and viewed things from a contextual point (Khan et al 2015: 8). They also found that transaction style tended to be at the lower levels while transformational style tended to be at the top of the organisation but aspects of both were found. Although this is a study from Pakistan which is not comparable with the Irish system, the findings are interesting in looking at the comparing front line versus senior and executive management.

A US study by Roberts-Turner et al (2014) explored the effect of leadership characteristics on paediatric nurses' job satisfaction and found that autonomy

associated with transformational leadership strongly affected job satisfaction. However they also found that to a lesser extent, distributive justice associated with transactional leadership had a positive impact. A greater number of years as a nurse also had a positive effect. The implications for leader characteristics were that the nurses perceived that their leaders were inspiring and encouraging as well as holding them to account. The implications for nursing leaders are in nurse recruitment and retention particularly the millennials who want honest feedback and fairness.

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2.6 New paradigm leaders

A more recent concept of both leadership and the organisation is the idea of viewing them as a paradigm (Daft 2005; Friesen and Johnson 1995). This success paradigm can be defined, as ‘... a way of thinking and doing to accomplish goals and ensure viability’ (Friesen and Johnson 1995: 3). The concept of ‘new paradigm leaders’ (Daft 2005) and the ‘success paradigm organisation’ (Friesen and Johnson 1995) have similar visions to transformational style as to how the organisation should develop. Some of these characteristics include organisational leadership, vision, values, resources and customers (Ginter et al 2013). Daft states, ‘One of the most important aspects of the new paradigm of leadership is the ability to use human skills to build a culture of performance, trust and integrity’ (2005: 25). Culture, integrity and the development and incorporation of the skills available within the organisation are crucial to success (Huber 2006; Carney 2006). The concept of human skills, as opposed to motor skills alone, indicates both cognitive and psychomotor skills or, intellectual stimulation and individual consideration (Bass and Avolio 1994) which are crucial for employee motivation and development, and the ultimate success of the organisation. This concept is in keeping with transformational leadership and the four Is of Bass and Riggio (2006).

2.7 Followership

Leadership roles are not only shaped by the individuals who occupy them, but also by the followers (Carney 2006). To persuade people to change indicates that

the leader has influence among his/her followers but as a reciprocal concept, the followers also influence the leader (Kouzes and Posner 2002). This is in keeping with Bass' idea (1985: 173) of 'engaging the full person of the follower' through team work and good communication skills. This is particularly true for leadership in healthcare where constant change with restructuring and budget cuts and staff shortages can alienate the front line staff.

2.8 Power and influence

Authority, power and influence are essential to 'control' other people according to Jooste (2004) however, how this is done is a crucial issue and more in keeping with a transactional style of leadership. Promote or develop might be more appropriate than 'control'. Power and influence are also facets of the theory of social structure discussed at the beginning of the chapter (Grenfell 2012). Daft (2005: 5) states that "Leadership occurs among people", not in isolation in the corporate offices. One of the key elements in the definition of leadership is influence (Daft 2005). To persuade people to change indicates that the leader has influence among his/her followers but as a reciprocal concept, the followers also influence the leader (Daft 2005; Sherman 2005).

The concept of influence is one of the principle characteristics that pervades all aspects of leadership (Carney 2006; Daft 2005; Antonakis et al 2004; Bass and Avolio 1994; Bass 1985). A leader's influence increases with judgement and the ability to convey ideas, which indicates that good communication skills and self-confidence are also essential for clarity of purpose (Antonakis et al 2004; Daft 2005; Anonson et al 2013).

2.9 Strategic focus

To develop and promote an effective and successful organisation, the leader needs to be aware of the external environment as well as the internal workings of the organisation itself (Carney 2006; Daft 2005). The external environment of both the business community as well as the broader social community, including the economy, is of crucial importance to the success of any organisation (Daft 2005;

Duncan et al 1995). This strategic focus includes the mission, vision and values as well as strategic goals, critical success factors (CSF) or key performance indicators (KPI) and evaluation processes (Daft 2005; Friesen and Johnson 1995; Duncan 1995). An analysis of the current state of the organisation, including its culture, is also critical to the strategic focus and forward planning (Carney 2006) particularly in the current turbulent economic times.

2.10 Decision-making

In clinical practice, clinical decision-making is for the expert health professional, an intuitive process based on years of experience while it is a rational, logical thought process in the scientific world (Pearson 2013). Accurate and timely information is required for effective decision-making at both a clinical and corporate level. In the late 20th and early 21st century, organisational models changed with a greater input from multidisciplinary teams and a more integrated model of care (Wong et al 2010). A study carried out in Canadian acute care hospitals found there were mixed results for senior nurse leaders as a result of these changes with some nurses having greater decision-making power while others claimed it diminished their role particularly at the policy making level (Wong et al 2010).

In a study of Directors of Nursing in Ireland, Carney (2004) identified organisations with flat structures, three layers or less; those with more than four layers were referred to as complex structures. She also found that Directors of Nursing were involved in strategic management including strategic decision-making if in flat structured organisations but not in the more complex organisations. In the flat structured organisation, this resulted in more effective communication downwards and the perception by those nurse managers below Director level that they are consulted and their opinions valued when it comes to corporate decision-making, albeit through the Director. The converse was true of those in the more complex structures (Carney 2004).

2.11 Governance

A definition of clinical governance states, 'Clinical governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver' (Health Service Executive 2012 Clinical Governance Informational Leaflet). Clear accountability arrangements are a fundamental building block of good clinical governance, bringing clarity to the authorities and clarifying responsibilities of individuals, teams and committees (or groups), for the delivery of safe, high quality, cost-effective care. Without such arrangements the risks to service user access to services, safety and quality of services can increase with potentially significant and, in the case of service user safety, catastrophic consequences (Quality and Clinical Care Directorate 2010). To achieve excellence in clinical governance (HSE 2010) they emphasise the importance of culture and accountability at personal, team and systems level.

Clinical Governance was introduced to drive improvement in the quality of patient care and to improve accountability (Travaglia et al 2011). Governance in healthcare has been traditionally the domain of management but in more recent times, healthcare professionals have become involved in both corporate and clinical governance the purpose being to improve both management and clinical outcomes (Correia and Denis 2016). Good governance at board level included three or more clinicians on the board, and for better clinical governance, the Director of Nursing and Medical Director also had extended roles in clinical governance and therefore better quality of care (Joanes et al 2017).

A systematic review by Nicholson et al (2013) found a number of elements necessary for good governance, the most commonly quoted being joint planning, integrated information communication technology, change management and shared clinical priorities. Shared clinical priorities included a team based approach in an integrated system and co-ordinated clinical pathways across the care continuum. This approach is now being promoted in Ireland both within each hospital group and between the hospital groups and aligned CHO areas.

A study by Correia and Denis (2016) carried out in the process of establishing a clinical directorate with general managers and surgeons, looked at the role of both groups within the new hospital structure. However, unlike the UK and Scandinavian countries, this model did not include the nursing profession. The overall conclusion was that there are commonalities between both management and medicine but clinicians can align criteria to their own interests which may be outside the organisation. The importance of a more inclusive model of governance is evident for the mission and goals of the organisation to be realised and keep the patient welfare central to healthcare. Overall in the acute care hospitals, clinical governance is now more inclusive particularly following the setting up of the hospital groups. In the hospitals in this study, the Directors of Nursing were all part of an inclusive model of both corporate and clinical governance with clinical governance committees that fed into the hospital clinical governance committee. The majority of the ADONs were members of the appropriate clinical governance structures and others were aware of the hospital system and how clinical risk fed into those structures.

2.12 Culture

Culture, simply put, is the way things are done (Carney 2006) or as Daft states, (2005: 557) 'Culture is a pattern of shared assumptions of how things are done in an organisation'. Organisational culture can be a force for change and innovation or it can stifle change (Carney 2006; Daft 2005). It dictates aspects such as the allocation of power and influence, communication, and basically determines behaviour (Covey 1992). This is especially true of the bureaucratic nature of the health sector and particularly the historic position of nursing within that sector. Culture plays a dominant and pervasive role in the operations of an organisation (Carney 2011). Conflict in operations management is often between quality of care and financial constraints as was demonstrated by the *Francis Report* (2013). A culture of over-emphasis on targets and staying within budget eventually obscured the patient focus and masked the insidious consequences of this detrimental deterioration of standards. It further supported evidence that the

culture in the hospital was not one which leads to the right people stepping in and stepping up at the right times.

The Portlaoise Report (2014: 36) gave the following definition of culture, ‘The patient safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation's health and safety management’. A positive culture is focused on high quality care delivery and a positive patient experience. However in meetings with service users, they found issues relating to clinical leadership, poor communication, lack of concern for service user concerns, and lack of empathy and insensitivity. These reports indicate the importance of good leadership and positive culture being central to high quality patient care.

Although the socialisation of nursing from a training and directed group, to an educated more autonomous group has heralded considerable change in organisational culture and in the power position of the nursing profession, full corporate involvement in decision-making and health policy and planning remain uncertain (Carney 2006). Carney (2011), in a study of fifty professional clinician (including nurses) and non-clinical managers in the acute sector, examined the influence of organisational culture on quality healthcare delivery. The influencing factors identified in rank order included, Excellence in care delivery, Ethical values, Strategic involvement, Cost versus quality, Professionalism and commitment and Strategic planning and thinking. These influencing values indicate a positive culture (Carney 2011) and are of the utmost importance in the health service today if the findings of the Portlaoise Report (2014) and the Francis Report (2013) are to be avoided in the future and patient quality and safety is to be at the centre of care.

2.13 Building organisational excellence

To build and maintain organisation excellence, leaders that are influential, as well as competent and visionary, are crucial. The confidence of the leader and the

confidence of the employees in the leaders' ability are essential if the market is to have confidence in an organisation's ability to deliver. This self-confidence is particularly so in the current fiscal crisis and even more so in the public sector's ability to deliver crucial services such as the health service. Central to this service is the nursing profession who make up the single biggest professional constituent of the health sector.

Transformational leaders motivate and energize staff to pursue mutual goals where personal values and respect are fundamental principles (Murphy 2005; Bass and Avolio 1994). Leaders as good teachers build trust and rapport and build skills and confidence in others (Pounder 2006). These leaders can have a strong influence on people through a combination of relation behaviours and human resource management (Gary 2008). The leader takes cognisance of place, people and opportunity and helps others to join in the journey (Smythe and Norton 2007) thus promoting job satisfaction and building organisational excellence.

2.14 Self-image and self-confidence

Self-image and self-confidence are also key aspects of leadership (Jooste 2004). Self-confidence refers to people's self-judgment in relation to their capabilities and skills or their perceived competence to deal successfully with the demands of a variety of situations (McCormack 2001). However, there is always the danger that image becomes the primary goal rather than being a quality of leadership style. Sethi (2009) promotes mindfulness at work as a key competency for leadership in the work place. This Jooste (2004) states promotes positive and effective behavior from the leader and so engenders awareness of the purpose of the organisation and focuses the employee.

2.15 Clarity

Clarity is essential for influence according to Dewan and David (2008). A leader's influence increases with judgement and ability to convey ideas, which indicates that good communication skills are essential for clarity. Communication is the process by which information and understanding is communicated which

influences and motivates others to act (Daft 2005). It is of vital importance both for understanding and motivation (Daft 2005; Handy 1993). If communication lacks clarity, then the vision is lost or misinterpreted (Dewan and David 2008) and it leads to confusion and lack of understanding of where the organisation is going therefore productivity falls (Ginter et al 2013). Clarity for understanding in nursing and across the health service is vital to ensure both the staff and the patients understand information imparted and the avoidance of errors and misunderstanding.

2.16 Change

In leading change, both Daft (2005) and Carney, (2006) recognise social and economic pressures but argue that leaders must keep pace with what is happening in the external environment. Now more than ever it is necessary to examine how the health services, including nursing services, are delivered and examine the best way to move forward. Reconfiguring the corporate and clinical governance structures will lead to a more comprehensive and cohesive approach to health service developments in the future thus promoting an improved and viable service (Ginter et al 2013). Excellent communication skills, training and participation to overcome resistance to change are required to facilitate this level of organisational change (Daft 2005). Bass and Avolio (1994: 135) put it best when they stated 'Nothing characterises the successful organisation so much as its willingness to abandon what has long been successful'. How much more should the health sector be willing to abandon what is proving to be not as successful as society would expect. Looking to the future and changes in medicine, and particularly in technology, is essential for an effective health service. Technology is influencing how healthcare is delivered at an ever increasing rate. What is successful today may be obsolete in a short period therefore looking ahead is critical for the health sector.

Following the fiscal crisis of the last number of years, change was inevitable. In attempting to push the boundaries of the nursing profession, not only the expanding role of the nurse in services delivery, but the governance structures and

the role of the nurse in the corporate structures also need to be considered (Lynch 2007). This can be very difficult not only within the power structures of a bureaucratic organisation where culture dictates the allocation of power and influence (Carney 2006; Daft 2005) but also within the profession itself, where role position and expectation can be embedded in this culture (Lynch 2007; Biddle 1986). Change is continuous in nature and must be kept in focus to maintain the long-term commitment of the organisation (Carney 2006; Bass and Avolio 1994). The health service is undergoing considerable structural change with the setting up of Hospital Groups and Community Health Organisations at present. However the aim is a more efficient and effective health service with less centralised decision-making so that decisions can be made closer to the patient ensuring the service is more patient centred.

2.17 A Theory of social structure

The French Sociologist, Bourdieu developed a theory of practice, or sometimes referred to as a theory of social structure (Grenfell 2012). This theory consists of three major concepts, Field, Capital and Habitus. This theory was initially applied to the French academic structures but has since been applied in the wider organisational context (Emirbayer and Johnson 2008; Swartz 2008). The three major concepts that make up this social structure can apply to any organisation, in this context healthcare. All three are interlinked and relate to power and influence. The theory explains greater and lesser dominant positions within a social structure, in this context the large acute hospital, and how those positions influence how we interact with others in that domain. The field of healthcare is the area in which we work with its hierarchical institutions, cultures and power positions. This hierarchical institution in turn influences our habitus, our place of work, or our identity in the workplace and how we react to different situations depending on the power positions of the people we interact with every day, and also how we perceive positions of power in the workplace. An example of this could be who is more likely to be heard by the Vacancy Committee (the committee in each hospital who accepts or rejects a case for recruiting a new member of staff) if presenting a business case for more staff – a consultant or the

nurse. Capital is a concept that is not necessarily related to economics but to such matters as perceived importance of an individual, due to their expert standing in a hospital or national and international standing. Expertise of the nurse or doctor in clinical practice, the ability of the CEO to acquire extra funding or the reputation for integrity and fairness can all contribute to Capital. Taking all three concepts together allow the social structure of the healthcare system, the hospital or the nursing profession to be examined in the context of practice.

2.17.1 Bourdieu's framework

Bourdieu's theory of practice (Grenfell 2012) or theory of social structure, consists of three major concepts, Field, Habitus and Capital. This notion of field refers to defined social space within institutions and is an area where people are willing to play the game of politics when something can be achieved. Habitus derives from the process of socialisation where an individual learns norms and behaviours within social structures and take this social world for granted. In this context it is applied to the acute hospital world. Capital can mean economic, cultural or social capital. There is also symbolic capital which equates with authority, power and prestige.

2.17.2 Habitus

Habitus relates to the individual's identity in the field or organisation with the concept of field and capital inextricably linked to habitus (Reay 2004). The common professional identity in medicine can be seen in the socialisation process and is referred to as the medical habitus (Witman et al 2010: 479). This socialisation process can also be applied to nursing and also relates to professional identity. Within this habitus or borne of habit (Moran 2011) behaviours may be tacit or unconscious and can be '...internally regulated by their habitus' (Rhynas, 2004: 180) but habitus is also strongly influenced by the field. This can be seen as constraining but should not be seen as defining. The concept of field and capital are inextricably linked to habitus (Reay (2004) but the habitus has not been applied to organisations to any great degree according to Emirbayer and Johnson (2008). However, they argue that habitus is also a significant concept in

organisational analysis. Swartz (2008) in a critique of their publication, agrees with this finding. The concept of habit or habitus (Latin) goes back to Aristotle and Plato as discussed by Moran (2011) who also discusses Husserl's contribution to the concept of habit which he claims was not recognised by Bourdieu.

The individual's disposition or the habitus is structured by the social world but in turn, this disposition structures the world of the individual (Reay 2004). This habitus '...predisposes individuals towards certain ways of behaviour...' (Reay 2004: 433). These behaviours may be tacit or unconscious and can be '...internally regulated by their habitus' (Rhynas 2004: 180) but habitus is also strongly influenced by the field. This can be seen as constraining but should not be seen as defining. A person can also have the potential and character to push the boundaries of the habitus and change habitual practice or modify structures thus changing the field position and his/her own capital. In the case of the nurse, these power positions were very evident in the historical position of the nurse where practical training and the 'good nurse' were expected norms. However, the education status of the nurse has changed the nurses' position in the field where a more collegial attitude is promoted. A person can also have the potential and character to push the boundaries of the habitus and change habitual practice or modify structures thus changing the field position or power position and his/her own capital, in the case of the ADON, this capital can be expertise, experience or a strong leadership role.

2.17.3 Field

There are many fields within society such as academia, politics, the economy or health. Many subfields also exist within each field (Digiorio 2010), for example within health these include, the economy, the government, the ministry, different lobby groups or different healthcare institutions. The hospital as a healthcare institution, for the purpose of this study, can also be seen as a field with its own subfields. These subfields include, the different professions, different groups, patients, different specialties, different cultures, different structures including governance and very importantly in this context, economic or budget structures.

From the perspective, this field is also a hierarchical structure where there are dominant and subordinate positions (Naidoo 2004). Within this structure, individuals or groups strive for dominant position which in itself can generate conflict. Positions in the field ‘...depend on the amount of specific resources that are possessed in relation to other occupants’ (Naidoo 2004: 458). The voluntary hospitals in this study are semi-autonomous fields in the Irish context. They get their budget from the Government/Department of Health, but have autonomy over how it is disseminated. Fields and sub-fields can also be seen as power structures (Emirbayer and Johnson 2008) such as consultants or the executive team of the hospital.

Within this field, the ADONs occupy a position between the front line staff (ward staff including nurses and Clinical Nurse Managers) and the executive management team. Their position within the nursing structure is clear but their exact position in the hospital hierarchy is not always evident. Because these are bureaucratic, hierarchical institutions, their structures will affect the power and influence that resides in the position of ADON.

2.17.4 Capital

The concept of capital, as Bourdieu explains it, does not exist alone but always in relation to the field (Emirbayer and Johnson 2008). Social capital has two components according to Ferlander (2013), a cognitive and a structural component. The structural component revolves around a social network including social support. Social support can be ‘...divided into emotional, instrumental and informational support and social companionship’ (Ferlander 2013: 116). She also suggests that cognitive aspects of social capital include values, attitudes, trust and reciprocity.

According to Digiorgio (2010) there are many forms of capital distributed within each field including, social, cultural, economic and symbolic. The position of the individual or group in the field depends on the amount of capital they hold.

Economic capital refers to the economy and in this context, specifically the budget. Control or influence over the budget and how it is allocated can dictate who holds power in a healthcare institution, in this case the CEO. Other areas of capital include:

- Cultural capital refers to education background, qualifications, skills and competencies. It can also refer to one's salary in the broader health context. Elitism can also be a feature of cultural capitalism.
- Social capital refers to membership of networks both outside and within these institutions. These networks can be of mutual benefit to those members promoting collegiality and a sense of belonging. In the context of influence and power, they can be very powerful.
- Symbolic capital relates to an honorary position or perceived importance within a field. This symbolic capital can be an important source of power.

(Digiorgio 2010)

The ADONs capital could be her/his integrity, education and expertise in the clinical area and in good governance. Capital can be accumulated through networking and building alliances both in the hospital and in the wider health care community.

2.18 Summary

This chapter reviewed some of the theories of leadership and the 4 I's of transformational leadership. New paradigm leadership was examined and has similarities to transformational leadership. Issues of power and leadership were also examined as well as followership and the strategic focus of organisations. Decision-making and governance were explored in relation to healthcare and culture was discussed in the light of recent reports in relation to poor delivery of healthcare. Change and competencies were discussed and Bourdieu's theory of social structure was also examined in the context of healthcare organisations. Following the publication of The Francis Report (2013) and The Portlaoise Report (2014), issues of leadership, power structures, poor decision-making and a lack of

good governance leading to poor standards of care were highlighted and are of particular importance in healthcare delivery at the present time.

Chapter 3

Methodology

3.1 Introduction

This chapter will address the design and method chosen to address the research question in this study; ‘What is the leadership experience of the Assistant Director of Nursing (ADON) in 5 Band 1 hospitals in the Dublin area?’ This group of hospitals are referred to as the Dublin Academic Teaching Hospitals or DATHs. A positivist approach to the study would have collected objective data that could then be quantified into scientific fact (Crotty 1998) thus presenting a particular stance explaining the human behaviour of this group of ADONs. However, the premise of my philosophical stance is that human behaviour is contextual and subjective so therefore cannot be measured by a quantitative approach. Thus a naturalistic approach was considered most appropriate to carry out the study. The naturalistic paradigm allowed the multiple realities of the ADON to be explored whereas the single reality of the positivist approach would not. The world of healthcare is complex and demanding, as is the world of the ADON, therefore descriptive phenomenology was the method chosen for this study. The concept of bracketing will also be reviewed. I will address the research question, aims and objectives of the study, sample size and data collection methods. Giorgi’s 4 step framework for analysis and how I used this for the process of analysis will also be reviewed. Ethical considerations including consent and confidentiality will be explained.

3.1.1 The research question

The research question was ‘What is the leadership experience of the Assistant Director of Nursing (ADON) in the Band 1 Dublin Academic Teaching Hospitals?’

The aim of the study

The aim of the study is an exploration of the leadership experience of the ADONs in order to describe the phenomenon of this leadership role in their own setting.

3.2 Epistemological view: social constructionism

Social constructionism is the epistemological stance taken for this study. This accepts that the beliefs and values of a society are socially constructed and that the beliefs and values each individual holds are shaped by the forces of that society (Crotty 1998). The current reality for any individual or community is their perceptions of beliefs and values which occur in the context of their social reality. Individuals and groups participate in the construction of their own social realities and consequently phenomena are created in that context (Muncey 2009; Crotty 1998). Hence people act and react to their perceptions, knowledge and experience of their worldviews shaped by their own society, and their interactions within that society. Internalisation of values and beliefs throughout life including childhood, education and all life's experiences within this socially constructed society makes each individual 'of that society' and not simply 'in that society' Crotty (1998) describes as meanings learned through a subtle process of enculturation or how we construct our social worlds.

Our culture shapes us and therefore influences the way in which we see and think (Cohen et al 2011; Crotty 1998) and gives us a definite way in which we view the world. However, culture can also restrict our understanding of phenomena where there are already preconceived notions of reality and meanings. Crotty states, 'The social world is already interpreted before the social scientist arrives' (Crotty 1998: 58). This is why phenomenology tries to 'go back to the things themselves' and understand the complexity of the person's multiple realities as in the case of this proposed study (Muncey 2009; Crotty 1998). For the ADONs who participated in this study, their perceptions of their reality were shaped by their social world or the many realities of the world of the hospitals in which they operated. This socialisation into the world of healthcare, and continuing experiences in the hospital environment, shaped their perception of that society and how they viewed or constructed their world.

3.3 Positivism

The classical view of science, or positivism, can be defined as being “concerned with a distinctive set of activities such as distinction, explanation, prediction and control” (Dyer 2006: 5-6). Positivist philosophy purports to examine facts and then present these relationships as scientific law where the truth of these laws can be studied. Positivism is based on realism with the ontological stance that there is one single tangible reality, which can be predicted and controlled (Crotty 1998; Guba and Lincoln 1994). Positivism implies analysis and interpretation of human knowledge resulting in a particular stance of the subject matter or social reality (Cohen et al 2003). This implies that ‘the meaning of a statement is, or is given by, the method of its verification’ (Cohen et al 2003: 8). This is the objective reality of positivism where rationality explains social behaviour (Cohen et al 2003; Crotty 1998).

Positivists or scientists construct theories systematically and in a controlled manner and have a firm basis in fact, forming the foundations of systematic and deductive reasoning (Cohen et al 2003; Crotty 1998). Its most distinctive feature is its empirical nature. The positivists found a home with the empiricists and materialists, the former believing in what could be measured as fact or inferred, and the later believing that everything can be understood in terms of the properties of matter and energy (Muncey 2009: 16). Empiricism provided the ‘underpinning rationale for all the immensely successful scientific work of the last 300 years. It consists in essence of a single powerful insight, that reliable knowledge about the world can only be acquired if it is based on information that is available in some form to the senses’ or what is now referred to as empiricism (Dyer 2006: 4).

Positivists deny that theories could represent hidden realities (Guba and Lincoln 1994). It follows therefore that information got from other sources such as the imagination is inferior or unreliable. Dyer states that (2006: 4), ‘The historical and practical importance of empiricism as an epistemological position has been its emphasis on what counts as knowledge must be acquired through the active exploration of material reality’. This means that the positivists believe that

explanations are only valid if they are based on evidence that has been obtained through some kind of practical information-gathering activity, such as empirical research. This also ensures a reality that is outside the observer, and so is objective truth. One of the most important features of empiricism is, 'its set of procedures which show not only how findings have been arrived at but are sufficiently clear for fellow scientists to repeat them' (Cohen et al 2011: 15). This ability to replicate study findings has been a feature of medical and scientific research since its inception with the result that some positivists completely reject other philosophical paradigms of inquiry. The philosophical perspective that underpins positivist research is quantitative, particularly empirical research in medicine.

3.4 The naturalistic paradigm

Following on from positivism, a new paradigm shift developed which was called post-positivism or naturalistic inquiry (Guba and Lincoln 1994). These post-positivists promoted understanding, rather than the predictive certainty of positivism (Guba and Lincoln 1994). This new form of naturalistic inquiry purported to have multiple constructed realities where different levels of understanding could emerge (Guba and Lincoln 1994). The proponents of this post-positivistic or naturalistic approach did not believe that human behaviour was governed by general, universal laws (Cohen et al 2011; Crotty 1998). Rather, they posit that human behaviour can only be understood by understanding the individual's interpretation of their world, as perceived by that individual. Therefore, their world is subjective and not objective (Cohen et al 2011; Crotty 1998). Social science is therefore seen as subjective in nature dealing with the experiences of people in specific contexts (Cohen et al 2011). That is to say, to understand the subjective or social reality, as individual people experience it, then mans' definition of that reality must be accepted, and how man copes in that context is the true reality for that person at that time (Muncey 2009; Cohen et al 2011; Crotty 1998). This enables society to make sense of the world in a way that the positivists cannot convey. The subjective nature of this new approach within a

social context also supports the concept of many realities, and not just one that is supported by positivism (Muncey 2009; Crotty 1998).

The theoretical stance chosen for this study is the naturalistic paradigm, as the research question is subjective in nature and occurs within the complex reality of the ADONs leadership role in healthcare. This paradigm is most suitable for this study, as contextualising the ADONs reality is paramount to understanding the multiple realities of their role in the bureaucratic hospital organisations. This paradigm sets out to understand individuals and their world with the result that there is no one theory fits all (Cohen et al 2011; Crotty 1998) but multiple behaviours within social contexts supporting the concept of the multiple realities of the post positivists, therefore this stance is suitable for this study. Positivism, with its single reality and linear causation, would not yield the rich data that naturalistic inquiry would in the exploration of this phenomenon in an attempt to gain some understanding of it (Muncey 2009; Crotty 1998) therefore descriptive phenomenology is the chosen method for this study. It supports an understanding of the complex experiences of the participants and offers the opportunity for insight and the creation of knowledge that is particular to that experience. Clonkin (2007: 276) states that phenomenology is ‘...inherently, a means of creating knowledge that is particular- knowledge that offers a portal of insight into the individual and idiosyncratic’. This study offers an insight into each individual participant experience that is personal to them and the common.

3.5 Phenomenology

The basis of phenomenology is understanding human experiences (Pringle et al 2011; Dowling 2007). This is supported by Landridge (2007: 10) who states ‘Phenomenology is the study of human experience and the way in which things are perceived as they appear to consciousness’. This philosophical movement, which began in the early 20th century, is attributed to Husserl and further developed by Heidegger (Langdrige 2007). Husserl was taken with consciousness as the basis of all experience (Moran 2000). Phenomenology relates to the ideal or true meaning of something and so refers to the basic units of

common understanding of a phenomenon (Streubert and Carpenter 1999). It requires the exploration of the structure underlying the experience rather than a mere description of the experience itself, ‘...phenomenological psychology is a rich description of some aspect of experience’ (Langdrige 2007: 2). Husserl believed that the essence or true meaning of a phenomenon could be discerned from any experience where the true nature, or the essence, is revealed, but phenomenological psychologists believed that a better understanding could be garnered from multiple experiences (Langdrige 2007). Phenomenology requires the researcher to ‘...imaginatively vary the data until a common understanding about the data emerges’ (Streubert and Carpenter 1999: 46). In this study, the aspect of the role of the ADON that was explored was the leadership role so as to develop an understanding of the role and get to the true meaning of their experiences. The participants (n=20) who described multiple experiences, were from the 5 largest hospitals in Ireland.

3.5.1 Consciousness and Intentionality

Husserl believed that any view of the world could only be understood through consciousness and all its manifestations, ‘Without consciousness there is nothing to be said or done’ (Giorgi 2005: 76). Phenomenology cannot be understood without first understanding the concept of ‘Intentionality’. This is at the core of phenomenology (Sokolowski 2000). This concept should not be confused or equated with common usage in everyday language of ‘intention’ as intending to do something’ or having the intention to carry out some action. Sokolowski (2000) explains intentionality as consciousness being directed towards something....or the consciousness and its relationship to an object. This represents subject-object dualism. This is the key to consciousness for Husserl, the person is always conscious or aware of something (Langdrige 2007). Streubert and Carpenter (1999: 45) explain how we experience things in how they appear to us. In other words ‘intentionality’ can be described as ‘...the way consciousness is turned out on the world, as it intentionally relates to objects in the world’ (Langdrige 2007: 13). It relates to what is experienced and also to the way it is

experienced. These two aspects of intentionality are inextricably related and exist within all experiences (Langdridge 2007).

Human consciousness has in the past been seen as being directed inwards towards our own thoughts and feelings, in other words ‘self-awareness’, rather than outwards towards objects that generate those thoughts and feelings (Langdridge 2007: 13). This represents subject-object dualism. Husserl moves away from this dualism with this concept of ‘Intentionality’. This means that ‘...the consciousness is always conscious of something’ (Streubert and Carpenter 1999: 45) and how we experience things in how they appear to us. In other words ‘intentionality’ can be described as ‘...the way consciousness is turned out on the world, as it intentionally relates to objects in the world’ (Langdridge 2007: 13). It relates to what is experienced and also to the way it is experienced. These two aspects of intentionality are inextricably related and exist with all experiences (Langdridge 2007). Lewis and Staehler (2010: 22) describe intentionality as ‘...an attitude we take towards an object that we are experiencing, it expresses the fact that in each of our experiences, we tacitly expect the object to appear and behave in a certain way’.

This concept of intentionality is at odds with the Cartesian view of the mind and body being separate. This view holds that awareness or consciousness is directed inwards towards our own thoughts and feelings rather than outwards towards the things or objects that instigate those feelings (Langdridge 2007). In this study, it was the ADON’s own experiences that were sought and the meaning of those experiences for them and the way they experienced the phenomenon in the context of their role as leaders. This concurs with Landridge (2007) consideration of intentionality in that the study supports the concept of what is experienced as well as the way it is experienced.

3.5.2 Noema and Noesis

Intentionality is the correlation of the way the world appears and our perception of it and all experiences (Langdridge 2007). Husserl posits there are two components

within consciousness, 'noema' and 'noesis' (Lewis and Staehler 2010: 23). He maintains that all experiences are experiences of something and so rather than the duality or distinction of subject and object, he modifies this into a correlation between what is experienced, the noema, and the way it is experienced, the noesis. This correlation is called intentionality (Langdridge 2007). It is important to distinguish between cause and relationship in this context, whereas there is a relationship between the noema and the noesis, one does not cause the other.

However, between noema and noesis the person is not the central point, rather it is the experience and the way it is experienced in a particular way. Phenomenological investigation is concerned with first-hand accounts of experiences. With these terms it is important that they are not thought of in everyday terms but in the phenomenological sense (Sokolowski 2000: 60), that is following phenomenological reduction. Phenomenological reduction was proposed by Husserl and revised by Heidegger and is a key epistemological strategy (Dowling, 2005). It follows the epoche and involves capturing the 'constituents of the moments experiences' (Conklin 2007). Epoche means the process by which presuppositions and preconceived ideas are suspended (Langdridge 2007) by a process called 'bracketing'.

3.5.3 Bracketing

To avoid the preconceived ideas and biases of the researcher being introduced into a study being undertaken and influencing the outcome, the concept of 'bracketing' was introduced (Dowling 2005: Lopez and Willis 2004). The intention was that this would introduce some objectivity (Dowling 2005). The suspension of preconceived ideas is referred to as 'bracketing'. According to Dowling (2005) this entails abstaining or setting aside any preconceived notions or biases about the phenomena being researched. The researcher is able to suspend his/her own perception of reality (Wonjar and Swanson 2007; Langdridge 2007). Langdridge (2007) referred to this as epoche which means the process by which presuppositions and preconceived ideas are suspended. McNamara (2005: 697)

states that, 'Things cannot be truly known in advance, from an external frame of reference: rather they must come to be known through internal reflection'.

McNamara (2005: 698) is critical of nursing research in relation to bracketing in that it is misinterpreted whereby, rather than the researcher's natural attitude being bracketed, they tend to bracket the natural attitude 'in order to remain faithful to their subjects experiences, not to the phenomena or the things themselves'. The natural attitude is the most basic way each person has of experiencing the world including all preconceived ideas. This also includes the researcher themselves. There is usually very little inclination to examine or analyse those attitudes or ideas (McNamara 2005). Wonjar and Swanson (2007) emphasise the importance of bracketing one's own reality or prior experiential knowledge and adopting a state of transcendental subjectivity (bracketing) in order to describe a phenomenon in its pure sense. They describe three stages of bracketing

- Separating the phenomenon from the world and inspecting it
- Dissecting the phenomenon to unravel the structure, define it and analyse it
- Suspending all preconceptions regarding the phenomenon

(Wonjar and Swanson 2007:173)

These stages are essential stages of bracketing as much is hidden from plain view in the natural world and therefore there is a lot to be revealed through the research process (Langdridge 2007). In my own case, I examined my own experiences in this context as I have considerable experiences of meeting ADONs and other leaders from the hospital environment. I had to examine my own thoughts of what I might expect from the ADONs in the study and attempt to clear my mind of preconceptions and biases.

All lived experiences have common features which Lopez and Willis (2004) call 'universal essences' or 'eidetic structures' – commonalities in the lived experiences are identified so generalised descriptions are possible. 'The essences

are considered to represent the true nature of the phenomenon being studied' (Lopez and Willis 2004: 728). Identifying essences takes time and energy according to Landridge (2007) as it is easy to slip back into the natural attitude whereby the researcher unwittingly allows preconceptions and one's own experience to influence the research findings. Essence can be discerned from any one experience but it is posited that multiple experiences are more likely to give the true nature of the essence (Langdrige 2007). He states that it is essential to examine the phenomena from many different perspectives in order to reveal the essences or fundamental structures of the phenomena.

Reflection following each interview and keeping a diary were the ways I attempted to bracket my own biases and keep them from influencing the research findings. One instance of this was following the third interview, I realised how busy the ADONs were on an everyday basis and realised that I had been unaware of my own presumption that time was not a major issue for them, until presented with the participant experiences. This experience revealed how easy it is to think one is bracketing but may not be. Whether anyone can truly bracket all one's biases and preconceptions is debatable but the conscious effort to do so is crucial in this methodology.

3.6 Sampling and sample

There are two methods used for sampling and these are Probability and Non-probability sampling (Cohen et al 2003). In phenomenological research non-probability or purposive sampling is usually the method of choice. The reason for this method of sampling is that the participants chosen for the study have a particular knowledge of the phenomenon in question (Streubert and Carpenter 1999). However, for this study, the total population of Assistant Directors of Nursing (ADONs) from the acute hospitals (band 1 hospitals) in the Dublin region was the sample chosen. This group of hospitals is also known as the Dublin Academic Teaching Hospitals (DATHs). To go outside this region would in all probability, not give a common experience of the phenomenon due to such differences as, different environmental factors, cultural issues, hospital size and

governance structures. The total population of ADONs in clinical practice in this group was 45 so I decided to include the whole group. In doing this I still retained the underlying principle that the participants chosen for the study have a particular knowledge of the phenomenon in question. I decided to take the first 20-25 participants who agreed to participate in the study. In the event 21 participants responded. One did not reply to three attempts to contact her by email for a time to meet to carry out the interview and therefore was not contacted again to avoid the perception of coercion. She did not respond at any time thereafter. 20 interviews were carried out (Appendix 6).

The participants were recruited firstly by getting permission from the Directors of Nursing to contact them. All relevant data was sent to each Director; information leaflet and consent form together with a letter requesting permission to contact the ADONs. In one of the hospitals I had to apply to the Nursing Research Committee for permission to contact potential participants and this was given. All Directors gave permission in writing. The length of time waiting for permission varied from weeks to months. Once permission was given, the information leaflet and the consent form together with a stamped addressed envelope was sent to each participant. There was no verbal contact to avoid the perception of coercion. If there was no response, this was followed two weeks later with an email with the same relevant data attached. In one hospital, I was invited by the Director to attend the Nursing Executive Committee meeting and address the ADONs about the study. Following questions, I left a number of envelopes there – one for each ADON – with all the study information and consent forms. I had no further contact until I was contacted by the ADONs agreeing to participate in the study.

Inclusion criteria included:

- All nurses at ADON level in clinical practice
- All nurses at ADON level in clinical practice but with different titles, e.g. Directorate Nurse Managers, Divisional Nurse Managers

Exclusion criteria included:

- All nurses at ADON level who were not in clinical practice, e.g. in administration

3.7 Data collection

‘The interview allows entrance into another person’s world...’ (Streubert and Carpenter 1999: 59) and so can generate rich, in-depth data. Semi-structured interviews are the most common method of collecting data in phenomenological research. This method allows for the maximum amount of information about the phenomena to be discovered (Langdridge 2007). Individual semi-structured interviews was the method of collecting data from individual participants, with some very broad questions posed at the beginning to help get started and put the participants at ease (Silverman 2010; Cohen et al 2003; Polit Beck and Hungler 2001).

An interview guide helped me through the interview process (Appendix 7). The construction of the interview schedule is very important to ensure the correct questions are put to the participant (Langridge 2007). A pilot interview with one participant was carried out to test for appropriateness of the questions and identify the key issues. The schedule had some changes made following this interview.

Some demographic data was collected prior to beginning the interview. This was to elicit length of time qualified as a nurse, length of time in the post and education details. Interviews were audio-taped and varied from approximately 35 minutes to one hour 30 minutes with field notes taken immediately following each one. This enabled me to record any impressions such as issues that caused frustration, undue tension and sometimes enthusiasm in the course of interviewing. This method of collecting data has both advantages and disadvantages. It can on one hand yield rich information relating to issues such as governance and decision-making aspects of a situation or institution, which can be openly discussed, or it can also be inferred which would be difficult to surmise by other means. Disadvantages include the possibility of undue influence of the researcher on the answer given, however precautions were be taken to avoid this

such as bracketing (Langdridge 2007). In spite of this, the study in question was suited to this method. The interviews were carried out in the participants' own hospitals usually in their own offices with 3 participants using other rooms in the building to give more privacy. The participants were given a choice in relation to the place of interview, either in their own workplace or outside of it but all chose their own hospitals. They also chose the time of the interview and I travelled to their place of work.

3.8 Analysis

This is the analytical phase where data collected is analysed and provides the results of the study (Silverman 2010: Polit, Beck and Hungler 2001; Burns and Grove 1999). 'The purpose of data analysis regardless of the type of data or the underlying research tradition is to organise, provide structure to and elicit meaning from research data' (Polit, Beck and Hungler 2001:381).

Transcribing data provides a verbatim account of the interview. This provides all the pauses, am's and um's and 'you know's'. It is not always clear to what extent all these should be transcribed, however, it is more accurate to include the nuances and thoughtful pauses as it gives more meaning to the script. It is also according to Langdridge (2007) somewhat disrespectful to 'clean up' a participant's language. A line number was allocated to each unit of data, a unit being a line. When quoting a participant e.g. (10-16) this means I am quoting from the participant and this is the line I can refer back to from the interview. This allowed me to check and recheck when developing meaning units and themes

It is necessary for the researcher to become immersed in the data for analysis to begin (Streubert and Carpenter 1999). This permits an understanding of the phenomenon under investigation (Streubert and Carpenter 1999). Georgi's framework for analysis consists of 4 steps. What he is attempting with this framework is the analysis of the meaning of personal experiences as told by the individuals relating to their everyday lives. A sample of meaning units is presented in Appendix 7A and a sample of a section of an interview in Appendix 7B.

These 4 steps are:

1. Read through the text several times to get a sense of the whole
2. Then read the text again to discern 'meaning units' or smaller units of meaning
3. Assess the meaning units for their psychological significance
4. The production of individual structural descriptions for each participant and then one or more general structural descriptions

(Giorgi 1985: 10)

Step 1

Getting a sense of the whole

Following transcription of each taped interview, each should be read a number of times to get the general sense of the whole. As the transcripts are long, it takes several readings to get this sense. I took this step both by reading the transcripts and also listened to each tape.

Step 2

Discriminating meaning units

Following immersion in the transcripts, the next step is to break down the transcript into manageable units. This is where statements of meaning and significance are identified and broken down into smaller units of meaning (Langdrige 2007). Initially I purchased 2 corkboards for this purpose and used post-its to help me build small units which became sub-themes. Themes were then developed. The literature also supported the development of these.

Step 3

Transformation of the lived experience into psychological language

This takes place through the process of reflection and imaginative variation. These transformations are necessary to gain an understanding of the events. This is where I capture the essential relationships in these statements of significance.

Step 4

Individual description of the situation

A number of subjects are preferable for this as the greater the number the greater chance of getting to what is essential. In this phase connections are made between the statements or central themes. These capture the essence of the phenomenon under investigation (Giorgi 1985; Streubert and Carpenter 1999). Twenty participants were interviewed and connections made between the different statements of participants to support the central themes of the study.

Rigour

Historically, positivism employed scientific rigor in research and was critical of qualitative research for lacking in this area. However, qualitative research is a different approach to the study of humanity and their individual experiences which could not be captured by quantitative methods. Rigour is a challenge but can be supported by applying the principles of trustworthiness, credibility and reflexivity.

Trustworthiness and Credibility

Credibility supports trustworthiness and refers to the truth of the data presented (Polit and Beck 2012). For credibility I kept a reflective journal and an audit trail including interview transcripts with quotes numbered in the research text for easy identification. A number of drafts of the final report were also kept. Member checking or respondent validation also promotes trustworthiness and credibility. This is a process where the data is returned to the participants for accuracy. It can take several forms, returning transcripts of interviews, carrying out participant interviews following data collection or returning some months later with the analysed data for validation. Although Giorgi does not advocate member checking, for trustworthiness and given the economic crisis of the time and the direct effect this had on the working environment of the participants, I decided that participant validation was desirable as a change in economic circumstances could alter previous perceptions.

Reflexivity

Reflexivity allows the researcher to reflect on expectations, background and previous experience of the phenomenon in question (Cope 2014). This process helps the researcher to develop an awareness of their own experience and values and avoid research bias. I addressed this through bracketing and keeping a reflective journal following each interview. This proved to be a learning curve as unconscious perceptions are difficult to bracket and must be recognised throughout the process. This became evident for me when, very early in the process, I realised I underestimated the contribution of the participants to health service delivery. Reflection on this revelation helped me to review my own subjective influences and expectations.

3.9 Ethical approval and consent

Ethical approval to carry out the study was sought and obtained from the Ethics Committee in DCU. The ethical principles considered in this study were respect for persons, consent and confidentiality (Gerrish and Lacey 2006; Beauchamp and Childers 2001).

The principle of respect for persons is that each person is autonomous and therefore has the right to self-determination. This was upheld by providing adequate information in the form of an information letter (Appendix 8) and allowing the participants to ask questions and make their own decisions relating to participating in the study. No individual was contacted in relation to participating in the study until the consent form had been received by the researcher to avoid the perception of coercion.

3.9.1 Access

To gain access to the sample, a letter requesting permission to contact the participants was sent to the Director of Nursing of each hospital (Appendix 9) explaining the nature of the study together with my contact details and those of my supervisor. A copy of the ethical approval from DCU, the participant information letter and the consent form were also enclosed.

3.9.2 Consent

Informed consent means the individual freely decides whether or not to take part in the study (Gerrish and Lacey 2006). Following ethical approval from DCU, a letter together with the information leaflet and consent form (Appendix 10) seeking permission from each Director to contact the Assistant Directors of Nursing was sent. Following written permission (by email) I posted the information letter and consent form together with a stamped addressed envelope to each potential participant. No direct contact was made with any potential participant until I received the signed consent form or an email stating their interest in participating in the study.

Prior to beginning the interviews, I again explained the reasons for the study and allowed time for any questions the participant might have. I also reiterated their right to withdraw at any time from the interview. When any queries were satisfactorily answered, I then signed the consent myself in the participant's presence. They were also thanked for their participation both before and on completion of the interviews.

3.9.3 Confidentiality

Confidentiality was maintained by keeping the taped interviews and all data in a locked cabinet in the researcher's own home. The computer where data is stored is password protected. The names and location of the participants within the hospital is kept confidential (Gerrish and Lacey 2006). The names of any individuals or places identified during the interviews were changed to maintain confidentiality.

3.10 Summary

This chapter looked at the different approaches to research and explained why I have chosen the descriptive phenomenological approach for this study. The sample size and access to the participants was explained. Data collection and Giorgi's framework (1987) as the method of analysis used was explained. I followed ethical requirements and that process was explained. I detailed the

consent and confidentiality aspects of the study. The following chapter will present the findings of the study with discussion.

Chapter 4

Findings and Discussion

4.1 Introduction

The methodology was presented in the last chapter. In this chapter, I will present the leadership perspectives of the Assistant Directors of Nursing (ADON) in the Dublin Academic Teaching Hospitals. A number worked in Directorates as Directorate Nurse Managers where their role was mainly within the Directorate. Others had more general duties across the hospital or sections of the hospital and this selection included those who worked the evening and night shift (See section 1.1.1). All of the participants were part of the executive nursing management team within their respective hospitals. I have presented the findings under a number of headings and subheadings.

4.2 Transactional leadership role

The leadership role is multifaceted and is shaped by those who inhabit the role (Sherman 2005). When asked to describe their leadership role, the responses of all participants were lengthy and focused initially on the transactional approach to leadership where the operational aspect of the role was described. The ADONs described a vast day-to-day workload and as if to reinforce this, they all walked at a very brisk pace. Their role includes professional issues such as frontline staff concerns, including staffing levels, skill mix, absenteeism and complaints. They also have an administrative brief which includes items such as budget, recruitment, project management and implementing all the relevant aspects of the service plan. Attending meetings and preparing reports and would be common to all the participants.

Tina described her leadership role by stating the enormity of the job on a daily basis:

Well I suppose the job is absolutely huge. It looks at everything from nursing, recruitment, information and....doing an action plan for staff following through, if there is any issues with disciplinary, looking after all of those, planning for areas like if there is maternity leave or people

leaving. You are shuffling between the areas on a daily basis dealing with any complaints, any IR issues, you have staff meetings (12-17)

This is in keeping with transactional leadership where the emphasis is on operations leadership. It also supports Bass (1985) that this is more supervision than leadership. Tina further states that her leadership role entails:

I suppose kind of cushioning at a certain level things like bullet-proofing the workplace, looking at absenteeism rates, looking at kind of the amount of incidents or risks that would be in an area trying to put things right there, looking at the volume of complaints that are coming from one area where you are dealing with the staff and dealing with the core issues that are surrounding those. (17-20).

Underlying this style is the supervisory role described by Bass (1985). Bass and Reggio (2006) describe the lack of a team approach with this style and Tina clearly indicates this as she describes ‘cushioning’ in protecting others from the operations aspect of the service rather than involving them as a team. This approach also supports the hierarchical structure of healthcare as described by Khan et al (2015) with little or no room for innovation. Tina clearly sees her role in the context of ‘bullet-proofing the workplace’ as maintaining the rules and regulations (Khan 2015). Roberts-Turner et al (2014), in a study of paediatric nurses’ job satisfaction, found that although transformational leadership supported job satisfaction, transactional leadership and distributive justice also had a positive impact. Addressing issues such as absenteeism and complaints and ‘trying to put them right’ concurs with the findings of Roberts-Turner et al (2014) that distributive justice is important to those nurses on the front line where staff are held to account when appropriate.

Teresa was not in a directorate position but her role was more general across the hospital. She described her leadership role as being different to other Assistant Directors:

Well our role is different possibly to a lot of the other ADONs in that we are in charge of everything to do with the running of the hospital and therefore I suppose we would not only just be in charge of nurses, unfortunately we are in charge of porters, we are in charge of health care

assistants, anything that goes wrong within this whole hospital in that timeframe. In that role therefore we would have to be leaders and managers and show by example (9-13)

Teresa clearly indicates caretaker leadership as described by Soferalli and Brown (1998) where she is in charge of the hospital as a whole. This describes a definite focus on the operations leadership in keeping with transactional style (Smith 2015). It also supports the idea that this is supervision and not leadership (Bass 1985). The caretaker leadership role leaves no room for innovation and according to Khan (2015) can adversely affect job satisfaction.

When asked about her leadership role, Connie talked more about operational leadership style:

I would be involved very operationally at local level so local issues every day to day questions and issues that arise, day to day staffing so I would be involved very much in that and have a close working relationship with staff and those particular issues (144-147).

This is in keeping with emphasis on operations management of transactional leadership (Soferalli and Brown 1998) and supports the concept of maintaining the status quo. The transactional style is reactive (Smith 2015) with a degree of micro-managing. Connie is clear here about her reactive style and micro-managing the staff in relation to issues that arise. On the other hand, Patsy is clear she does not micromanage:

I suppose it can change day to day never mind week to week. I suppose not an awful lot of micromanaging but looking at the strategic planning within an organisation but again you'll have some daily fire fighting, am...practices that you'll need to carry forward for your staff on the ward as well (7-10).

Although Patsy does have an operations management role, she is also clear she has a strategic role. Micromanaging is indicative of a transactional style of leadership and does not allow for staff development or intellectual stimulation (Bass and Riggio 2006). Bass and Avolio (1994) maintain that one of the greatest assets of a company is its employees. However, in a micromanaged environment, the concept of a learning and questioning organisation is stifled (Avolio et al

2009) with a lack of creativity or a different approach to problem solving. This maintains the status quo of transactional leadership.

As an out of hours manager, Eileen explains her role: 'All I do so as the site nurse manager I would have responsibility to achieve the smooth running as far as possible for the hospital' (12-13). Here she explains her operations management role as hospital wide. All the out of hours ADONs have this role which they explain as very extensive. Eileen explains her very busy schedule which is very much operations management. She describes it as gatekeepers, 'gatekeepers... gatekeepers who keep the place safe and ticking over' (131).

This concurs with Huber's (2006) description of transactional leadership that it is gatekeeper leadership where the emphasis is on operations management. Keeping the place 'ticking over' is in keeping with maintaining the status quo and lacks any developmental or strategic aspect (Huber 2006). Intellectual stimulation or individual consideration (Bass and Riggio 2006) are not features of this style.

Later she talks about her leadership role:

Well my leadership role would be more on the ground you know would be leading the staff at ward level and in this hospital we would have very few managers on at the week-end and nights (164-166) ...so we do have a big leadership role for the staff nurses, you know to guide and direct them in the right way in relation to decisions in dealing with incidents and situations (167-170)

She describes her leadership role in this context as a supportive role for the frontline staff. This is in keeping with inspirational motivation (Bass and Riggio 2006). It is important that the leader supports the team in difficult times, such as budget cuts and encourages them in the way forward. This could also be said to be a supervisory style (Bass 1985) where the staff are guided as to what to do in complex situations. The extensive operations management brief can leave very little room for the leadership role.

When asked to describe her leadership role Antoinette stated:

I would have a team of CNSs as well under me, I would work in that role. I would work very closely with XXXand then there's the day to day issues from a clinical point of view so you've got everything from staffing resources and then you have your annual plan and try to plan ahead but as I say just trying to deal with the issues as they come up as well. (7-13)

She works across the hospital in XXX and also liaises with two other hospitals in that capacity. She views the role from a day to day perspective and is also aware of the broader role implementing the annual plan. Her description encompasses the busy life of an ADON in addressing daily concerns and clearly trying to fit in some forward planning. This is in-keeping with Sherrman's (2005) description of the leadership role as multifaceted and shaped by those in that role.

Molly talks about skill mix concerns, she states:

If you haven't got a good skill mix on board on any given day well then the whole thing kind of starts unravelling so if needs be I move people around from one area to another (13-15).

The correct combination of skill mix and staffing levels has yet to be determined. In his unpublished PhD thesis, Shannon (2012) looked at skill mix in nursing in Ireland and how this was determined in Irish hospitals. He found that neither policy makers nor the nursing participants had any clear procedure for determining skill mix but custom and practice often prevailed. The perception of nurse managers at ward level was that the greater the activity of a consultant on a ward, the greater the need for more nursing staff. Directors did not express this view. The policy maker saw the trade unions as determining skill mix. With so many divergent views and no international framework for determining skill mix, it will remain an area of concern for all ADONs in this study as does staffing levels.

4.3 Transformational leadership role

The findings presented under this theme reflect the transformational leadership role of the ADONs. When asked to describe their leadership role, although initially they mainly focused on the transactional context, their transformational role emerged over the course of the interviews. Their role in promoting staff development became evident as well as their supportive role towards front line

staff in a difficult economic climate. Patient centred care and quality and safety were standards that were consistently supported by the ADONs and seen as crucial to the service. Maintaining standards in difficult times are aspects of idealised influence that are supported by Bass and Riggio (2006). The frustrations of the participants were also described particularly in relation to staffing levels and recruitment.

4.3.1 Supportive role

Eileen describes her main role as a leader:

One of our main leadership roles is the listening and assessing the situation and guiding the staff, advising and guiding from there (719-720).

Individual consideration supports and promotes the potential of others (Bass and Riggio 2006) and according to Carney (2006) particularly their leadership potential which she goes on to describe as essential for the success of an organisation. Eileen's description of her listening and guiding role is in keeping with Pounder's (2006) idea of leaders as good teachers who build trust and confidence in their followers. This supportive role of the ADONs was evident throughout all the hospitals despite the moratorium and economic constraints. Communication is a key competency in nursing and the health service overall and is particularly important in nursing for quality patient care. Daft (2005) states that is the process by which information and understanding is communicated which in turn will influences others as to how to respond. Poor communication in healthcare all too often ends up with distressed families and staff as evidenced by the Portlaoise report (2014). Listening skills and responding appropriately is crucial to patient centred care.

Olive looks at being supportive as developing competency and autonomy:

My overall leadership function is to ensure the ICNs (*intensive care nurses*) are fully competent and able to manage any situation if I am away (69-71).

She goes on to speak of 'leading from the back' and allowing others take the lead to support their development, what she calls, 'Stepping outside the box, it is very much part of development' (146-147) and viewing leadership as change. She encourages the staff and allowing managers to be innovative and creative and take a leading role, 'Absolutely, instead of coming and doing the same things all the time (153)'. This supports Carney's (2006) view of the transformational leader promoting the leadership potential in others. This concurs with Aquinis and Pierce (2008) and the concept of succession planning in promoting potential leaders at all levels of the organisation and not just at senior level. This supports individual consideration and intellectual stimulation (Bass and Avolio 1994). Olive's approach supports the individual development of the staff in gaining confidence in the leadership role as they are trusted in this situation. It also supports a learning environment and new and innovative ways of approaching old problems. This is particularly important in the climate of economic constraint and gives the frontline staff the encouragement to solve problems and concerns that arise or present case for change. One such case could be nursing policy change where updating is necessary for greater effectiveness. This will then be presented to the Nursing Executive by Olive for approval.

When I asked Teresa about her leadership style, she described it as:

Well I suppose what is a leader... you can be someone that somebody wants to emulate you lead in the sense that you help people you empower people you're mentoring people (27-29)

Teresa is clear about the supportive role in mentoring and empowering the staff. Wanting to emulate another supports the concept of Charisma (Daft 2005) where followers look up to the leader and imitate or emulate them. The charismatic leader will have followers and will influence them as well as being influenced by them. This again is in keeping with idealised influence and supports Avolio and Day's (2009) idea of transformational leadership being inspirational and transformational. Sarav et al (2017) describes the need for strong clinical leaders among the medical profession but this can equally be applied to the nursing profession. They advocate a transformational style in the areas of intellectual stimulation and team appreciation of working rather than individual practice.

Teresa is clearly visible to the staff and leadership happens among people where they can see her style and observe behaviours.

Promoting team appreciation is evident from Dympna when expressing her role as a team player as well as a visible leader when she states ‘...it filters through right down through the ADONs that I am working with as a team and it comes down through the staff ‘(181-182).

This supports the premise of team-work for success (Pounder 2006). She also describes herself as both transformational and transactional depending on the circumstance:

I feel that I am a transformational leader that is how I would describe myself but also transactional in that I can adapt I am very adaptable and I can adapt to different situations (170-172).

Saravo et al (2017) support the idea that both transformational and transactional styles are necessary for effective leadership in healthcare. In their study they found that four weeks training improved leadership style but also found that although the transformational style improved team motivation and commitment, the transactional style was more appreciated as it clarified accountability and high performance. They found that patient safety and prevention of errors dictated a controlling process where transactional leadership style was at times more appropriate in the clinical setting. Dympna is clear that she can adapt to different situations and that both styles are applicable in the healthcare setting as indicated by stating, ‘I always say tell me what’s going on let me know what’s happening then I can do something about it’ (184-185) in which case the style she applies depends on context. A transactional style of leadership may be more appropriate in circumstances of risk to patients. As the Francis Report (2013) demonstrated a lack of leadership led to poor risk management and therefore no proper accountability processes with the resulting poor quality care.

When explaining her leadership role Patsy explains:

it's the way you do it and it's the way you ask you know it the way you ask your CNMs or your nurses on the ward you know how you do it rather than being dictatorial to them because sometimes you get a lot of resistance to that and I suppose in today's climate it is quite difficult to be on the ward you know and it challenges everywhere you do you know and I do understand and I think sometimes if you feel you are a good leader and if you work with them the staff basically will do a lot more with you and for the directorate really (217-223)

Transformational leaders motivate staff to pursue mutual goals where respect is a fundamental principle (Murphy 2005). Patsy clearly respects the staff on the front line and understands the difficulties they face in a time of staff shortages. Resistance to change is a well know phenomenon and at the time of this study, change appeared to the ADONs to be constant with staff shortages and staff being constantly moved to fill gaps in staffing levels and changes due to budget cuts. Respect with good listening skills are necessary for understanding and if the staff feel their opinions are respected, as Patsy states, they will work with her.

The supportive role not only relates to frontline staff but also to the ADONs themselves. When asked how they were supported, most of the participants were very positive about the support structures and the opportunities available to them. One of the most common supports available on a daily basis was peer support. This was highly valued

When asked about the support for the ADONs themselves, John states:

ADONs themselves have suggested...meeting and then we could provide support, information, you know motivate each other and help each other. I think there is a huge culture within the Senior Nurse Manager here to actually promote and develop the Assistant Directors. (575-580).

John is clearly very positive about the support for ADONs as a group and promotes the idea of peer support and networking. He goes on to say, '...they actually invested in xxx senior managers. I was one of them and we went off and did our masters... and we were the first group in the country that did that (590-593). This initiative was for all managers across the services and is a very good

example of the learning organisation and supporting the concept that the greatest assets of an organisation being its employees (Bass and Avolio 1994). This also supports the idea of intellectual stimulation encouraging employees towards continuous quality improvement promoting high standards of patient care (Carney 2006). This level of support is very much appreciated by John and demonstrates the level of support that is there for the development of the ADONs. Informal peer support was mentioned by a considerable number of ADONs and recognised as one of the better support structures there for everyday issues. Nichol and Tracey (2007) suggest that networking is crucial for information flow and collegiality and support and also for career development.

When Martin discusses development opportunities for the ADONs, he states:

...it's very hard to do your job unless you're trained to do it properly, that is important. If you have that you'll have confidence to do your job. So there are other good things about the organisation and certainly there are opportunities within the organisation for it (634-637)

Martin discusses confidence in his role if the proper training opportunities are there. Self-confidence is a key aspect of leadership (Jooste 2004) and Martin is clearly happy with the opportunities offered in the hospital to support him having confidence in his role. He is also the only person who mentions carrying out investigations as part of his role:

There is a lot of training opportunities within the hospital as well, things like doing investigations is hugely time consuming, you have to drop everything and just do it for 3 or 4 weeks but we got very good training on that. A group came over from England for that and we had 3 days training and that was good..... (633-637).

Martin also signals the time consuming element of some aspects of his role. Investigations are crucially important in the health service to maintain standards and hold people to account (Francis Report 2013; Portlaoise Report 2014). Carney (2006) and Ginter et al (2013) also identified accountability as the new critical success factor at the time. Creating a supportive environment and

identifying opportunities for development are part of this concept for the leader. Personal and professional development opportunities encourage staff to strive to reach their potential and develop self-confidence. Martin clearly appreciates the opportunity for development in this critical area.

While the majority of the ADONs were positive about their own opportunities for self-development, SB spoke about support for the ADONs development needs: 'I think role development wouldn't be the strongest here...'(387). When Deirdre was asked about the role of the ADON in the future she stated:

I think it might be worth looking at the role and some of what you will have gathered might be contributing, or hopefully will contribute to that, am...I have a sense that the role has become lost in the busyness of what we have to do on a daily basis (667-669)

She is being positive about the outcome of the study and its findings in relation to the role but clearly feels that the enormity of the workload is threatening to overshadow all aspects of the role except for the operations management aspect, 'the business of what we have to do on a daily basis'. Personal and professional development opportunities support self-confidence and competence in dealing with complex healthcare situations. Leadership if not nurtured and developed can become more transactional leadership where a contractual relationship develops (Bass and Reggio 2006). If the daily workload becomes too great, then a transformational and supportive style may be lost.

4.3.2 Role identity

A number of ADONs expressed the view that their role was changing in the context of new developments in the structure of the profession. Habitus relates to the individual's identity within an organisation or field (Swartz 2008; Reay 2004) which is inextricably linked to role. Roles must be seen in context as each person has a number of roles depending on the setting such as home, socialising or work (Brooks et al 2007; Biddle 1979). Roles are also characteristic of a group of persons within a context, such as doctors or nurses within a hospital setting who share an identity. This concurs with Bourdieu's concept of habitus where groups

learn from the socialisation process and the norms of behaviour of the field or hospital. This is particularly significant in Ireland at present as healthcare has moved towards specialisation (Brooks et al 2007). These groups identify more and more with each other such as the different specialties within the nursing profession. The ADONs do identify strongly with each other and value peer support that offers. These settings can facilitate or constrain behaviours in the sense they can influence how behaviours can change or adapt depending on the context (Squires 2004; Biddle 1979). However, with the increasing complexity of health care and also society in general, conflicting expectations leading to role conflict is increasing (Brooks et al 2007).

When Emma is asked to describe her role, she states:

I suppose I would describe it as quite a complex role which involved co-ordination of services demonstrating leadership skills, planning and organising, god it's so complex really when you think of it, human resource management, financial management, I would say I'd probably really need time to think exactly what my role entails, conflict management, involved a lot in strategic management at the moment in relation to my areas particularly the acute medical unit because that's one of my units (7-12)

The complexity of Emma's leadership role is clearly evident from her description. She has a number of roles across many departments which concurs with Brooks et al (2007). Role overlap is evident here (Mc Kenna et al 2003) and as Emma states, 'I would... need time to think exactly what my role is' clearly indicating the multifaceted nature of the role. Identity can become obscured when change occurs and at this time, with Directorate development and healthcare reform, the role of the nurse was changing and expanding. In 2003, a discussion paper on The Challenge for Nursing and Midwifery was published by the Department of Health and Children exploring the expanding role of the nurse and nurses taking on new roles. This was as a result of the Hanley Report (2003) for the reduction in NCHDs working hours. In this report, he also advocated the expansion of the nurse's role, essentially taking on some of the doctors roles such as IV cannulation. Although this report relates to clinical practice, it can equally be

applied to leadership and management role expansion such as Directorates. While new roles and expansion of roles was accepted, there was concern about training and development for the roles. The 2003 Report relating to nursing and midwifery advocated for clear objectives, consultation with stakeholders and providing education and support. Since that time there has been considerable expansion of the nursing roles but not always with clear objectives in terms of patient care. This affects role identity for Emma where the habitus has now been altered and social norms are changing. Role development does not always support setting realistic goals, developing protocols, demonstrating patient safety or audit. When a role becomes too complex with too many facets, its essence or core can become lost in that complexity and in the case of healthcare, patient safety may then be compromised.

In describing her role in relation to new grades in the profession such as the Advanced Nurse Practitioner (ANP), Cara refers to the role of the ADON previously and states:

I suppose if we're looking to look at a service, it would be the ADON you'd contact or go to see... and I suppose that's (*the role*) lost in translation somewhere you know, that doesn't get valued (329-333).

She states that she feels that the ADON role would have been more prominent prior to the development of the ANP role but has now become lost to a degree. She looks at the relatively new role of the ANP in relation to that of the ADON and states:

I suppose when it comes to policy, they'll go to the ANP, like looking at all the national programmes who are ANPs or Specialist Nurses so...that's where the ADON role gets lost, they have a good global picture and understanding of management and financial input but they ...I suppose they go for the clinical expertise and the clinical programmes and stuff like that (307-312)

She is conscious that with policy development, it is the Advance Nurse Practitioner (ANP) who is now consulted and not the ADON as would have previously been the case. Higgins et al (2014) in an Irish study explores the role of

ANPs and CNSs and their prominent position in the national context such as membership of national committees. Again similar to Elliot (2014) in her review looks at building leadership capacity in ANPs, Cara now thinks that the emphasis is on those roles and clinical expertise where they are being developed in a leadership capacity with a national role rather than on the management and overall global picture of the ADON. Here again the field or the hospital as a social structure is changing and affecting the social norms she was used to. Role overlap and role ambiguity have increased, which can lead to tension, due to the unprecedented changes, not only in the role of the nurse, but in the radical change in the Irish nursing education system over the last decade (McKenna et al 2003).

In describing her role, Eileen (out of hours ADON) states, 'We get phone calls that a toilet is blocked, that a bird has come in the window, whatever' (118-119)... 'You do get landed with everything' (214). Social identification for Eileen does not appear to be with the group but with the organisation, however, in this instance there appears to be multiple disparate identities (Blake and Meal 1989: 22) which can lead to uncertainty rather than the identity of the professional nurse. A site manager, Eileen is responsible for the running of the hospital but clearly demonstrates that the role of the professional nurse in this key position is seen as the administrator for all situations. It is not necessarily the individual who loses role identity in a changing health service but it may be the others who see the nurse as the fixer. Historically, nurses, mainly uneducated and untrained, provided care but had the status of servants whose duties included domestic and household affairs (Fealy 2006: 17). Up to a few decades ago, cleaning would still have been part of the novice nurse's duties with an apprentice type training rather than education the model. The legacy of this may be in some situations the nurse is still seen as the person who deals with all things whether domestic and household or part of the professional role of the nurse. She goes on to state in relation to a new role that is related to another group and unrelated to nursing but has been imposed on them, 'Now it is a constant battle and we were only discussing it between ourselves yesterday about what action were going to take from here, where do we go from here ...because we don't see that it is a nursing issue (107-109).

Maintaining role identity may not always be easy in the complex area of healthcare where conflicting expectations leading to role conflict is increasing (Brooks et al 2007).

Margaret discusses identifying or finding her organisational identity in a strained service and keeping her professional identity in nursing. She states:

Ideally we'd (*nursing*) have it all but we can't, the reality is we can't so what we've got to have is that bit in the middle, a knowledgeable influential healthcare provider and that's in the health service, whatever kind of healthcare you are providing but that it's person focused. That would be my bit if I could influence the world (661-664).

She is seeking out an identity and holding on to that identity in the bit she can influence. In the increasing complexity of health care and also society in general, conflicting expectations leading to role conflict is increasing (Brooks et al 2007) and it more important than ever that care is patient focused and safe. The nursing profession is a very well educated workforce and in a pivotal position to ensure the patient is central to care.

Caroline reflects on the operational role of the past for ADONs and the uncertainty of the role and identity of the profession into the future:

I suppose in the past it was much more day to day and getting through the week and getting through the month whereas now it's, you know 'Where do we want to be this time six months?', 'Where do we want to be this time 12 months?', 'Where do nurses need to be?', what roles and development can we get nurses through and how that impacts on everything else and also what will nurses need for that and how is that going to impact on the care (319-324).

She reflects on the identity and role development for the profession into the future. She also expresses a more transformative dimension to her deliberation about the future role and identity of the profession in the future. Social identity derived from the group concept through which one identifies oneself (Blake and Mael 1989). Roles are seen in context depending on the setting (Brooks et al 2007; Biddle 1979). The setting is the changing Irish healthcare delivery system, a more discerning society and where the evolving role of the nurse fits in this

context. The social capital of nursing and her value to the healthcare system needs to be articulated where nursing is valued for its expertise and collective intelligence.

Tina discusses her identity within the nursing context of the hospital, she states, 'Within nursing, very strong, in the directorate, not so much' (603). She is very clear about her strong identity in the nursing domain but not in the directorate. This equates with Bourdeiu's (Grenfell et al 2012) concept of dominant and dominated role with her professional role within nursing appearing to be dominant but her leadership role in the directorate appearing to be more towards dominated.

4.4 Wider health system

The health system in Ireland is governed by the Government and the Department of Health. National policy and planning in consultation with key stakeholders is decided at this level. The Chief Nurse, who resides in the Department of Health, is the nursing and midwifery representative who advises the Minister on issues pertaining to the professions as well as having an input in wider policy development. A new development, The Special Delivery Unit (SDU), was set up as a result of the fiscal crisis to improve the efficiency of the admission and discharge system in the acute hospitals and resides in this Department. The aim is to allow greater access to the acute services by improving the flow of patients through the system. There is a separate section for both scheduled care and unscheduled care. Unscheduled care focuses on those patients admitted through the emergency departments including those waiting on trollies. Scheduled care focuses on waiting lists in the hospitals. Monitoring and accountability systems have been set up in this context. There is a strong nursing presence in these units who visit the hospitals regularly. These units are seen as target driven in relation to admissions and discharges and would have a direct effect on the ADONs areas of responsibility. National nursing policy development would also emanate from the Chief Nurses Office in the Department of Health. The New Hospital Groups System was also under discussion at Department level at the time of interviewing the ADONs and would directly impact on them. On asking about their

involvement at national level in the wider healthcare system, it appears that very few get the opportunity to participate at a national level in relation to national planning and policy development. The majority felt there was a role for the ADON but were vague as to what that role might involve. Very few were included in national strategic groups or committees. It appeared that the DON mainly took that role while the ADONs were involved in local hospital committees.

When Emma was asked about her own or the ADON's involvement in any areas of health policy and planning nationally, she stated:

I think it would be good yeah, I think the ADON should be involved in national policy and policy making rather than a group in the SDU or in the Department of Health. They should have one nurse at that level and even a CNM2 as part of the group so yeah there should be nominations from the groups and it should be nationally (534-537).

When Margaret was asked if she had a role in the wider healthcare service, she stated:

We do a little bit of it but it seems to be a very small, exclusive group. I would say quite often is that whoever sets up the group puts in people that they like. We don't put all the ADON's in a hat, you know, if I was up in the health service and I was going to do a policy say for example on public health nursing I would put all the ADON's in public health nursing and I'd put a few of them out, I'd want one for the North, I'd want one for the East and West and put them all in because at the moment there is probably one person that goes to all of those and if you look at the back of all of these policies and you look at it and you see 'Ah yeah, there you are, XXX she's there. She has been there for years. She has been in every group that's actually ever existed (669-677).

Margaret clearly feels that roles in national committees is the domain of a limited group that are known to those setting them up and not representative of the wider nursing profession. She is clear about how a good national representative body should be set up for policy development but she feels membership of these committees remains unchanged for the most part.

When Majella was asked if there was a role in the wider health system for the ADON, she stated: 'I don't know the answer to that question really, I suppose I am familiar with always working in the acute hospital setting' (536-537). When followed up by prompts such as 'in the Department of Health and policy and planning issues', she stated, 'Yes, I would say there would be huge scope there but I don't know how that can be orchestrated or I don't know how anyone can tap in (541-542). Later when asked about the potential for ADONs influencing health policy and planning in the national healthcare context, she states: 'Oh yes absolutely, but again I suppose we would have to come together and kind of create a force for change' (598-599).

Olive is one of a limited few involved in the wider health system with ties both nationally and internationally. She sits on national committees and also was a member of an international committee. She stated, 'At national level there is an infection control nurse on all committee's developing national guidelines, I am at present on two of these committees (34-35). She sees this as an opportunity to 'liaise with colleagues...and advise nursing homes and long term care facilities within our area (73-75).

When Laura was asked how she saw her role in the wider health system overall, she stated:

Yea, I mean...it's difficult to...it's the influence or the lack of influence possibly that we have in some respects and...in other respects then you know, possibly more influence than we did in terms of even the care programmes, obviously nurses would have been involved in those, not at our level because they wanted and rightly so, the people who were delivering the service at the coal face, but I think nursing in general can influence those things. I think we possibly don't influence, and I know I've said that I think that we sometimes don't influence enough (461-467).

John thinks 'it's one of the most unexploited areas of ADONs' (658). Laura clearly thinks that they have the capability to influence events and decisions but perhaps don't engage in the process. This is an area that is clearly in the consciousness of both John and Laura but it can be difficult to change established practices. The concept of field and habitus can be seen in this context where

power and influence reside with others and is supported by the bureaucratic structure of the health services.

4.5 The wise man versus the spokesman

The 'wise man or the spokesman' are terms suggested by Witman et al (2010) in relation to professional identity in their study of leadership of medical department heads where doctors bridge the world of medicine and the management world. They used Bourdieus' social theory of field, habitus and capital (Grenfell 2012) in this study which is relevant to the nursing profession the findings could also be applied to the ADONs. The wise man is the clinical expert in the field and respected and has influence within that field. The spokesman on the other hand has to balance the budget and implement managerial decisions that may not be welcome by colleagues and may view the spokesman as a traitor with a loss of both respect and influence. This role of the medical Director is not the panacea it was once presumed to be with this leadership role carrying its own pitfalls. This concept can also be applied to nursing leadership. As a wise man, the ADONs authority is based on the nursing habitus or domain, the place where she is a clinical expert. This is the domain the nurse has been socialised into with norms and behaviours implicit in that world. The wise man's authority and influence is based in the ADONs nursing world and her proven expertise within that world. The spokesman on the other hand, represents a management role in the hospital or Directorate, which can cause conflict and frustration for the ADON. When asked if her role and responsibilities have changed in recent times, Connie states:

I would actually say it's much more... sometimes we joke about we feel like little mini assistant managers and accountants at times, so definitely from that perspective the role has changed quite a lot.... I just think that that has changed hugely (211-215)

She clearly states the huge change in her role in relation to management and balancing the budget. A number of key concepts in role theory have been identified (Biddle, 1979; Khan et al 1964) which include position, expectations, context, function and the social system. The context is a complex hospital environment functioning amidst severe economic constraints while the position of

the ADON is between managing safe staffing levels and these financial constraints. Expectations of an ever more discerning and knowledgeable public and quality and safety of patients must always be at the forefront of decisions made. She goes on to state:

well I suppose because resources are so scarce so it is a constant battle and you are kind of trying to weigh up between the safety of the numbers that you actually need of nursing staff and the cost of having them there, so we are trying to look at that, to see how can we staff a unit in the best possible way and the safest way (220-223)

On one hand, in her role, she is trying to implement change in the nursing world and is a wise woman in that world which makes influencing easier. On the other hand she is the spokesperson for administrative decisions that are being made at a national level in a time of fiscal crisis. Balancing staffing levels with the budget is for BC is about safety in her wise woman capacity. This dichotomy is also emphasised when there is a perception that money comes before the patient. Molly states:

I am answerable to XXX who also controls my budget but I have a certain amount of control on it but ...I need to keep an eye on that as well...if I have to employ agency or overtime, sanction overtime, I'm always conscious of how will this impact on the business side of things (26-30)

The dilemma for the nurse of being the wise man or the spokesperson where patient safety needs to be balanced with a more administrative function where policy and budgetary cuts have to be implemented, is a very fine line. The ADON has a number of roles in this context (Brooks et al 2007). However, the participants in this study put great emphasis on patient care and safety, accepting the wise man identity as primary, while accepting that outside forces impacted their role considerably in this area with the constant pressure of feeling they have to balance between finances and patient care.

Deirdre expresses the daily struggles with constant changes that have to be implemented for frontline staff. She states:

there is a certain amount of...fatigue with regard to 'well, we have to do this, this week' and then there's another change next week and they have to follow on with that, so basically I would say that...my focus has narrowed right down to making sure that the patients get the best care that they can regardless of what patients we're dealing with...(163-166)

Deirdre is clearly aware of the effect of constant change for front line staff and so has focused her role on patient care in a complex and changing environment. This concurs with both the wise man and spokesman concept where patient safety and care is the primary responsibility of all staff. The results of the Francis Report (2013) and the Portlaoise Report (2014) clearly indicate the consequences of not putting patient care first, leading to distress for patients and their families and sometimes death. Regardless of context and conflicting expectations leading to role conflict and fatigue, these reports have shown that there cannot be any compromise on patient safety. Constant change does not allow for the bedding in of changes or their evaluation and therefore the benefits cannot be proven.

It is evident that identity and balancing influence between the two worlds of the 'wise man and the spokesman' is not an easy task. The impact of contextual factors must not be forgotten in the current climate. The participants in the study were very aware of these factors and referred to them throughout the study. These were the current fiscal crises having a severe impact on the health budget, the need to reform the health service, and also the dilemmas facing those in charge from the DON and CEO to the government. Kathleen demonstrates this point by stating,

I have to recruit for staff, why do I have to go through all this red tape of going to a vac (*vacancy*) committee, and then again I can see why I have to do that I suppose, because of the economic climate that we have, if we were in the Celtic tiger era...(554-557)

Kathleen clearly would like a bygone era to return but sees the administrative function relating to budget and the reality of the process for clinical practice. Before the economic downturn, ADONs recruited staff themselves as necessary. However, now they all have vacancy committees where a business case must be presented to the committee who make the decision sometime later and then inform

the ADON. There is usually no change to this decision once made. This process can be frustrating and erodes the role of the ADON in this area.

4.6 Power and influence

The findings presented under this theme focus on issues of power and influence in the acute hospital setting. Witman et al (2010: 482) in their study of medical directors and their influence in the hospital setting considered the hospital as 'the field of power' This concept is derived from Bourdieu (cited in Witman et al 2010). Influencing factors such as types of power will be examined and influencing tactics will also be explored.

In considering the factors influencing power and influence in the health sector and particularly in the hospital setting, it is necessary to first look at what Mintzberg (1979) calls The Professional Organisation. This type of bureaucratic organisation is complex, set in a turbulent environment and organised mainly around experts and is typical of the large acute hospital. This environment generates considerable uncertainty such as government or ministerial change and also the increasing demands of a more discerning public. In the current climate, the fiscal crisis has caused unprecedented uncertainty with greater demands for health care within a shrinking workforce and an ever decreasing budget. This was made explicit by Deirdre,

Well, survival is a challenge at the moment you know from a financial point of view, we're absolutely crippled, you know they expect us to stay within budget and yet they keep slicing the budgets the whole time and because it's an acute services area, you can't close the gates (539-542)

This bureaucratic type of organisation also relates to the perceived lack of power that resides in nursing leadership, specifically Directors of nursing (DON). Eileen states,

I know there's a DON group, you know they have an association, I mean I would personally think that they don't use their influence enough, I think we never hear a statement on the TV or radio saying you know that the

Association of the DONs are concerned about the cuts in hospitals or you know whatever it is (253-257)

She goes on to say, 'I don't think they are political enough' (257-258).

This relates to French and Raven's positional or legitimate power (cited in Gabel 2012) and is based on the position and authority that a person holds. The hierarchical nature of the hospital structure also bears this out when attitudes and one's position within structures reveal one's position in the hierarchy (Witman et al 2011). With this statement she is implying that all nurses lack power at a national and political level, as lack of power across nursing leadership implies that it is not invested in any group of nurses. However, she also implies that they have power within their own structures,

when we see the opportunity to do something obviously then through the DON, they have...they have other fora for influencing and maybe if we can't influence something we can get it influenced through the DON (78-80)

There is the implication here that although the DONs have local power within the hospital environment, they don't exercise their positional and political power at a national level. However, expert power (Gabel 2012), although not mentioned for this group, it is for the ADON group:

well I suppose the SDU is linked into the emergency programme so I would be involved in influencing.... how we can reduce the waiting times (306-307)

Information is power. This has been demonstrated by a number of studies (Gabel 2012). They suggest that considerable power lies in having information and the power to distribute it. Having information prior to decisions being made, enhances one's ability to influence those decisions (Brazier 2004). Laura states

But what's more difficult is trying to influence the staff when you know, when its something from within that's being decided that really impacts on them and it is hard obviously for staff on the ground to accept a lot you know...(349-354)

Again, Denise shows her frustration that she puts down to a lack of trust in the nursing profession. When trying to get permission to recruit staff and is being refused despite a good case, the consultant intervenes and immediately permission is granted. She states,

but for me it's frustrating because you know I should be able to represent what was required for nursing and not have to go to the clinical director or a medical person (190-192)

Again she states, 'I don't know, I think there's a lack of trust there or something that they just assume that because we always had it, we'll want it so' (*staffing levels*) (203-204)

Leadership roles are not only shaped by the individuals who occupy them, but also by the followers (Carney 2006). To persuade people to change indicates that the leader has influence among his/her followers but as a reciprocal concept, as the followers also influence the leader (Daft 2005; Sherman 2005). This is in keeping with upward influence as well as downward influence. As a group, Denise states that groups have more influence than individuals alone, 'Yea...groups are more influential than individuals' (544).

Following from this, organising themselves into lobby groups might be an option. However, the bureaucratic nature of the professional organisation mitigates against this but time of crisis or recession can be the opportunity to change this concept.

4.7 Decision-making

There are different levels of decision making in all organisations including the acute voluntary hospitals. At the top level of each voluntary hospital, there is the Board, followed by the Executive or Corporate Committee comprised of the CEO and the Chief Officers or Directors of the services. Then there is the Nursing Executive Committee followed by the Directorate Committees. There would also be CNM2 committees chaired by the ADON. There are also a number of

committees and sub-committees throughout the hospital of which the ADONs are members or in some instances the Chair.

The Hospital Board has a very high level decision-making function. Items are brought to the Board by the Corporate Committee. These include keeping them informed of corporate issues such as risks, overcrowding, parliamentary questions and anything that might bring the hospital into disrepute or damage public perception in the organisation. Financial management and investment would also be brought to the Board for a decision. The Director of Nursing is always 'in attendance' at these meetings but is not a voting member.

The Executive Management Committee or the Corporate Committee is where most of the corporate decisions are made and any crisis handled. This would include high level decision making and strategic long term planning such as new service developments or a crisis that aired in the media. Directives from the Health Service Executives or the Minister of Health and parliamentary questions would also be addressed at this level with appropriate decisions cascaded down for information purposes or implementation. The Director of Nursing is a member of the Executive Management Committee.

Next in the structure is the Nursing Executive Committee and the Director of Nursing. All ADONs are members of this group. Information from the Board and Executive Management is passed on to the members of the group to keep them informed such as any structural changes within the hospital or major budgetary cuts. Strategic nursing and operational issues would be discussed and decisions made.

Strategic issues would include reports from the Special Delivery Unit in the Dept of Health, budgetary issues, project development, recruitment and retention of staff and nursing education and development. Statistics and metrics such as absenteeism rates and complaint trends are also a part of this discussion with decisions made as appropriate. Operational issues, including clinical issues such

as immediate staffing levels, business case acceptance or rejection by the Vacancy Committee, any escalation of complaints or incidents are discussed and decisions made. Certain Reports relevant to Nursing and Patient Care overall would be discussed such as the Francis Report (2013). This committee meets every 1-2 weeks.

At Clinical Directorate level, the Clinical Directorate team make operational decisions on an on-going basis at their weekly meetings. They also have meeting with the consultants within their directorate on a regular basis.

A number of ADONs (n=12) are not attached to Directorates but have responsibility for a number of services with one ADON having Directorates included in her brief. Others are mainly operational and function on a hospital-wide basis and cover all services in the hospital out of hours (between 4pm and 8am). Two Divisional Nurse Managers have responsibility for a number of areas in the hospital. The ADONs would also chair CNM2 Committees meetings for this group within their area. CNM3s could also attend these meetings.

ADONs are also members of committees, subcommittees and subgroups within the hospital that relate to both clinical and strategic issues within the hospitals. These include groups such as those relating to new developments or new builds, the Hygiene Committee and the infection control committee. A number (n=2) are members of national or international committees.

Team and organisational decision-making is a process from scanning to implementation but as Bass and Riggio state (2006) this does not always happen. Decisions are sometimes made and implemented before proper consultation on choice or any evaluative process on alternatives available. Lack of involvement in the decision-making process is a source of considerable dissatisfaction among Nurse Leaders with the converse also true (MacPhee et al 2010). When asked to describe their involvement in decision-making and corporate decision-making, the response from the ADONS was varied. Some felt that they were not involved in

decision-making appropriate for them while others were happy with their level of involvement. All the ADONs were members of the Nursing Executive Committee and as such were involved in decision-making in relation to nursing operational issues and some strategic issues. In other instances they were informed of decisions that were made at Board or Executive Management level but would affect them such as the moratorium on recruitment and budgetary issues. They would usually be informed of these decisions at their Nursing Executive meetings. In some instances, the opinions of the ADONs were sought and fed back to the Executive.

Antoinette is positive about her decision-making involvement in organisational strategic developments. She states:

...in terms of decision making for the hospital...I would be involved in a huge amount of decisions in terms of say like the new ward block that went up there in terms of the services that went there, in terms of the equipment that went in there the plans and the design of it we were involved from day one (27-31)

Antoinette is clearly involved in decision-making at an organisational strategic level. This concurs with structural empowerment and Siirala et al (2016) who state that decisions are made at three levels, operational, tactical or strategic. Anne is evidently involved in the decisions at the hospital strategic level for the development of the new build rather than at the corporate executive level. She is a fully functioning member of the project committee bringing this project to full realisation. Enabling others to act (Kouzes and Posner 2002) emphasises the positive impact of involving others in the decision-making process and the collegiate nature of such relationships. Structural empowerment also supports collaboration and shared decision making (Patrick et al 2011). Lack of involvement in the decision-making process is a source of considerable dissatisfaction among Nurse Leaders with the converse also true (MacPhee et al 2010). That sense of being at the top table, which for the purpose of this study is the Corporate Committee, and having an influence on decision-making engenders a sense of being effective and contributing to the development and goals of the hospital.

When asked about her role in corporate decision-making, Teresa stated:

To a degree yea (48)...and you know we have to look at things from a very, very high level and we do go to the executive meetings where all the other ADONs... we meet our Director of Nursing and our Deputy Director of Nursing and in those meetings we would make decisions at a corporate level but I don't know if we are actually the decision makers but we can certainly help and say what our opinions... (53-58)

Teresa is positive about her role as a member of the Nursing Executive Team where her input is clearly sought about nursing strategic issues. She also has some input into corporate issues and while the decision may not be made at her level, the opinion of the ADONs is sought and considered for feedback to inform Executive Management. These concerns would include overall staff shortages in the hospital or strategies for national and international recruitment and retention of staff. This is in contrast to Mary who stated: 'we get feedback from that point of view, but that's what it is, feedback' (82). Deirdre clearly expresses her view that at these meetings they are not involved in giving their opinions that could help inform corporate decisions but are passive recipients of decisions made. Information feedback includes changes in budget allocation or updates on reducing waiting lists.

In relation to involvement corporate decision making, Eileen states:

The site nurse managers in the last 2 years are members of the Nursing Executive....we always have a representative at the Nursing Executive where nursing strategic decisions are discussed and reached and we would also be part of the nurse administration, the management the operations level of things in the hospital (29-33)

Eileen is a site ADON and in her role is responsible for the overall running of the hospital out of hours. She is relatively new to the Nursing Executive Committee and is comfortable with her role in decision-making with her colleagues at this level. She is involved in nursing strategic decisions but not in corporate decision-making. She sees her strategic role in this context as part of the nursing workforce. As such she would be involved in nursing strategic decision-making such as dealing with escalating complaints and bed shortages. Operational issues such as emergency admissions and bed allocation is an everyday function of her

role. This concurs with structural empowerment in a nursing context where empowerment at all levels of nursing leadership is promoted (MacPhee et al 2010; Lassinger et al 2001) and support and access to information are available. Patrick et al (2011) in their study of staff nurses also found that structural empowerment and informal empowerment structures supported high standards and positive relations with colleagues. These studies indicate the importance of good relations and involvement of all grades of nurses at the appropriate level of decision-making to maintain high standards of care and a safe environment.

When asked about her role in decision-making or corporate decision-making, Denise talks about her role as a nurse manager in the Directorate:

We would meet weekly and I suppose yea, I suppose decisions related to the services for the Directorate we would make decisions on and then they're submitted to the corporate team and so I think as an organisation they do ...am, they allow a lot of decisions to be made within the directorate because I suppose they appreciate the ...people experienced in that specialist area but yea, I guess that goes to the corporate team and often things have to be changed or altered (57-62)

Organisational decision-making is a process from scanning to implementation (Bass and Reggio 2006) but this does not always happen. This is particularly true in the context of a complex healthcare organisation such as the acute hospital service. In a time of fiscal crisis, well thought out decisions may be changed at the corporate level.

Denise obviously feels appreciated for her expertise and input but also demonstrates an understanding that decisions must sometimes change. Strategic organisational decisions taken at directorate level in relation to that directorate go directly to the Executive Committee and are presented by the consultant as team leader of that Directorate. These would include escalating staff shortages when there was a moratorium that is a risk to safe standards and bed shortages which could not be sorted at Directorate level. Nursing issues can also be brought to the Nursing Executive Committee.

Deirdre makes the point about external drivers influencing decision-making and the constant struggles in relation to patient safety and staffing levels versus the cuts in budget and staying within budget. She states:

you're just trying to scramble and I think the...moratorium, the financial situation, the external drivers, I think all of those have big influences on people just coming in trying to get through every day and just keep people as safe as possible (672-675)

Here Deirdre expresses frustration where external drivers, such as directives from the HSE or the fiscal crisis, affect everyday operational decisions. In this context, operational decision-making is coming to the fore with the primary focus of keeping the patients safe and getting through the day. In the Francis Report (2013) it was found that financial issues and targets took precedence over patient safety to the detriment of patient well-being. This report demonstrated that the core values of the nursing can be lost when the nurse is 'trying to get through the day' whereas Deirdre is clearly keeping the patient safety at the forefront of care.

When asked about her role in decision-making, Olive explains her role from daily or operational issues to corporate and organisational strategic issues:

The role is also very strategic as I liaise directly with the DON, CEO and Clinical Director in relation to XXX issues...dealing with operational issues and Nurse Admin...dealing with the daily issues (9-13)

Olive has a hospital wide strategic brief. She evidently has an input into decision-making from operational to organisational strategic levels as indicated by her, direct links with the Clinical Director and DON to CEO at corporate level. She goes on to state:

I have more direct contact with senior management in relation to decision making and senior management respect my opinion and views. I have been exposed at a more senior level in decision making which I find challenging (23-26)

Olive clearly states that her decision-making role is across the hospital from operational up to corporate level. XXX is a critical issue across the health service

which causes patient morbidity and sometimes mortality. It is also a huge drain on a hospital's budget so this role is crucial in the acute sector. Being listened to and respected for your opinion is important for decision-making across the acute setting and makes for greater cohesion in the process (Wong et al 2010). Although she finds the role challenging she has the autonomy to make decisions where the consultants listen: 'I would have autonomy to make decisions directly relating to patient care by dealing with the consultants and their team (18-19)'. Advising consultants and their teams supports the strategic organisational aspect and the decision-making role in this critical area. Infection issues affect patient well-being and have major budgetary implications in relation to spending on drugs, bed occupancy and waiting lists so consultation and decisions are very important as is the evaluative process (Bass and Riggio 2006) in this area.

In reply to the decision-making question, Caroline is confident she has influence in decision-making in both a strategic role and operations management. She states, 'Well I have got a strategic role in relation to service development and planning and then I have also got a day to day operational role' (4-5). Later in the interview, she goes on to elaborate further:

While I can be very influential in making decisions...but from a strategic point of view it generally has to be agreed by the senior management team. I would be very involved in putting proposals forward and developing business cases. It depends what sort of decision you are talking about...if it's more strategic then obviously it needs to go through the senior management team (22-29).

Caroline is positive about her level of decision-making from day-to-day operational perspective as well as some strategic organisational input from the Directorate in putting forward proposals and business cases. Business cases are often related to employing more nursing staff and must be submitted to the Vacancy Committee. Here the case may be rejected or accepted and is a frustrating process for all ADONs. She also acknowledges that 'more strategic' decisions are made at a higher level of the executive management team and clearly accepts that. These would relate to issues such as financial resources for project development such as further clinic development for the Directorate.

When asked about her involvement in decision-making and corporate decision-making, Molly states that she is involved in these decisions.

In the corporate side of things I suppose, definitely when you're part of the likes of steering groups, you're I suppose able to get your point across...you're heard then and you can affect change that way. I suppose you know, because...I don't have a business manager I would be very reliant on having a good relationship with the deputy CEO and am able to approach her when I need something done so I'd go directly to her (189-195)

An instance Molly gives of an organisational strategic issue is refurbishing a room with the accompanying paperwork and disruption to ward staff but was in a position to go directly to the deputy CEO and expedite the matter. She is involved in steering groups such as looking at patients and families in XXX and a nutritionist group to effect hospital-wide change for the benefit of the patient. Operational concerns such as patient safety and risk management as well as staffing levels are big concerns which Molly manages on a daily basis. She is also clearly happy with how she is kept informed on corporate issues. She states: 'Information can come through various channels and you're kept up to date with what's happening (218-219).

In relation to involvement in corporate decision-making, Deirdre states: 'we get feedback from that point of view, but that's what it is, feedback' (82). When followed up by inquiring if her decision-making is more operational Deirdre stated, 'Very much so' (56).

Operational decision-making is an extensive part of the ADON's role and being informed of developments is also important. Receiving information after decisions have already been made by is feedback and does not give the person any power to influence or change decisions (Lassinger et al 2011). Receiving feedback on developments from corporate management is important for the ADON but here Deirdre is clearly not happy with her lack of involvement in any nursing strategic role.

Connie states she has no voice or no identity in some decisions as financial issues have taken priority. She states:

I don't really, I mean I just feel that I don't (line 36) ... so I have put a business case as to why we need our staff covered but that decision was made at a more superior level so I sometimes feel that in the decision making, I don't actually get a voice. Sometimes you could be listened to but the decision is made elsewhere (45-48)

Identity is strongly related to organisational identity and information about organisational developments directly impacts the person's ability to make or influence decisions about the organisations future goals and direction (Lassinger et al 2011). Having no control in hiring nursing staff, previously the domain of the ADON, has left Connie without a voice in this area. Financial issues were a great concern with all participants while the majority of ADONs indicated that they override all other concerns. Because of financial constraints, Dympna now has a clear pathway when making decisions:

I always will think the patient comes first, then your staff and then the organisation and any decision I make that's how I make my decision, patient, staff, organisation (135-137)

Again role and identity are eroded as the ADONs state they have no voice in this decision making process. This concurs with the study by Witman et al (2010) of whether to focus on the Administrative function or the nursing habitus – that of patient safety – and clearly Dympna puts patient safety first at the operational level (Siirala et al 2016).

Tina spoke about decision making and directorates. She stated:

I suppose decision-making for the planning of a service, you may be quite limited depending on what team you are part of (48-49)...Depending on what that relationship is, depending on what consultants in the areas would or would not welcome your input there so that can be largely dependent on the consultants lead...but as a rule you would be asked for your opinion. Generally the plan would already be made for the area. They would be looking for your input rather than starting off and start from scratch on it.

How much they would take it on board would be very dependent on who those consultants are (51-57)

Antoinette clearly states the lottery nature of decision-making in organisational strategic matters. Power structures and power positions within these bureaucratic organisational structures can either be empowering or perceived as disempowering (Lassinger et al 2011). This concurs with Bourdieu's concept of the field as a very bureaucratic organisation with its own power structures (Grenfell 2012). They also found that if the perception is that the leaders, the DONs, lack power, then this permeates downwards through the profession and creates a sense of disempowerment throughout.

Laura is evidently quite frustrated with the decision-making process, she states:

Ok, we probably have less ability to make decisions now than we did because in many respects, before we had embargos and everything, you could decide when you needed to employ a nurse or whatever whereas now that decision is taken from you and you're very much constrained as to what you can do you know. Within this organisation we have to go to a vacancy committee so I'd have to go and say for instance I have 5 nurses going on maternity leave in XXX and I'm seeking permission to try and replace some of them and without that permission, I actually can't do anything so whereas before you would just go and do that, you would have the authority to do that. So in terms of that its quite frustrating so in one since people keep talking about being strategic and all that yet you cannot make a decision as simple as that in your own place of work. (19-29)

Her previous level of decision-making appropriate for her has now been removed in relation to the hiring of staff for her own department. A number of ADONs were frustrated about this but understood the reasoning behind. It demonstrates the erosion of the role that was Laura's and also an aspect of the role of all the ADONS.

4.8 Culture

Behaviours are influences the behaviour of people in that they influence the behaviours of others (Schein 2010) or it's just the way things are done (Carney 2006). To deliver quality of care in healthcare institutions, Carney (2011) in a review of the literature focusing on organisational culture for quality of care,

found a number of themes emerging that have a positive impact on organisations including, excellence of care delivery, ethical values, strategic involvement, cost versus quality, professionalism and strategic planning and thinking.

According to Mintzberg (1979), The Professional Organisation is a bureaucratic organisation, in this study the large acute hospitals. These are complex organisations set in a turbulent environment and organised mainly around experts. This turbulent or changing environment generates considerable uncertainty such as a change of government or minister and also the increasing demands of a more discerning public. In the current climate, the fiscal crisis has caused unprecedented uncertainty with greater demands for health care and a shrinking workforce. There is no single line of authority as in the business organisation so autonomy resides at the base with the professionals and the apex with the CEO. The culture within these hospitals stems from the sometimes conflicting values of cost versus quality, excellence in care delivery versus targets set.

Organisational culture reflects the values, beliefs and behavioural norms of the staff and can influence the attitudes and behaviours (Tsai 2011). Leadership and culture are inextricably linked with the leadership as the organisational leaders set the tone for ethical behaviour and professionalism (Schein 2010). Carney (2006) found that strategic involvement was not associated with strategic involvement but culture was driven by the way things are done. The Portlaoise Report (2014: 36) describes a positive culture as one committed to preventing harm and good team communication where ‘culture and behaviour are critical components of safe and effective care’. However, what they found was a culture of insensitivity and a lack of empathy, unprofessional behaviour and lack of integrity or truthfulness in family accounts. The Francis report (2013) and the Portlaoise Report (2014) both found disengagement from management and leadership responsibilities with a focus on the organisation and not on the patient. They also found that the nursing profession shortcomings in the nursing profession including lack of empathy and a failure to build a positive culture. The failure of leadership to act with professionalism and ethical values can have devastating consequences. In my

study I found participants with a huge workload but without fail put patient care above all else in a time of considerable budget constraints, reduced staffing levels and more demands on services.

John describes a meeting with the Director of Nursing, he states:

Particularly in the current climate it's nice to feel that at least your immediate line manager is actually acknowledging that times have changed, you are under pressure, they appreciate what you are doing but we also accept the fact that we have to do this. The answer to that would be yes, there is a culture of promoting developments (615-621).

John is clear about transparency and honesty from his line manager and professional leader in relation to work pressures but acknowledges that change must be accepted. He also acknowledges a culture of development. In a bureaucratic organisation which is turbulent and changing, leadership is paramount to maintain standards and promote innovation and creativity rather than the old ways of doing things. In a culture where leaders promote positive developments, whether that is professional development or developments in work practice and care delivery, the themes of excellence in care delivery, professionalism and quality of care are maintained (Carney 2011).

In describing the need for change, Margaret states:

You need to be at the executive table, you need to be at the CEO's table or at least there has to be an organisation where there are selling their ideas, how many places are we having meetings with everyone saying, 'actually, if we did this differently'. Not that we can't have something, but actually we need to be creative about how we get the money for it. Instead of which we go, 'Oh no, we can't afford a teapot and that's it.' (515-519)

Margaret speaks about being at the CEO's table but this is corporate management and nursing is represented by the Director of Nursing who will bring ideas for change if appropriate. Innovative change and creativity in care delivery can be brought to the Executive Nursing Committee as all ADONs sit on this where innovations can be discussed and decisions made. Margaret is very positive about

change herself but does not always meet with positivity, 'we can't afford a teapot so that's it'. A culture of resistance to change is a feature of human nature and sometimes takes time to be accepted. In a time of constant change in the midst of a financial crisis, it might not get the reception one would like. However, a time of crisis can also be the best time to make changes as has been evidenced by the health sector overall where productivity has increased while budget cuts are implemented.

When Cara is asked if there is anything she would like to see to support the leadership role in the future that is not there now, she states:

They have leadership development courses but they're not there for everybody, I'll be hung for saying this (*laughing*) but you know it is am ...I think that kind of equity across the thing needs to be there...and recognition for the work you're doing, I think there's a lot taken for granted within the ADON role and a lot comes to the ADON role when it can't be fixed at another level, 'nurses will sort it out' (396-400)

Cara does not agree that leadership development courses are available on an equitable basis. Unlike John previously, she feels a lack of support and being taken for granted. A culture of assuming the nurse will deal with whatever is amiss in other areas is a feature of the old traditional ways when the culture of nursing was to be the 'good nurse' of the 1950's. Fealy (2002) argues that this image of nursing did not serve nursing well where nurses carried out their role within a bureaucratic hierarchy in the hospital system which in the past was determined by medicine and where a culture of subservience existed. It was the 1990's before this model was reviewed and followed by an education model rather than a training model. However, the nursing workforce is now a well-educated workforce with the extended role well recognised and respected.

In discussing the change in her responsibilities in recent times, Emma states:

I would probably say that in the last year that I would think that yes we have become more involved in strategic planning than what we would have been in the past, but that is because in my areas there is an awful lot of change going on because you have the xxx programme you have the xxx programme you have the xxx programme and I would be involved an

awful lot more you know in that and in planning for the future and all of that (258-263).

Emma is happy to be involved in this strategic aspect of planning in relation to the organisations. This concurs with Carney's (2011) review that strategic involvement and strategic planning and thinking have a positive impact on organisational culture. However, when asked later if the culture supports the development of the ADONs she goes on to state 'no I don't think the culture helps it, I think it's improving but no I think there is a certain culture I think it's in all hospitals and I don't think it supports the ADON as such' (449-451). One of the best assets of an organisation is its employees where intellectual stimulation and inspirational motivation support strong leadership and a positive culture. Emma states, 'I think as an ADON I am kind of caught in the middle' (250). In this context she is talking about being caught between senior management and the CNM 2 at the front line when changes are being imposed. Her style is, 'to and look at different ways and different solutions' (247) with the CNM rather than impose directives. Culture is not a simple concept to understand and can be affected by values, attitudes a positive patient experience (The Portlaoise Report 2014). Imposition of directives in the health sector was not uncommon during the fiscal crisis whereas sometimes, the front line staff have creative and innovative solutions if heard.

Emma describes the culture:

I would probably describe it as autocratic it's probably changing a bit more now but I think it's the same in every organisation I don't just think it's here. It's the same everywhere it's just a culture that's all the time you know that's very evident and I think it is changing and I think maybe with the directorates it will change more and responsibilities and roles will change and then the whole culture itself will change with it. I just think it's been difficult to change it maybe with finances and everything up until now and all of that.(456-462)

Emma clearly thinks she is in an autocratic institution where the culture is in line with that concept. It concurs with Bourdieu's concept of field and habitus and the

dominated and the dominant (Grenfell 2012). But she does think it's changing but is of the opinion that it is the same type of culture and organisation everywhere.

4.9 Governance

In healthcare organisations there are two types of governance, corporate governance and clinical governance. They are not mutually exclusive as governance issues such as quality and safety are common to both and addressed across different levels of the health service. The main underlying tenet of both governance structures in the acute care system is the quality and safety of patient care. The Health Service Executive Code of Governance (2015: 3) gives the following definition of governance, 'Governance can be defined as the framework of rules, practices and policies by which an organisation can ensure accountability, fairness and transparency in an organisation's relationship with its stakeholders'. The stakeholders here include everyone from the Minister of Health to the general public or service users. Bassett and Westmore (2012: 23) on the other hand define clinical governance as, '...a system of continuous improvement that allows organisations to identify and address weaknesses'. The Boards and the Corporate Executive are responsible for corporate governance and high level clinical governance such as risk. Boards need to set the tone for good governance which permeates down through the organisation to all levels (Jones et al 2017). Clinical governance is the responsibility of all those in clinical practice, that is, accountability, fairness and continuous quality improvement. For the purpose of this study, stakeholders are the Boards of each hospital, all employees of the DATHs and all service users including patients, families and the public. The general ADONs would be a member of clinical governance teams across the hospital structure and the Directorate ADONs would be involved in clinical governance with their teams. All ADONs would have a voice in any governance matter brought to the Executive Nursing Committee. Relevant clinical governance issues would also be discussed at the CNM2 meetings.

When Caroline was asked about her involvement in the clinical governance of the hospital, she stated:

We have got a clinical governance committee for the xxx directorate and that obviously then feeds into the overarching committee and I actually would formulate all the work for that clinical governance committee. Although the clinical director in the department is meant to chair that meeting it usually ends up being me that will chair it (171-175).

This committee has a director and a multidisciplinary group from within the directorate. This is in keeping with the HSE Code of Governance (2015) and also the underlying principle of clinical governance which is quality improvement and patient safety (Bassett and Westmore 2012), Caroline states: ‘...at that meeting we review all the risks’ (178). Items would include risk, policy and procedures and audit findings. As the person who evidently coordinates the reports for the committee and chairs in the consultant’s absence, she is central to good clinical governance in that directorate. Over the last number of years, clinical governance has been the driving force for the quality improvement agenda (Travaglia et al 2011) where staff held accountable for safety and quality of patient care. Quality improvement and patient safety have come to the notice of the public in recent times. The Francis Report (2013) which spans both corporate and clinical areas, highlighted that quality and safety is everyone’s responsibility with very serious consequences when this is forgotten in achieving targets. Caroline goes on to highlight that the code of practice of the nurse has always supported good clinical decision-making supporting good governance ‘... making sure that our practice is based on very sound decision-making and evidence-based, so I think we’re a little bit ahead of the posse there (95-96).

John explains his role in clinical governance in the mental health area of the hospital as follows:

I like to give a lot of time to each unit and staff but I do visit the unit every day. I do discuss clinical issues that are challenging with the senior nursing staff on duty on a daily basis. I do attend all case conferences... and I am consulted in great detail by consultants and medical professors... so I would have a responsibility to make sure that you know that patient care is being delivered but it is being delivered in a safe environment, that it is patient centred (263-269)

John is very clear that patient safety and patient care are at the forefront of his everyday role as well as being respected for his expertise in the area. This continuous examination and discussion of clinical issues concurs with quality improvement to highlight gaps in the system being central to good clinical governance. (Jones et al 2017). There is a collaborative approach in this context and GG is clearly listened to. The emphasis on consultation with front line staff is also of paramount importance where patients may not be fully responsible for their actions. The importance of front line staff being involved on a daily basis with governance decisions or challenges is of vital importance and concurs with Bassett and Westmore (2012), who include continuous improvement to allow organisations to identify and address any gaps or weaknesses in the system. This continuous examination of any gaps in the clinical governance of the area on a daily basis not only follows a sound process but allows for learning from any events discussed or weaknesses identified.

When Patsy is asked about her involvement in clinical governance in the hospital, she states:

I know its role (76)...there's clinical governance and I suppose people are aware of the stream of where you have to take things if needed and I think what they are trying to do within all directorates, is that each directorate has a clinical governance and a committee set up to formulate it and it would be represented by a lot of people in the directorate. I am aware of the clinical governance structure of the organisation. We have systems in place to review issues (85-90).

In this instance, Patsy is clear there is a structure in place to review any issues that arise. She explains that clinical governance as a formal process is being established within the directorate system as Directorates are at an early stage with multidisciplinary clinical governance committees then being set up. She indicates that this integrative process is beginning in light of the structural changes in the hospital, that being the setting up of Clinical Directorates. There is a clear accountability process within the Directorate team; the Medical Director, the Nurse Manager and the Business Manager and clinical governance is part of this process. it is important in setting up these governance committees that there is an

integrative process hospital wide to ensure that clinical issues are not ignored and lessons are learned from any issues that may arise (Portlaoise 2014).

When Cara is asked about her involvement in the clinical governance in the hospital, she states:

...not directly on the clinical governance group, there is a senior clinical governance group and we have governance structures that feed up, committees that would be involved that would be linked into clinical...you know there are structures that decisions have to be made through that process (96-99).

She is clear here that she is not directly involved in the governance structures although very aware of what these are and goes on to give an example. She goes on to explain, if a risk is identified in relation to CPR then:

...a report is prepared with the chair of the CPR committee and that's brought to the patient safety committee so that the risks are coming up at that level and then if it's a senior hospital management decision in relation to resources, they're informed through that process (109-112).

It is crucial for safe effective care that everyone is aware of the clinical governance systems in any hospital. Clinical governance is everyone's responsibility from Board to ward (Jones et al 2017). The Portlaoise report (2014) highlighted the lack of clear integration of the regional risk management structures and audit with their hospital governance. There was an overemphasis on the risk management process when issues arose rather than on the quality and safety issues highlighted from adverse events and subsequent learning. This would have ensured that the focus on risk management did not obscure the real safety and quality lessons that were evident in the various adverse event reports. Whether it is across hospital structures or regional structures, integration of the systems is crucial for quality improvement and risk management.

Emma states that she is aware of clinical governance within different units, she states:

The clinical governance of these units I suppose they overlap really on the groups, particularly on the acute medical unit because the nursing governance really will lie with the CNM2 who has overall charge of the

unit and then part of that is the medical assessment unit and the CNM1 will have real control there or as such will manage it.(210-214)

She sees the Clinical Nurse Manager 2 (CNM2) as the ward manager, having responsibility for clinical governance in the ward or unit with the CNM1 also having considerable responsibility in this area. Health care reform in Ireland is aimed at improving the efficiency and effectiveness of care delivery with patient centred care and patient safety at the core. These reforms need to be underpinned by good governance frameworks or models if reform is to succeed (Nicholson et al 2013). The findings from the Francis Report (2013) would strongly advocate good clinical governance structures across the healthcare sector as lack of these can lead to poor risk management. It is of the utmost importance that the frontline staff are aware of the clinical governance and their role in it but the systems need to be integrated throughout the hospital to ensure patient safety and accountability.

Cara states she is not on a clinical governance group but is aware of the structures that facilitate this in the hospital. She states:

Am...not directly on the clinical governance group, there is a senior clinical governance group and we have governance structures that feed up, committees that would be involved that would be linked into clinical am...you know there are structures that decisions have to be made through that process (96-99)

Dympna emphasis the necessity of being aware of the clinical governance, she states:

...but where clinical governance is concerned I feel that we're all very aware of it well I certainly am very aware of it I hope my staff would be as well I hope that they realise and that's how I explain it to them if I am ever talking about it, it is the umbrella overseeing everything the whole umbrella over the organisation and it oversees everything else (273-277).

Clinical governance has been the driving force behind the quality improvement agenda. This concurs with Travaglia et al (2011) who found in a systematic review of the literature that staff should be held accountable for safety and quality of care.

They found the features of clinical governance to be, ‘the use of clinical governance to promote Q and Safety; creation of clinical governance structures to improve safety and quality; effective use of data and evidence; sponsoring a patient-centred approach (Travaglia et al 2011: 63).

When I asked Kathleen about her involvement in clinical governance in the hospital, she stated:

Well, we have a clinical governance structure in the hospital, we have a director of the management team who set up a clinical governance committee on that as well and we meet that as well, again we’ve only had 3 meetings with that, every 2 months, that's the directorate and that feeds into the other (264-267).

There is a clinical governance committee in the hospital and one for the Directorate. The members of the main committee come to the meetings of the Directorate, as Kathleen states, ‘They come to our clinical governance meetings, yea’ (281) and that is the process for integration. In any new structures that are set up in the hospital system or in healthcare, it is imperative that there are structures for clinical accountability and transparency set up in tandem. Traditionally governance was the domain of management but in more recent times, it has become the responsibility of both clinicians and management up to board level. According to Jones et al (2017) good governance will include both nursing and medical clinicians. The emphasis on good clinical governance structures and integration of those structures cannot be over-emphasised.

4.10 The essential meaning structure of the leadership role

The essential meaning structure of the leadership role of the ADON is the balance between the clinical role and the management role. The out of hours role describes the balance within an operations management role. This balance is between maintaining patient safety in the clinical environment including the emergency department, and having a managerial role which dictates the ADON has a managerial role throughout the hospital such as staff allocation and addressing staff absenteeism. One ADON referred to this role as ‘gatekeepers’ with a very extensive brief and answerable for both professional clinical decisions and

management decisions, sometimes including domestic and household roles as well as professional decision making.

When exploring the supportive role, the ADON has to balance the development needs and aspirations of the staff with the budget allocation. This is seen throughout the study not only in relation to developmental needs but also in relation to employing frontline staff. Frustration at not being allowed recruit staff and understanding the need for budget cutbacks in the middle of an economic crisis were evident in varying measures when staff were being asked to do more with less. A number of participants expressed the difficulty with staff shortages and the constant need to fill the gaps while implementing change and also balancing the budget. This is in keeping with the findings of Witman et al (2010) who coined the phrase ‘wiseman versus spokesman’. The wiseman is the clinical expert in the field and respected as such while the spokesman on the other hand has to balance the budget. The wiseman is empathetic and understanding while the spokesman is objective and logical. It is a difficult road to steer for the ADON but the one area all participants agreed they would not compromise was patient safety. All were aware of the crucial importance of good governance. In light of the reports that have been published in recent time such as the Francis Report (2013) and the Portlaoise Report (2014), it is of fundamental importance to healthcare that patient safety is not compromised, this positive finding was very clear in this study.

4.11 Summary

In this chapter I have reviewed the findings of the study and documented what I think is a fair representation of the views of the ADONs. The very diverse roles and working briefs they have is extensive and at times frustrating. The role of the ADON is multifaceted and this is discussed in the context of the characteristics of transformational and transactional leadership. The transactional role was discussed in relation to the extremely busy schedule these ADONs have on a daily basis. Elements of supervision and micromanaging were evident but limited. Transformational leadership was evident in the supportive role the ADONs

demonstrated towards staff with both a transactional and transformational role evident at times. Role identity is discussed where some participants felt their role was becoming 'lost in translation' as one participant stated. Their role in the wider health system was also explored and the sometimes conflicting roles of being in a management position while balancing that role with the nursing clinical role. The concept of power and influence was explored in a hierarchical organisation. Decision-making is a crucial part of everyday life in healthcare and occurs at different levels of the hospital with different opinions on their involvement at the different levels. Governance was discussed and strong governance systems were evident at both clinical and corporate levels. Patient safety was a topic articulated by all ADONs and its importance in delivery of care. The culture of the hospitals was also discussed with varying opinions evident.

Chapter 5

Conclusions and Recommendations

5.1 Introduction

I began this journey through discussions with colleagues and a number of Assistant Directors of Nursing from different healthcare institutions. This thesis resulted from those discussions. To put the period of time in context, I will give a brief background. At the time of data collection, Ireland was going through an economic downturn that we had not experienced in the history of the state. As a result there were many hardships that had not been experienced previously. The health sector was not immune from this with considerable budget cutbacks and an exodus of personnel taking advantage of early retirement packages offered with the resultant diminution of staff. The nursing profession was not immune from this situation. There were shortages of staff across the sector and a moratorium on nursing recruitment, except in exceptional circumstances, compounded the situation. The nursing profession as other health professions felt this keenly. Into this setting I came and asked already stretched nurses to give me their time to carry out the study.

In chapter 1, I began the journey by reviewing the evolution of the profession from a poor uneducated background to the concept of the ‘good nurse’ to reform of the hospital system. During this time, the voluntary hospital sector, funded both by the state and charitable donations and often owned and run by the religious orders, were at the forefront in caring for the sick through the 19th and 20th centuries and began training nurses in their own hospitals. These hospitals remain voluntary hospitals and make up the Dublin Academic Teaching Hospitals today. The apprentice training model developed from there but offered nurses very little education opportunity with practice based on a more practical caring position. Research or evidence-based practice was not a component of this training which did not allow for a questioning environment but did support the unquestioning and obedient nurse.

Following the Report of the Commission on Nursing in 1998, a radical change occurred in nursing education rarely seen in the world. Nursing became a fulltime degree programme. From 2005 all nurses graduating in Ireland have degree status while many also have Masters degrees. At the same time the Matron became the Director of Nursing and the Assistant Matron became the Assistant Director of Nursing. Issues identified were the hierarchical nature of the health service with a command and control style of management with micromanaging prevailing. The report also highlighted the lack of a clear role for middle management, the Assistant Director of Nursing. They were seen more as administrative, implementing decisions already made by the Director and carrying out instructions. A clear detailed job description was advocated which is in operation at this time in the DATHs (Appendix 2 and 3).

In chapter 2, The literature review explored different facets of leadership from theory to some aspects of leadership such as decision-making and governance which are crucial for strong leaders in healthcare and particularly the ADONs in this study. Culture is all pervasive in any organisation but a culture of openness and questioning is crucial for building organisational excellence particularly in the acute hospitals where patient safety is paramount and can be compromised if high standards are not maintained. Bourdieu's theory of social structure, or sometimes called a theory of practice, was explored in the context of the ADONs position in a large acute voluntary hospital. This theory is about power and influence. The position of the ADON between the frontline staff and executive leadership can be difficult to navigate particularly in matters of staff shortages and budget cuts where the front line see only less staff and more work for them.

In chapter 3 Phenomenology was the methodology applied and discussed and the research question presented. The research question was 'What is the leadership experience of the Assistant Directors of Nursing in the Dublin Academic Teaching Hospitals? Giorgi's framework was used to analyse the data. The findings and discussion chapter will be discussed under key findings.

5.2 Summary of key findings

Having interviewed 20 ADONs in some of the busiest hospitals in the country, the overarching impression was of the enormous workload the majority carried each day and yet found time to meet me and give me their time and opinions in a very gracious manner. All the ADONs emphasised patient safety and patient care and when cutbacks and workloads became even more demanding they kept this at the forefront of their actions. Support for front line staff both in their daily work and in offering them opportunities for development was also a common theme despite the staff shortages.

5.2.1 The leadership Style of the ADONs

The style varied between transactional and transformational with a transformational style being more evident. The transactional style was more evident with the Out of Hours ADONs who had charge of the hospitals when management and administrative staff had left at the end of the day. They were tasked with the smooth running of the hospital from emergency admissions to personnel calling in sick to ward emergencies and as one participant put it to ‘unblocking toilets’.

The participants on being asked to describe their leadership role initially tended to describe a transactional style or what was an operational management role. This ranged from nursing issues and healthcare assistants, information giving, recruitment, attending meetings, writing reports and what was termed fire fighting to managing skill mix and staffing levels on a daily basis amidst the moratorium and staff shortages. Skill mix and staffing levels are not well defined in nursing in Ireland or indeed in any country and often these issues are defined by historical levels or habitual practice. This is an area that causes considerable concern throughout healthcare organisations and not just the acute sector. In an unpublished thesis on skill mix by Shannon (2012) he found that staffing levels were understood to be the numbers employed or the grade mix and not the competencies they required to carry out their role. This is concerning at a time

when quality improvement and patient safety are at the forefront of healthcare institutions.

With the day to day workload being so heavy, it is difficult to take a leadership role. A number of ADONs from different areas discussed being operationally oriented in the day to day management and working closely with frontline staff. This was seen as vital in the climate of the time where frontline staff could be very stretched due to shortages and as they saw it, constant changes coming down the line. As one ADON put it, approaching staff could be difficult in the circumstances as they sometimes just saw another manager coming with a clipboard ticking boxes while they were trying to carry out clinical care and adhere to safe practice. Too much change can serve more to frustrate than to support particularly if changes don't have time to be embedded and evaluated. Constant changes can end up being disregarded or ignored. The changes at the time of the economic downturn in Ireland were constant where targets in activity levels, particularly discharge planning, could threaten to overtake patient safety. As one ADON stated, it's all about safety. The involvement of the Special Delivery Units (SDU) for both scheduled and unscheduled care in the hospitals was a cause of some concern to the staff where targets had to be met and visits from these units were viewed with some scepticism by some ADONs. However, despite constant targets, there was an understanding that these had to be done which was a testament to those ADONs and front line staff who held quality and safety constantly to the forefront of care. The style was at times more operations management mixed with some transactional style. Shades of transactional style are sometimes necessary when addressing issues of risk and patient safety.

5.2.2 The supportive role

The transformational role manifested in different ways. One of these was their support for the frontline staff both in their working day and in professional development. The majority across all areas discussed the ways in which they supported the staff. This support was expressed in various ways. Support at the frontline was common to all ADONs who were very conscious of the constant pressure on staff nurses and Clinical Nurse Managers. They expressed these

supports in various ways including listening and understanding concerns, checking in with each ward or unit first thing every morning to ensure they were aware of issues that might arise and particularly staffing level problems. Moving frontline staff from one area to another when shortages arose was not uncommon nor was it welcomed by those being moved. Good communication and listening skills helped to diffuse potential difficult situations. A number of ADONs discussed empowering staff and took whatever opportunities arose to do this. Olive discussed 'thinking outside the box' which demonstrates creativity and innovation. Front line staff are often the best people to come up with solutions to problems they face but too often get overlooked by the hierarchy and decisions are made without proper consultation and consideration. At the time of this study, the fiscal crisis had affected everyone with budget cuts and targets being imposed across the services. With cuts also in salary, it was difficult to be constantly asking them to do more for less and with less staff. However, in this study, the commitment to encouraging creativity when possible and showing respect – 'guiding and advising them' as one ADON put it – demonstrated individual consideration and inspirational motivation (Bass and Reggio 2006) which is necessary to maintain standards in a difficult time and also supports the team.

Support was also shown in other ways, in promoting development through mentoring and suggesting such activities as 'shadowing' at meetings the front line manages would not usually attend. One ADON supported the managers in taking risks with new ideas (these risks never compromise patient safety) and new ways of doing things. New and innovative ways and being creative are being encouraged across the health service to improve effectiveness and efficiency of care but not everyone is comfortable taking such risks. There were varying opinions in the support available to the ADONs themselves with some being very positive while others felt the supports were not fairly distributed. All agreed that peer support was the best support they could have and the collegiality was evident.

5.2.3 The wise man versus the spokesman

Managerial roles and clinical roles vested in the same person don't always sit easy. This is the clash between implementing management decisions that affect frontline staff and functioning in a professional clinical role. This can cause stress particularly as part of a management team. The Directorate Nurse Managers are a management team of three people and it is crucial that they respect each other and have a degree of collegiality. This is not always the case but even in a team that functions very well, it can sometimes be difficult with colleagues but more so with frontline staff in the nursing domain. Connie joked about being like a manager or accountant at times which demonstrates the necessity of clarity in the managerial and leadership role and clarity in the nursing role.

5.2.4 Power, influence and culture

Power, influence and culture are related with the culture of an organisation supporting powerful positions or empowering the employees. There were varying opinions on the levels of power or influence residing with the ADON. Denise demonstrates these perceptions effectively when she relates the case where she presents a business case for more staff and was rejected but when the consultant presented her case, it was approved immediately. She found this very frustrating but it effectively demonstrates the culture of what Bourdieu would call the field, habitus and capital combined. The power residing in the consultant combined with the field of power being the hierarchical hospital institution and the lack of power in the habitus of the nurse, that is the expectation as she put it herself, that there is a lack of trust, or an assumption that the nurse just wants what was always there. It demonstrates that there is varying levels of power structures that have yet to be breached. However it must be said that others did not demonstrate such a level of frustration although it was there to some degree at times.

5.2.5 Decision-making and governance

Decision-making and governance are two areas that linked the ADONs with corporate governance structures. Corporate management were sometimes perceived as imposing decisions rather than rather than seeking the ADONs

opinion. Other ADONs perceived they were involved at the appropriate level of governance particularly in the Directorate structure. However, they were all well aware of the clinical governance structures in the hospitals and the methods of information flow with patient safety always to the fore. They were involved in decision-making at executive nursing management level through regular meetings with the Director of Nursing where nursing executive decisions were made and information flow was upwards and downwards. Committees abounded and the ADONs were members of a number including some who were on clinical governance committees. Frustration again was felt by some as their decision-making ability to employ staff now resided with a vacancy committee. Although trying to be fair with budget cuts and shortage of staff, frustration in this area was evident.

5.3 Critique of methods used

Phenomenology was the chosen method underpinning the research process as it was deemed to be appropriate for eliciting the essence of the participants experience and I believed one of the best methods for understanding the human experience. Descriptive phenomenology helps the researcher to get to the heart of complex experiences and these participants resided in the very complex environment of healthcare. The large acute hospitals are turbulent dynamic complex environments where quantitative methods would not capture the richness nor the essence of the experiences. Indeed some participants spoke at length about their experiences and seemed happy to be given the opportunity while others were conscious of helping shape an area of research. There have been criticisms of phenomenology in the nursing profession. McNamara (2005) is critical of nursing research in relation to the concept of bracketing and maintains that nurses only bracket to suit the subject under investigation and not true to the concept. Bracketing is a difficult concept and one can only take the word of the researcher that it was attempted so he has a point. However, I know from my own experiences that sometimes it is not possible as we may be unaware of our preconceptions but keeping an open mind to the idea and reflecting after each interview supports this.

5.3.1 Gaps in methodology

Phenomenology is a research method that allows the nurse to explore the real live experiences of the world of healthcare, whether the world of the patient or the nurse. The purpose of phenomenology as a research method is to get to the truth of things by exploring the meaning of life experiences at a particular point in time. The main phenomenological methods used in nursing research are interpretive and descriptive. Lopez and Willis (2004) highlight the differences in both methods. The descriptive approach is useful for uncovering the essence or true meaning of the phenomenon while the interpretive approach can uncover hidden aspects of the experience. For this reason the latter approach may be considered more appropriate than the former approach. However, descriptive phenomenology presents the data in a way that is relevant and significant for the audience. The results of the study using this methodology are not generalizable, one reason the positivists are not supportive. However, the results do give the lived experiences of the participants, an aspect not captured by quantitative methods.

Crotty (1996) was critical of the phenomenological methods used nursing research and challenged them. While acknowledging the importance of the subjective experience, he thought that nurses were not objective but focused on the experience and not on the phenomenon. Therefore nurses did not shed any light on the phenomenon in question. Giorgi (2000) argued that objectivity was present in nursing research. He claimed that objectivity was present as the nurses sought to understand the subjective experience of the participant. The opinions of Crotty (1996) generated much debate with the nursing profession divided on his work. One of the criticisms is that the philosophical underpinnings of the method used are not clearly demonstrated. In this study, the philosophical underpinnings are clearly outlined. However, there could be an argument made for interpretive phenomenology rather than descriptive.

Bracketing is the suspension of preconceived ideas and biases the researcher might have about the research study and thus it introduces objectivity to the study (Dowling 2005). This suspension can be achieved through a process of internal

reflection. However, it has its critics. McNamara (2005) is critical of nursing research and argues that bracketing is misinterpreted. He maintains that there is very little inclination to examine one's own attitudes or ideas and suspend them. It is easy to slip back and allow preconceived ideas and biases to influence research findings (Langdridge 2007). It is critical that all appropriate processes are followed to demonstrate the rigour of research studies. In this study, continuous reflection and a reflective journal supported the concept of bracketing.

Phenomenology has real value as a research method in nursing studies. The method used and its philosophical underpinnings need to be fully explained. The method chosen needs to address the purpose of the study and the research question. Nursing research in Ireland has only come to the fore in the last couple of decades and therefore the challenge is to constantly examine and address methodology and rigour.

5.4 Recommendations for practice

When I began this process, I was not sure of where it would take me or if any real learning would be gained. At the end of the process, as well as contributing to learning, I myself have learned a lot that will inform me in my own role. There had been a dearth of research into the workings of this group so the findings of the study will contribute to the knowledge base of this cohort.

The following are recommendations for practice:

- The extensive workload of this group is too great to be sustainable over a long period without burnout and loss of job satisfaction.
- ADONs are very well placed to deal with clinical governance and head up these committees. They have an extensive knowledge of risk and always put the patient and safety issues first.
- The role of the ADON should be reviewed in light of all the changing healthcare structures. Their individual and collective intelligence should

be utilised on both a local and national level to support innovation and creativity in clinical practice.

- They need to have greater exposure to corporate, national and international practice and events in relation to developments in the profession and the wider health service. Travelling to other health services or countries on short exchange programmes could be set up.
- Succession planning needs to be further developed. Networking opportunities and building alliances both within and outside the hospital structure need to be promoted.
- Role development within the DATHs and the Hospital Groups should be more structured with exchanges made available promoting greater learning and building confidence.
- Media training to gain confidence to take up wider national or international roles should be incorporated into professional development (this exercise is not necessarily for public media appearances but for personal and professional development if they are to take up roles on a national and international stage).
- The social capital of nursing and its value to the healthcare system needs to be clearly articulated where nursing is valued for its expertise and collective intelligence.

A follow up study with this group would be of great interest to explore how they are coping with the new hospital group structures and what has changed for them. How they are integrating within the group structure might be explored and what, if anything, has changed within the DATHs structure following that restructuring. A wider study of the role of the ADONs in the country would be beneficial, incorporation the HSE hospitals, to explore their role and how they are coping with the structural changes that have been implemented.

5.5 Reflections on the findings of the study

The findings of this study demonstrate the multifaceted role of the ADON and how pivotal they are to the effective and efficient working of the hospitals. Aspects of both transactional and transformational leadership roles were evident with some participants demonstrating more of one style than the other. Style sometimes depended on context. Out of hours ADONs demonstrated more of a transactional style which was a result of their hospital wide role. This effectively was management responsibility for the smooth running of the hospital overnight. However, they did demonstrate some evidence of transformational leadership in staff support and patient safety. Other ADONs, including Directorate Nurse Managers, demonstrated strong evidence of transformational leadership in staff development and particularly governance and patient safety. Some participants discussed leading from the back while others led from the front. In discussing their leadership style, it is important to discuss it in the context of a world recession and the impact that had in Ireland and particularly the health sector budget. Major cuts meant less finance for staff development and the moratorium on recruiting frontline staff meant staff shortages with staff being consistently moved to fill gaps were a constant feature.

One of the principal findings was that of patient safety. All participants spoke of patient safety and its importance particularly in the context of budget cuts, reduced staffing levels and greater demands on the services. A number of reports relating to healthcare have been published including the Francis Report (2013) and the Portlaoise Report (2014) demonstrating the devastating consequences when there is poor leadership. These reports highlighted the disengagement of management and leadership from their responsibilities with the resultant fall in standards, unprofessional behaviour and a focus on the organisation and not the patient. Despite cutbacks, moratoriums on staff recruitment and budget targets to be met, strong leadership in patient safety was demonstrated by all the ADONs. They supported the clinical governance system in place and its integration throughout the hospital structure.

Leadership in the context of the supportive role of the ADONs was generally evident. This was evident both in their own role and that of frontline staff. The majority of ADONs felt they were supported by their Directors and development opportunities were available to them. Some availed of these opportunities while others were not in a position to avail of them at the time of the study but intended to later in their careers. Others disagreed and did not feel supported. Peer support was seen as the most important form of support for the majority. All the ADONs agreed that supporting frontline staff was an important part of their role. One ADON spoke of guiding and advising staff while another participant speaks of stepping outside the box by looking at different ways of doing things to promote staff development. Succession planning and promoting potential leadership development was an aspect of some participants supportive role which supports individual consideration and intellectual consideration (Bass and Avolio 1994). Mentoring and empowering staff, shadowing at meetings and supporting educational opportunities where possible was seen as part of the supportive role. Cutbacks were seen as limiting development opportunities. One ADON expressed the hope that this study would contribute to clarifying the role of the ADON given the enormity of the workload which she felt limited opportunities to show leadership. The difficulty of supporting staff in this complex environment is a difficult task and has to be balanced with available resources. Staff are not always happy about decisions made in this area.

A number of ADONs expressed the opinion that their role identity was being eroded, or as one stated the role was 'lost in translation' while another stated, it was 'lost in the busyness' of the daily workload. It was felt that the new professional grade of the Advanced Nurse Practitioner was now the person being sought out for expertise and opinion while the ADON was forgotten in the professional restructuring. Others felt positive about their role and role identity and that they had a voice that was heard by corporate management. Maintaining role and organisational identity is crucial if the essence of the nursing profession is to be maintained and valued. This can be blurred with the increasing demands of healthcare in a strained health service but as we have seen, the ADON is

pivotal to ensuring patient safety, good governance and values are maintained. It is crucial the the role of the ADON is valued across the service.

Involvement in the wider health system outside of the hospital structure was very limited for these ADONs. A small minority were involved at a national level with only one indicating international involvement. There was little opportunity to get involved at a national level or in national policy and planning opportunities. It was suggested that the same people were always chosen for national committees and groups without regard for the expertise required. Others thought the opportunities were there where they could influence developments but they did not always engage in the process. Greater development opportunities at a national and international level would benefit this group given their crucial role in patient safety and good governance. This group of ADONs are pivotal to the smooth running of the hospitals but perhaps their collective intelligence and expertise are not being fully utilised.

It was evident that outside forces, particularly the economic downturn, were having an impact on the role of the ADONs. They had to balance the clinical aspect, particularly patient safety, good governance and staff shortages, with the managerial aspect of policy implementation and budget cuts. Although patient safety was never compromised, constant change being imposed sometimes in what appeared to be a weekly basis, was causing a degree of fatigue. Balancing between the two worlds of the 'wisemam and the spokesman', the clinical and managerial world, was not an easy task. This was in the context of a fiscal crisis having a severe impact on the budget with the need to reform the health service. The participants in this study demonstrated leadership traits and attributes in areas such as patient safety, good governance and a supportive role in a difficult climate despite considerable workloads. It is difficult to demonstrate leadership capability in such an environment. However, leadership as integral to the role of the nurse and the development of leadership capacity and capability is central to the development of the profession, including the role of the ADON.

5.6 Reflections of the researcher

Looking back on the process from the start of the doctorate programme to completing the study, it has been at times a steep learning curve. The taught component was comprised of a varied group of professionals from diverse backgrounds. This generated reflection on the different experiences and approaches which would not be found with a homogenous group. Going out to carry out aspects of the assignments was both daunting and educational. Going into companies that I would not encounter in my own working environment, although somewhat unnerving at first, gives a different perspective on how things are done and also builds confidence. I was privileged to attend a meeting in a private company to see how meetings were run and learned how efficiently the leader ran the meetings. This was done in a relaxed manner because everyone was prepared and it finished in the allocated time. Not being prepared would not have been acceptable. In another setting the leader discussed how she balanced risk with productivity. From a professional perspective, it taught me the value of diverse opinions and the value of bringing diverse groups together as a way of getting broader perspectives on problems and projects which I now strongly advocate.

Carrying out the study itself taught me a lot. The willingness of a very busy group of professionals in difficult times to give me the benefit of their experience reaffirmed for me that there are very committed nurses in the health service. This is not always recognised. On reflection, I was surprised at the ‘busyness’, as one ADON put it, of the group. They were very professional and pleasant which reminded me of the importance of the values of caring and kindness and why these core values must not be forgotten in an age of technology and social media. Going through the process of the study itself taught me a lot about research although I still have a lot to learn. I feel very strongly about the importance of disseminating the findings of studies and have already arranged to give presentations to different groups (once this last hurdle is complete). Too often nurses carry out studies but the results are not disseminated. It is something I constantly encourage in my work. Studying for this doctorate has given me a renewed confidence in myself and in the nursing profession.

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Appendix 1

Director of Nursing, Assistant (Acute) Grade Code 2910, 2911, 2912

In exercise of the powers conferred on me by Section 22 of the Health Act 2004, I hereby approve the qualifications, as set out hereunder, for the appointment and continuing as **Director of Nursing, Assistant** in the HSE.

1. Professional Qualifications, Experience, etc

(a) Eligible applicants will be those who on the closing date for the competition:

(i) Are registered, or be eligible for registration in the General Nurse Division, and other divisions as relevant to the specific service, of the Register of Nurses and Midwives, as appropriate, maintained by the Nursing & Midwifery Board of Ireland (Bord Altranais agus Cnáimhseachais na hÉireann).

and

(ii) Have 7 years post registration nursing experience and 3 years nursing management experience at a minimum of CNM2 in an acute setting.

and

(iii) Possess a post graduate qualification at not less than level 8 (QQI) in health care or management related area.

and

(b) Candidates must possess the requisite clinical, leadership, managerial and administrative knowledge and ability for the proper discharge of the office.

2. Annual registration

Practitioners must maintain live annual registration on the General Nursing Division of the Nurses & Midwifery Register maintained by the Nursing & Midwifery Registration Board (Bord Altranais agus Cnáimhseachais na hÉireann)

3. Age

Age restriction shall only apply to a candidate where s/he is not classified as a new entrant (within the meaning of the Public Service Superannuation (Miscellaneous Provisions) Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age on the first day of the month in which the latest date for receiving completed application forms for the office occurs.

4. Health

Candidates for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.

5. Character

Candidates for and any person holding the office must be of good character.

Dated this day of February two thousand and sixteen.

Rosarii Mannion
National Director of Human Resources

Appendix 2

Director of Nursing, Assistant Job Specification, Terms and Conditions

Job Title and Grade	Director of Nursing, Assistant (Grade Code: 2910: Band 1)
Campaign Reference	NRS04201
Closing Date	Wednesday 7th September 2016 @ 12 Noon
Proposed Interview Date (s)	Mid October 2016
Taking up Appointment	A start date will be agreed at job offer stage
Location of Post	<p>Galway University Hospitals (University Hospital Galway and Merlin Park University Hospital).</p> <p>There is currently one whole-time, permanent and one whole-time, specified post available. The specified purpose contract is for a duration of 12 months. Initial assignment will be to University Hospital Galway. The successful candidate may be required to work in any service area within the vicinity as the need arises.</p> <p>A panel may be created as a result of this campaign for Galway University Hospitals from which current and future, permanent and specified purpose vacancies of full or part-time duration may be filled.</p>
Informal Enquiries	Ms Julie Nohilly, Director of Nursing & Midwifery, Galway University Hospital. Tel: 091-893343
Details of Service	<p>Saolta University Health Care Group is one of seven new hospital groups announced by the then Minister for Health, Dr. James Reilly TD in May, 2013, as part of a re-organisation of public hospitals into more efficient and accountable hospital groups that will deliver improved outcomes for patient. The Saolta University Health Care Group comprises of 7 hospitals:</p> <ul style="list-style-type: none"> • Letterkenny University Hospital • Sligo University Hospital • Mayo University Hospital • Roscommon University Hospital • Portlinculla University Hospital • Merlin Park University Hospital Galway • University Hospital Galway <p>The Group has one overall Group Management Team, turnover of €820 million and operates with 1,781 beds and staffing of 8,274 WTE (9,768 headcount) in January 2016.</p> <p>The objectives of the groups are to:</p>

	<ul style="list-style-type: none"> • Achieve the highest standard of quality and uniformity in care across the group • Deliver cost effective hospital care in a timely and sustainable manner • Encourage and support clinical and managerial leaders • Ensure high standards of governance, both clinical and corporate and recruit and retain high quality nurses, NCHDs, consultants, allied health professionals and administrators in all our hospitals. <p>There is an evolving Group governance structure with 4 Clinical Directorates which manage the clinical specialities across each site:</p> <ul style="list-style-type: none"> • Medicine • Perioperative • Diagnostics • Women and Children's <p>Each Directorate has a set of key performance indicators to improve quality, drive performance, and ensure efficiency.</p> <p>The Group provides a range of high quality services for the catchment areas it serves and GUH is a designated supra-regional cancer service provider meeting the needs of all the counties along Western seaboard and towards the midlands from Donegal to North Tipperary.</p> <p>Saolta University Health Care Group aims to meet its service plan targets. Its priority is to implement the national clinical care programmes across the Group and establish a performance management culture with the development of Key Performance Indicators.</p> <p>Vision The formation of the hospitals groups, which will transition to independent hospital trusts, will change how hospitals relate to each other and integrate with the academic sector. Over time, the Group will deliver:</p> <ul style="list-style-type: none"> • Higher quality service • More consistent standards of care • More consistent access to care • Stronger leadership <p>Greater integration between the healthcare agenda and the teaching, training, research and innovation agenda</p> <p>Our Academic Partner is the National University of Ireland, Galway and we are developing further international partnerships in the UK and the USA.</p>
Mission Statement	<p>Patients are at the heart of everything we do. Our mission is to provide high quality and equitable services for all by delivering care based on excellence in clinical practice, teaching, and research, grounded in kindness, compassion and respect, whilst developing our staff and becoming a model employer.</p> <p>OUR VISION STATEMENT</p> <p>Our Vision is to build on excellent foundations already laid, further developing and integrating our Group, fulfilling our role as an exemplar, and becoming the first Trust in Ireland.</p>

	<p>OUR GUIDING VALUES</p> <p>Respect - We aim to be an organisation where privacy, dignity, and individual needs are respected, where staff are valued, supported and involved in decision-making, and where diversity is celebrated, recognising that working in a respectful environment will enable us to achieve more.</p> <p>Compassion - we will treat patients and family members with dignity, sensitivity and empathy.</p> <p>Kindness - whilst we develop our organisation as a business, we will remember it is a service, and treat our patients and each other with kindness and humanity.</p> <p>Quality – we seek continuous quality improvement in all we do, through creativity, innovation, education and research.</p> <p>Learning - we will nurture and encourage lifelong learning and continuous improvement, attracting, developing and retaining high quality staff, enabling them to fulfil their potential.</p> <p>Integrity - through our governance arrangements and our value system, we will ensure all of our services are transparent, trustworthy and reliable and delivered to the highest ethical standards, taking responsibility and accountability for our actions.</p> <p>Teamworking – we will engage and empower our staff, sharing best practice and strengthening relationships with our partners and patients to achieve our Mission.</p> <p>Communication - we aim to communicate with patients, the public, our staff and stakeholders, empowering them to actively participate in all aspects of the service, encouraging inclusiveness, openness, and accountability.</p> <p><i>These Values shape our strategy to create an organisational culture and ethos to deliver high quality and safe services for all we serve and that staff are rightly proud of.</i></p>
Reporting Relationship	<ul style="list-style-type: none"> • Professionally accountable to the Chief Director of Nursing Saolta University Health Care Group • Operationally accountable to the Director of Nursing and Midwifery in the appointed hospital site. • Reports to the Clinical Director with operational matters within Directorates.
Purpose of the Post	The successful candidate will lead and co-ordinate the development and delivery of the nursing service in their relevant area.
Principal Duties and Responsibilities	<p><u>Management and Leadership</u></p> <p><i>The Assistant Director of Nursing will:</i></p> <ul style="list-style-type: none"> • Support the principle that the care of the patient comes first at all times and will approach their work with the flexibility and enthusiasm necessary to make this principle a reality for every patient to the greatest possible degree. • Participate in the appropriate and effective management of the service. • Participate in the development of the overall service plan and in the monitoring and review of activity against the plans. • Participate in the overall financial planning of the service including the assessment of priorities in pay and non-pay expenditure. • Assist with the direction and supervision of the nursing service to provide a high level of

	<p>patient care and clinic/functional area/sector management.</p> <ul style="list-style-type: none"> • Provide innovative and effective leadership, support and advice to nursing and allied staff at all levels. • Provide guidance to nursing and other staff in the implementation of nursing and policies. • Maintain good employee relations and promote good communication with all relevant staff. • Give support and counsel to nursing and allied staff as necessary and take action in accordance with agreed service policy, if necessary. • Plan and guide activities to provide optimum patient care in accordance with service policies and procedure. • Ensure adherence to all standards and guidelines relating to professional nursing practice and behaviour. • Undertake other relevant duties as may be determined from time to time by the Director of Nursing or other designated officer. • Participate and engage in projects and service developments by representing senior nursing on committees and groups. • Be responsible for monitoring of nursing rosters/ skill mix. <p><u>Professional /Clinical Responsibilities</u></p> <p><i>The Assistant Director of Nursing will:</i></p> <ul style="list-style-type: none"> • Provide a high level of professional and clinical leadership. • Provide safe, comprehensive nursing care to service users within the guidelines laid out by An Bord Altranais. • Practice nursing according to Professional Clinical Guidelines, National and Area Health Service Executive guidelines, local policies, protocols and guidelines, current legislation. • Manage, monitor and evaluate professional and clinical standards ensuring an evidence based care planning approach. • Manage own case load in accordance with the needs of the post. • Participate in teams as appropriate, communicating and working in cooperation with the other team members and the wider multi disciplinary teams. • Facilitate coordination, cooperation and liaison across health care teams and programmes. • Formulate, manage and implement best practice policies and procedures. • Ensure that service users and others are treated with dignity and respect. • Adhere and contribute to the development and maintenance of nursing standards, protocols and guidelines consistent with the highest standards of patient care. • Maintain professional standards in relation to confidentiality, ethics and legislation. • Assist in the development of service policies and procedures and the implementation of same and to update them as required. • Participate in development of quality initiatives including clinical audit, standard setting, investigation of complaints and untoward incidents.
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Education and Training

The Assistant Director of Nursing will:

- Contribute to service development through appropriate continuous education, research initiatives, keeping up to date with nursing literature, recent nursing research and new developments in nursing management, education and practice and attend staff study days as considered appropriate.
- Provide support/advice to those engaging in continuous professional development in his/her area of responsibility.
- Participate in the identification, development and delivery of induction, education, training and development programmes for nursing and non-nursing staff.
- Participate in in-service training, orientation programmes and appraisals of all nursing staff. Also, participate in nurse training programmes and any other programmes pertaining to future development in the hospital.
- Provide support supervision and professional development of appropriate staff.
- Engage in performance review processes including personal development planning e.g., by setting own and staff objectives and providing and receiving feedback.

Clinical Governance, Quality Assurance, Risk, Health & Safety

The Assistant Director of Nursing will:

- Ensure that effective safety procedures are developed and managed to comply with statutory obligations.
- Be aware of risk management issues, identify risks and take appropriate action.
- Comply with the policies, procedures and safe professional practice of the Irish Healthcare System by adhering to relevant legislation, regulations and standards.
- Assist in the development, implementation and review of Health and Safety statements, risk registers as appropriate.
- Document appropriately and report any near misses, hazards and accidents and bring them to the attention of the relevant person(s).
- Maintain a feedback mechanism and report to senior management where appropriate.
- Work in a safe manner with due care and attention to the safety of self and others.
- Ensure adherence to policies in relation to the care and safety of any equipment supplied for the fulfilment of duty. Ensure advice of relevant stakeholders is sought prior to procurement
- Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role e.g. Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc.
- Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

Performance Management

The Assistant Director of Nursing will:

	<ul style="list-style-type: none"> • Drive, promote and support a performance measurement and management culture. • In conjunction with the Director of Nursing develop a Performance Management system for the nursing profession in their area. • Identification and development of monthly Key Performance Indicators (KPIs) which are congruent with the Groups strategic and service plan. • The management and delivery of KPIs / Nursing Metrics and other quality measurement tools in ward / departments as a routine and core business objective. • The development of Action Plans to address non-attainment of KPI targets. • To develop individual Plan of Actions (POAs) with the Director of Nursing and agree performance targets. <p>General Conditions</p> <ul style="list-style-type: none"> • Employees must attend fire lectures periodically and must observe fire orders. • All accidents within the Department must be reported immediately. • Infection Control Policies must be adhered to. • In line with the Safety, Health and Welfare at Work Act, 2005 all staff must comply with all safety regulations and audits. • In line with the Public Health (Tobacco) (Amendment) Act 2004, smoking within the Hospital Buildings is not permitted. • Hospital uniform code must be adhered to. • Provide information that meets the need of Senior Management. • To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service. <p>Risk Management, Infection Control, Hygiene Services and Health & Safety</p> <ul style="list-style-type: none"> • The management of Risk, Infection Control, Hygiene Services and Health & Safety is the responsibility of everyone and will be achieved within a progressive, honest and open environment. • The post holder must be familiar with the necessary education, training and support to enable them to meet this responsibility. • The post holder has a duty to familiarise themselves with the relevant Organisational Policies, Procedures & Standards and attend training as appropriate in the following areas: <ul style="list-style-type: none"> ○ Continuous Quality Improvement Initiatives ○ Document Control Information Management Systems ○ Risk Management Strategy and Policies ○ Hygiene Related Policies, Procedures and Standards ○ Decontamination Code of Practice ○ Infection Control Policies ○ Safety Statement, Health & Safety Policies and Fire Procedure ○ Data Protection and confidentiality Policies • The post holder is responsible for ensuring that they become familiar with the requirements stated within the Risk Management Strategy and that they comply with the
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	<p>Group's Risk Management Incident/Near miss reporting Policies and Procedures.</p> <ul style="list-style-type: none"> • The post holder is responsible for ensuring that they comply with hygiene services requirements in your area of responsibility. Hygiene Services incorporates environment and facilities, hand hygiene, catering, cleaning, the management of laundry, waste, sharps and equipment. • The post holder must foster and support a quality improvement culture through-out your area of responsibility in relation to hygiene services. • It is the post holders' specific responsibility for Quality & Risk Management, Hygiene Services and Health & Safety will be clarified to you in the induction process and by your line manager. • The post holder must take reasonable care for his or her own actions and the effect that these may have upon the safety of others. • The post holder must cooperate with management, attend Health & Safety related training and not undertake any task for which they have not been authorised and adequately trained. • The post holder is required to bring to the attention of a responsible person any perceived shortcoming in our safety arrangements or any defects in work equipment. • It is the post holder's responsibility to be aware of and comply with the HSE Health Care Records Management/Integrated Discharge Planning (HCRM / IDP) Code of Practice. <p>The above Job Description is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.</p>
<p>Eligibility Criteria</p> <p>Qualifications and/ or experience</p>	<p>6. <u>Professional Qualifications, Experience, etc</u></p> <p>(a) Eligible applicants will be those who on the closing date for the competition:</p> <p>(iv) Are registered, or be eligible for registration in the General Nurse Division of the Register of Nurses and Midwives, as appropriate, maintained by the Nursing & Midwifery Board of Ireland (Bord Altranais agus Cnáimhseachais na hÉireann).</p> <p style="text-align: center;">and</p> <p>(v) Have 7 years post registration nursing experience and 3 years nursing management experience at a minimum of CNM2 in an acute setting.</p> <p style="text-align: center;">and</p> <p>(vi) Possess a post graduate qualification at not less than level 8 (QQI) in health care or management related area.</p> <p style="text-align: center;">and</p> <p>(b) Candidates must possess the requisite clinical, leadership, managerial and administrative knowledge and ability for the proper discharge of the office.</p> <p>7. <u>Annual registration</u></p> <p>Practitioners must maintain live annual registration on the General Nursing Division of the Nurses & Midwifery Register maintained by the Nursing & Midwifery Registration Board (Bord Altranais agus Cnáimhseachais na hÉireann)</p> <p>8. <u>Age</u></p> <p>Age restriction shall only apply to a candidate where s/he is not classified as a new entrant (within the meaning of the Public Service Superannuation (Miscellaneous</p>

	<p>Provisions) Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age on the first day of the month in which the latest date for receiving completed application forms for the office occurs.</p> <p>9. <u>Health</u> Candidates for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.</p> <p>10. <u>Character</u> Candidates for and any person holding the office must be of good character.</p>
Post specific Requirements	Demonstrate depth and breadth of management experience in an acute setting as relevant to the role.
Other Requirements Specific to the Post	N/A
Skills, Competencies and/or Knowledge	<p><u>Professional/Clinical Knowledge</u></p> <ul style="list-style-type: none"> • Demonstrate a high degree of commitment, professionalism and dedication to the philosophy of quality health care provision. • Demonstrate relevant knowledge, expertise and experience from an acute hospital perspective in order to discharge the duties of this senior nursing post. • Demonstrate evidence of policy development and translating policy into working practices/action. • Demonstrate knowledge and experience of quality audit/assurance systems. <p><u>Planning and Organising Resources</u></p> <ul style="list-style-type: none"> • Demonstrate ability to plan, organise and deliver services in an efficient, effective and resourceful manner, within a model of patient centred care and value for money. • Demonstrate ability to manage deadlines and effectively handle multiple tasks. <p><u>Building and Maintaining Relationships: Leadership, Staff Management & Team Skills</u></p> <ul style="list-style-type: none"> • Demonstrate leadership skills and ability to influence others. • Demonstrate flexibility and openness to change and ability to lead and support others in a changing environment. • Demonstrate ability to manage, motivate and develop staff to maximise performance at work. • Demonstrate the ability to foster a learning culture amongst staff and colleagues to drive continuous improvement in services to patients. • Demonstrate ability to work effectively with multi-disciplinary teams. <p><u>Evaluating Information and Judging Situations</u></p> <ul style="list-style-type: none"> • Demonstrate the ability to evaluate information and solve problems <p><u>Commitment to Quality Care</u></p>

	<ul style="list-style-type: none"> • Demonstrate understanding of, and commitment to, the underpinning requirements and key processes in providing quality patient centred care. • Demonstrate an ability to monitor and evaluate service performance and levels of care. <p><u>Communication and Interpersonal Skills</u></p> <ul style="list-style-type: none"> • Demonstrate effective communications and interpersonal skills including: the ability to present information in a clear and concise manner; the ability to engage collaboratively with all stakeholders; the ability to give constructive feedback. • Demonstrate competency in general use of information technology-computers, office functions, internet for research purposes, email, preparation of presentation materials etc.
<p>Campaign Specific Selection Process</p> <p>Ranking/Shortlisting/ Interview</p>	<p>A ranking and or short-listing exercise may be carried out on the basis of information supplied in your application form. The criteria for ranking and or short-listing are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements.</p> <p><u>Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process.</u></p> <p>Those successful at the ranking stage of this process (where applied) will be placed on an order of merit and will be called to interview in 'bands' depending on the service needs of the organisation.</p>
<p>Code of Practice</p>	<p>The Health Service Executive / Public Appointments Service will run this campaign in compliance with the Code of Practice prepared by the Commission for Public Service Appointments (CPSA). The Code of Practice sets out how the core principles of probity, merit, equity and fairness might be applied on a principle basis. The Code also specifies the responsibilities placed on candidates, facilities for feedback to applicants on matters relating to their application when requested, and outlines procedures in relation to requests for a review of the recruitment and selection process and review in relation to allegations of a breach of the Code of Practice. Additional information on the HSE's review process is available in the document posted with each vacancy entitled "Code of Practice, information for candidates".</p> <p>Codes of practice are published by the CPSA and are available on www.hse.ie/eng/staff/jobs in the document posted with each vacancy entitled "Code of Practice, information for candidates" or on www.cpsa.ie.</p>
<p>The reform programme outlined for the Health Services may impact on this role and as structures change the job description may be reviewed.</p> <p>This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.</p>	

Director of Nursing, Assistant
Terms and Conditions of Employment

Tenure	<p>The current vacancies available are permanent/whole time and specified purpose/whole time. The specified purpose vacancy is for a duration of 12 months.</p> <p>The posts are pensionable. A panel may be created from which permanent and specified purpose vacancies of full or part time duration may be filled. The tenure of these posts will be indicated at “expression of interest” stage.</p> <p>Appointment as an employee of the Health Service Executive is governed by the Health Act 2004 and the Public Service Management (Recruitment and Appointment) Act 2004.</p>
Remuneration	The Salary scale for the post is : €54,870: €55,952: €56,996; €60,201: €61,210: €62,382: €63,477: €64,566: €65,066
Working Week	The standard working week applying to the post is 39 hours
Annual Leave	The annual leave associated with the post will be confirmed at job offer stage
Superannuation	<p>This is a pensionable position with the HSE. The successful candidate will upon appointment become a member of the appropriate pension scheme. Pension scheme membership will be notified within the contract of employment. Members of pre-existing pension schemes who transferred to the HSE on the 01st January 2005 pursuant to Section 60 of the Health Act 2004 are entitled to superannuation benefit terms under the HSE Scheme which are no less favourable to those which they were entitled to at 31st December 2004</p>
Probation	Every appointment of a person who is not already a permanent officer of the Health Service Executive or of a Local Authority shall be subject to a probationary period of 12 months as stipulated in the Department of Health Circular No.10/71.
Protection of Persons Reporting Child Abuse Act 1998	As this post is one of those designated under the Protection of Persons Reporting Child Abuse Act 1998, appointment to this post appoints one as a designated officer in accordance with Section 2 of the Act. You will remain a designated officer for the duration of your appointment to your current post or for the duration of your appointment to such other post as is included in the categories specified in the Ministerial Direction. You will receive full information on your responsibilities under the Act on appointment.
Infection Control	Have a working knowledge of Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc.

<p>Ethics in Public Office 1995 and 2001</p> <p>Positions remunerated at or above the minimum point of the Grade VIII salary scale (€ 64,812 as at 01.01.10)</p>	<p>Positions remunerated at or above the minimum point of the Grade VIII salary scale (€ 64,812 as at 01.01.2010) are designated positions under Section 18 of the Ethics in Public Office Act 1995. Any person appointed to a designated position must comply with the requirements of the Ethics in Public Office Acts 1995 and 2001 as outlined below;</p> <p>A) In accordance with Section 18 of the Ethics in Public Office Act 1995, a person holding such a post is required to prepare and furnish an annual statement of any interests which could materially influence the performance of the official functions of the post. This annual statement of interest should be submitted to the Chief Executive Officer not later than 31st January in the following year.</p> <p>B) In addition to the annual statement, a person holding such a post is required, whenever they are performing a function as an employee of the HSE and have actual knowledge, or a connected person, has a material interest in a matter to which the function relates, provide at the time a statement of the facts of that interest. A person holding such a post should provide such statement to the Chief Executive Officer. The function in question cannot be performed unless there are compelling reasons to do so and, if this is the case, those compelling reasons must be stated in writing and must be provided to the Chief Executive Officer.</p> <p>C) A person holding such a post is required under the Ethics in Public Office Acts 1995 and 2001 to act in accordance with any guidelines or advice published or given by the Standards in Public Office Commission. Guidelines for public servants on compliance with the provisions of the Ethics in Public Office Acts 1995 and 2001 are available on the Standards Commission's website http://www.sipo.gov.ie</p>
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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Appendix 3

Director of Nursing, Assistant Job Specification, Terms and Conditions

Job Title and Grade	Director of Nursing, Assistant (ADON) (Grade Code: 2911)
Campaign Reference	
Closing Date	<i>To be inserted by NRS</i>
Proposed Interview Date (s)	<i>To be inserted by NRS</i>
Taking up Appointment	A start date will be indicated at job offer stage
Location of Post	<p>Midland Regional Hospital Portlaoise</p> <p>There is currently one permanent, whole-time post available in this location.</p> <p>A panel may be formed as a result of this campaign for Midland Regional Hospital Portlaoise from which current and future, permanent and specified purpose vacancies of full or part-time duration may be filled.</p> <p><u>Informal Enquiries</u></p> <p>Name: Angela Dunne Email: angeladunne@hse.ie Tel: 057 8696434</p>
Details of Service	<p>The role of the ADON Surgical Department will be to drive service standards and new developments at the MRHP.</p> <p>The ADON with speciality expert in Surgery will be assigned to manage Operating Theatre & Pre Operative Surgical Services, to include the Day Surgery, Endoscopy services,</p> <p>Responsibilities will include management of Operating Theatre Department, Surgical Unit, Endoscopy unit and ICU at the MRHP</p> <p>The post holder will oversee pre& post operative Surgical Services for all patients Adult and Paediatric, requiring elective surgery and emergency surgical including pre operative assessment and chronic pain management.</p> <p>The post holder will participate in service reconfiguration in line with clinical care programmes.</p> <p>The ADON Surgical Department will manage strategically and report to the Director of Nursing & Midwifery.</p> <p>The post holder will be expected to influence and lead on identified clinical and non clinical programmes as defined by the Director of Nursing and Midwifery</p>

	This will include, contributing to the development of key process and outcome standards and objectives, the development of key performance indicators and monitoring of same taking a lead in quality assurance programmes.
Reporting Relationship	The post holder will report to the Director of Nursing & Midwifery
Purpose of the Post	<ul style="list-style-type: none"> • Strategic management of an effective and efficient high quality theatre department ensuring peri-operative patients requiring anaesthesia or surgical procedure have the best outcomes in line with international evidence. Providing leadership in context of the multidisciplinary, multiprofessional team and a specific focus on and leading, managing and performance enhancement of the Nursing and Healthcare Assistant team. • Provide highly visible leadership of the hospitals nursing and support workforce and foster a culture which values continuing professional development that empowers nurses and to achieve excellence in the delivery of patient care • Provide leadership and management on the Quality & Patient Safety Agenda • Work collaboratively with the Director of Nursing & Midwifery and other Assistant Directors of Nursing to develop a culture which reflects Clinical Quality and Governance and monitor its effectiveness
Principal Duties and Responsibilities	<p><u>Management</u></p> <p><i>The Assistant Director of Nursing Surgical Department will:</i></p> <ul style="list-style-type: none"> • Participate in the appropriate and effective management of Operating Theatres, Day Ward, and Endoscopy and ICU services. • Ensure visibility of senior management throughout regular "walkabouts" and other means of communication. • Ensure that the provision of nursing services are patient centred, holistic and evidence based • Ensure that the services to patients and their families are appropriate, accessible and are delivered in a manner that respects privacy, dignity and individuality. • Ensure that systems are in place to monitor and evaluate outcomes • Assist and review policies / protocols / guidelines in relation to nursing practise . • Convene and participate in meetings with Nursing and Allied Healthcare staff as necessary • Work as part of a multidisciplinary team in delivering patient centred care • Ensure that all staff within the service are aware of their responsibilities in relation to risk, audit and quality initiatives. • Ensure that effective channels of internal and external communication are developed and fostered across all departments in order to provide a seamless service • Ensure effective communication with the Director of Nursing on issues

	<p>requiring strategic resolution</p> <ul style="list-style-type: none"> • Advise the Director of Nursing on professional issues, clinical, quality and standard issues, education, professional development and any such matters that are likely to impact on the profession of nursing • Provide expert professional leadership to Nurses and support staff within the services • Provide effective leadership in implementing changes in practice and processes that are deemed necessary within the services • Monitor staff rosters to ensure staffing levels and appropriate skill mix meet the needs of the service user by providing quality and safe nursing practices • Participate in the development of the overall service plan and in the monitoring and review of activity against the plans. • Provide innovative and effective change management, leadership, support and advice to staffing groups at all levels. • Maintain good employee relations and promote good communications with all relevant staff in line with HSE Dignity at Work Policy . • Manage and discharge the necessary Human Resources functions of the service e.g Manage staff attendance in line with HSE Policy • Give support and direction to staff as necessary and take action in accordance with agreed policy, if necessary. • Ensure adherence to all standards and guidelines relating to professional nursing practice and behaviour. (NMBI Code of Professional Conduct & Ethics for Registered Nurses & Midwives 2014) <p><u>Professional /Clinical Responsibilities</u></p> <p><i>The Assistant Director of Nursing Surgical Department will:</i></p> <ul style="list-style-type: none"> • Foster a culture within nursing which values continuing professional development and empowers staff to achieve excellence in the delivery of patient care within the Hospital. • Provide a high level of professional and clinical leadership • Monitor nursing staff in their day to day practices in the provision of safe, comprehensive nursing care to service users within the guidelines laid out by Nursing & Midwifery Board of Ireland • Practice nursing according to Professional Clinical Guidelines, National and Area Health Service Executive guidelines, local policies, protocols and guidelines, current legislation. • Manage, monitor and evaluate professional and clinical standards ensuring an evidence based care planning approach. • Manage own case load or directorate in accordance with the needs of the post • Participate in teams as appropriate, communicating and working in co-operation with the other team members and the wider multi disciplinary teams. • Facilitate co-ordination, cooperation and liaison across health care teams and programmes.
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	<ul style="list-style-type: none"> • Formulate, manage and implement best practice policies and procedures • Ensure that all service users and others are treated with dignity and respect • Adhere and contribute to the development and maintenance of nursing standards, protocols and guidelines consistent with the highest standards of patient care. • Maintain professional standards in relation to confidentiality, ethics and legislation. • Assist in the development and roll out of divisional policies and procedures and the implementation of same and to update them as required. • Participate in development of quality initiatives including clinical audit, standard setting, investigation of complaints and untoward incidents. <p><u>Education and Training</u></p> <p><i>The Assistant Director of Nursing Surgical Department will:</i></p> <ul style="list-style-type: none"> • Contribute to service development through appropriate continuous education, research initiatives, keeping up to date with nursing literature, recent nursing research and new developments in nursing management, education and practice and attend staff study days as considered appropriate. • Provide support/advice to those engaging in continuous professional development in his/her area of responsibility. • Participate in the identification, development and delivery of induction, education, training and development programmes for nursing and non-nursing staff. • Participate in in-service training, orientation programmes and appraisals of all nursing staff. Also, participate in nurse training programmes and any other programmes pertaining to future development in the hospital. • Provide support supervision and professional development of appropriate staff • Engage in performance review processes including personal development planning e.g., by setting own and staff objectives and providing and receiving feedback. • Monitor nursing practices in the interest of quality and patient safety and when deficits are identified support individual nurses in developing and maintaining competence through individual competency developmental plans if required <p><u>Health & Safety/ Risk Management</u></p> <p><i>The Assistant Director of Nursing Surgical Department will:</i></p> <ul style="list-style-type: none"> • Ensure that effective safety procedures are developed and managed to comply with statutory obligations. • Be aware of risk management issues, identify risks and take appropriate action • Comply with the policies, procedures and safe professional practice of the Irish
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	<p>Healthcare System by adhering to relevant legislation, regulations and standards.</p> <ul style="list-style-type: none"> • Assist in the development, implementation and review of Health and Safety statements, as appropriate. • Document appropriately and report any near misses, hazards and accidents and bring them to the attention of the relevant person(s). • Maintain a feedback mechanism and report to senior management where appropriate. • Work in a safe manner with due care and attention to the safety of self and others. • Ensure adherence to policies in relation to the care and safety of any equipment supplied for the fulfilment of duty. Ensure advice of relevant stakeholders is sought prior to procurement. <p><u>Note</u></p> <p>This broad outline reflects the recommendation in the Commission on Nursing that middle nursing and midwifery management should:</p> <ul style="list-style-type: none"> • Have a defined management role and not merely retain a "gatekeeping" administrative function. • Have defined management responsibility with explicit delegation of authority from the Director of Nursing & Midwifery • Have definite functional roles either in managing units of care or in the management of functional responsibilities such as in bed management and practice development co-ordination. • Have the authority to manage their area of responsibility without constant reference to more senior management. However, as in all management, there should be effective communication with front-line and senior management • Liaise with Practice Development Co-ordinators • Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc and comply with associated HSE protocols for implementing and maintaining these standards. <p>The above Job Description is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.</p>
<p>Eligibility Criteria</p> <p>Qualifications and/or experience</p>	<p><i>Candidates must, on the latest date for receiving completed application forms for the office:</i></p> <p>a) (i) Be registered in the General Division of the Register of Nurses & Midwives</p>

	<p>maintained by Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) or be entitled to be so registered and</p> <p>Have at least seven years (7) post registration experience of nursing including a minimum of two years (2) experience/involvement in nursing management, and quality improvement. and</p> <p>Have a level 8 post-registration National Qualifications Authority of Ireland major academic award (or equivalent) relevant to nursing and</p> <p>b) Candidates must possess the requisite knowledge and ability (including a high standard of suitability and management ability) for the proper discharge of the duties of the office</p> <p>c) Candidates must have undertaken training in management appropriate to the post</p> <p><i>Please note that appointment to and continuation in posts that require statutory registration is dependent upon the post holder maintaining annual registration in the relevant division of the register maintained by Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland)</i></p> <p>Health A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.</p> <p>Character Each candidate for and any person holding the office must be of good character.</p> <p>Age Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation (Miscellaneous Provisions) Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age on the first day of the month in which the latest date for receiving completed application forms for the office occurs.</p>
Post Specific Requirements	<p>Demonstrate significant post registration nursing experience</p> <p>Demonstrate depth and breadth of nursing experience in Operating Theatres, Surgical/ Anaesthetic, or other related services.</p>
Other Requirements Specific to the Post	Information Computer Technology Literacy Skills is essential to the post and knowledge and experience in sourcing nursing evidence via search engines.
Skills, Competencies and/or Knowledge	<p><u>Professional/Clinical knowledge</u></p> <ul style="list-style-type: none"> Relevant knowledge in the area of Operating Theatres, Surgical/Anaesthetic, or other related services.

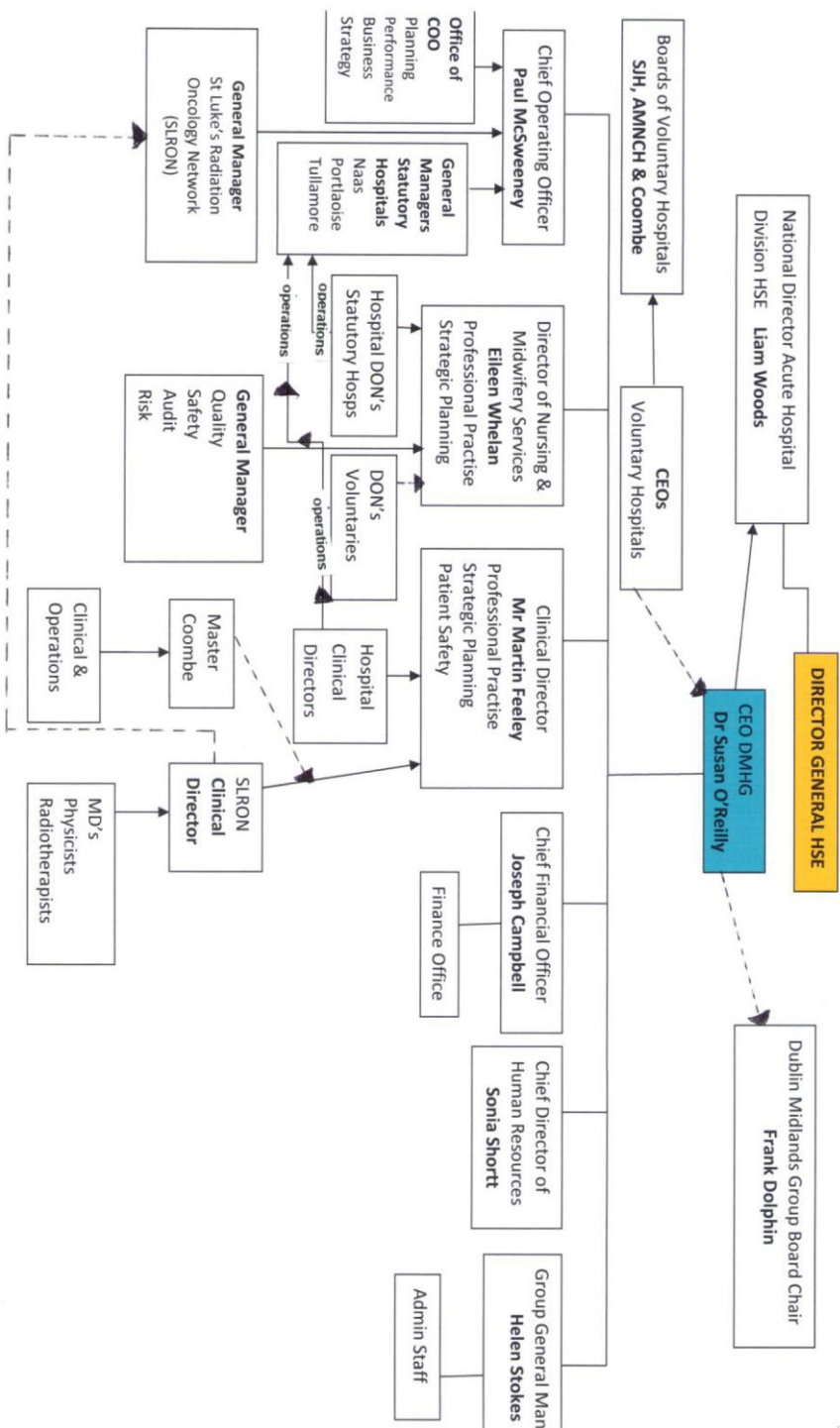
	<ul style="list-style-type: none"> • Demonstrate a high degree of commitment, professionalism and dedication to the philosophy of quality health and social care provision. • Demonstrate relevant knowledge. • Demonstrate evidence of policy development and the ability to translate policy into action. • Demonstrate knowledge and experience of quality audit/assurance systems. <p><u>Planning and Organising Resources</u></p> <ul style="list-style-type: none"> • Demonstrate ability to plan, organise and deliver services in an efficient, effective and resourceful manner, within a model of person centred care and value for money. • Demonstrate ability to manage deadlines and effectively handle multiple tasks. <p><u>Building and Maintaining Relationships: Leadership, Staff Management & Team Skills</u></p> <ul style="list-style-type: none"> • Demonstrate leadership skills and ability to influence others, including leading on cultural change. • Demonstrate flexibility and openness to change and ability to lead and support others in a changing environment. • Demonstrate ability to manage, motivate and develop staff to maximize performance at work. • Demonstrate the ability to foster a learning culture amongst staff and colleagues to drive continuous improvement in services to patients. • Demonstrate ability to work effectively with multi-disciplinary teams. • Encourages an ethos of staff initiative and promotes service related project work to channel improvement and innovation contribution <p><u>Evaluating Information and Judging Situations</u></p> <ul style="list-style-type: none"> • Demonstrate the ability to evaluate information and solve problems <p><u>Commitment to Providing a Quality Service</u></p> <ul style="list-style-type: none"> • Demonstrates a compelling vision for the role and contribution of nursing to the service. Presents a positive view of future possibilities in relation to role expansion of the nurses Creates an enthusiastic and committed work climate • Demonstrate understanding of, and commitment to, the underpinning requirements and key processes in providing quality patient centred care. • Demonstrate an ability to monitor and evaluate service performance and levels of care • Demonstrates an understanding of the importance of monitoring Clinical Audit
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	<p>and Nursing metrics results in each department ensuring action plans are developed ,implemented and evaluated in order to achieve 100% compliance</p> <p><u>Communication and Interpersonal Skills</u></p> <ul style="list-style-type: none"> • Demonstrate effective communications and interpersonal skills including: the ability to present information in a clear and concise manner: the ability to engage collaboratively with all stakeholders; the ability to give constructive feedback. • Demonstrate competency in general use of information technology-computers, office functions, internet for research purposes, email, preparation of presentation materials etc.
<p>Campaign Specific Selection Process</p> <p>Ranking/Shortlisting / Interview</p>	<p>A ranking and or shortlisting exercise may be carried out on the basis of information supplied in your application form. The criteria for ranking and or shortlisting are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements.</p> <p><u>Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process.</u></p> <p>Those successful at the ranking stage of this process (where applied) will be placed on an order of merit and will be called to interview in 'bands' depending on the service needs of the organisation.</p>
Code of Practice	<p>The Health Service Executive will run this campaign in compliance with the Code of Practice prepared by the Commission for Public Service Appointments (CPSA). The Code of Practice sets out how the core principles of probity, merit, equity and fairness might be applied on a principle basis. The Code also specifies the responsibilities placed on candidates, facilities for feedback to applicants on matters relating to their application when requested, and outlines procedures in relation to requests for a review of the recruitment and selection process and review in relation to allegations of a breach of the Code of Practice. Additional information on the HSE's review process is available in the document posted with each vacancy entitled "Code of Practice, Information for Candidates".</p> <p>Codes of practice are published by the CPSA and are available on www.hse.ie/eng/staff/jobs in the document posted with each vacancy entitled "Code of Practice, Information for Candidates" or on www.cpsa.ie.</p>
<p>The reform programme outlined for the Health Services may impact on this role and as structures change the job description may be reviewed.</p> <p>This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.</p>	

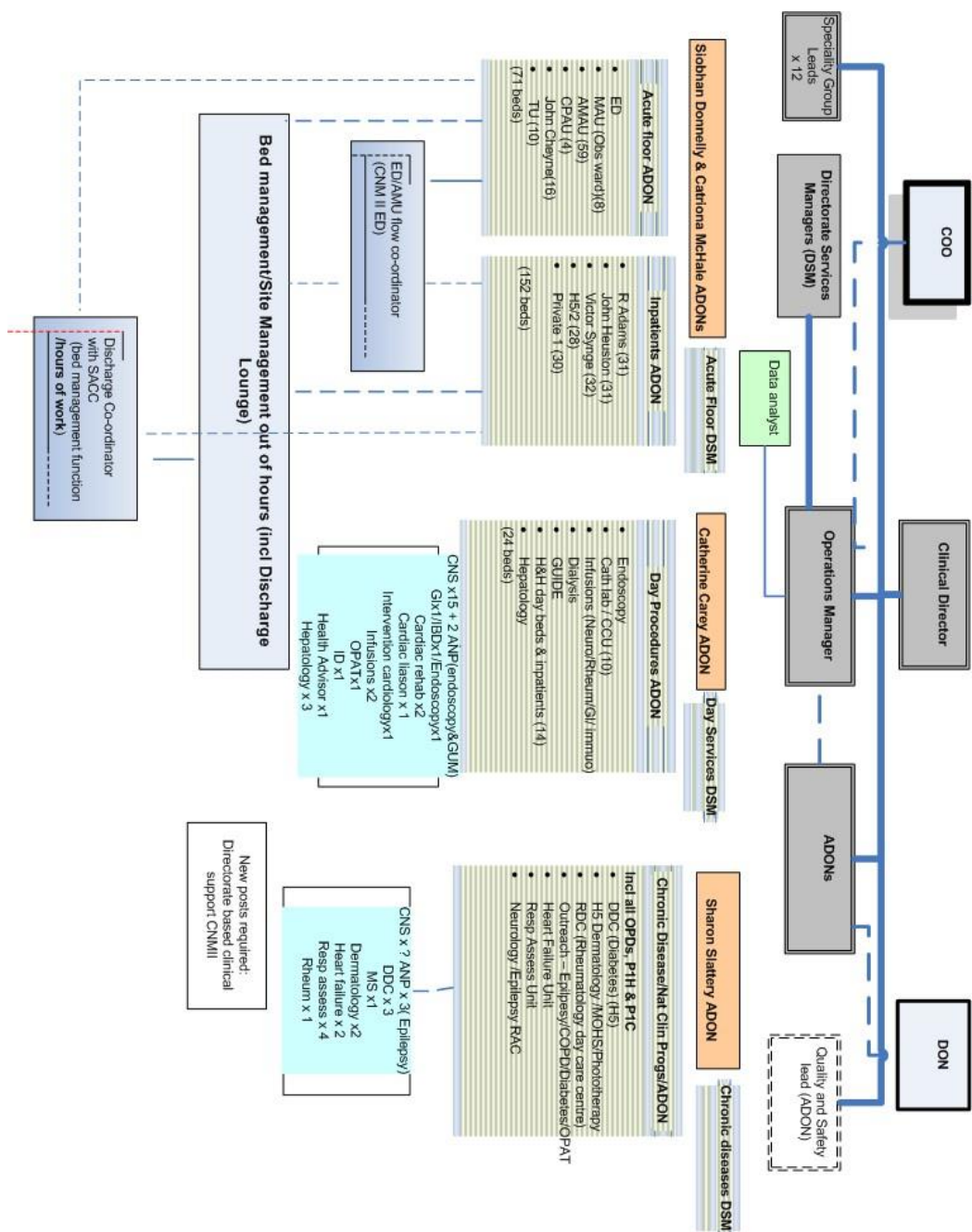


April 2015

Governance & Management Structure: Dublin Midlands Hospital Group



Appendix 5



Appendix 6

Hospitals and participant numbers

Name	Sent out	Scripts sent for approval and returned/ comments
Hospital A		
<i>Patsy</i>	DNM	Sent: Yes/ needed reassurance re confidentiality – email sent
<i>Laura</i>	DNM	Sent: Script not returned but approved interview
<i>Kathleen</i>	DNM	Sent
<i>Eileen</i>	DNM	Sent
Hospital B		
<i>Martin</i>	Mental Health	Sent: Yes - email
<i>Molly</i>	Hospital wide role	Sent: Approved by email 22/03/13 -Requested information – sent by email
<i>Denise</i>	DNM	Sent
Hospital C		
<i>Margaret</i>	Hospital wide education role	
<i>Olive</i>	Hospital wide role	
<i>John</i>	Mental Health	
<i>Eileen</i>	Out of Office Hours	Sent
<i>Teresa</i>	Out of Office Hours	Sent
<i>Deirdre</i>	Out of Office Hours	Sent
Hospital D		
<i>Connie</i>	DNM	
<i>Emma</i>	DNM	Sent: Approved by email
<i>Tina</i>	DNM	
<i>Majella</i>	Education +Clinical role	
Hospital E		
<i>Dympna</i>	Lead ADON	Sent
<i>Cara</i>	Divisions	Sent
<i>Antoinette</i>	Divisions	Sent

Appendix 7

Interview guide

How would you describe your role as Assistant Director of Nursing?

Could you tell me about your role in decision –making – could you tell me about that?

Do you have a role in strategic/corporate decision-making?

Could you tell me how you are involved in the overall management of the hospital (clinical management/operations management/ hospital executive)

Could you tell me about your involvement in the clinical governance of the hospital?

What level of authority do you function at as ADON?

What are the differences between your leadership role and that of DON

Have your role and responsibilities changed at all in recent times?

As ADON how do you influence and lead the newly announced health reforms by the DOH (reconfiguration of hosp trusts, the abolition of the HSE, the development of the 7 new directorates – one being the hospital directorate, the clinical care programmes, the SDU, how are you going to partner with your community colleagues, clinical governance structures)

How do you see the ADON positioned in these structures – or repositioned?

Do you think the culture of the organisation supports the development of leadership competencies in the ADON

Could you tell me what you think are the competencies required for effective or influential leadership in nursing at the present time?

How do you see your role in the wider health system overall?

Would you see the role of the ADON as influencing health policy and planning in a wider healthcare context?

How do you see the role of the Assistant Director of Nursing developing going into the future?

What do you see as your main challenges as ADON?

How would you describe the supports that are there for you in your role as ADON

Is there anything you would like to see to support the leadership role of the ADON in the future that is not there now?

Overall, how would you describe your main leadership functions in the hospital?

Prompts:

Could you tell me more about that....

You mentioned xxx, could you explain that a little more...

How do you feel about that...

Appendix 7A

Sample of Meaning Units and Themes

Example of meaning units	Theme	Sub-themes
if I have delegated something to them – to use it as an educational thing as well. And then, when they are halfway through it – say “Come back to me now and let me know how you are getting on, what you are doing and that.” And bring them to various different meetings with me	Transformational role of the ADON	Supportive role
...respect that they are very busy individuals as well and am... not be condescending about the way that you approach it or sort of...pushing it on them, you get far more buy in I think then		
lead and develop the nurses that are working across the directorate		
care and discharge are good and that you know that’s a vital part of our role so I’d say, obviously there are a lot of other aspects to it but I’d say good quality of patient care and service to the patients. That’s the most important part of it.		Role Identity
For effective leadership in nursing today you need to be very level headed, look at problems from all angles don’t take the first option, think outside the box. You need to be very concise and consistent in your decisions		
we are looking at education and we’re talking actually today about the terms of reference for the acute medical nursing group so yeah that I would think influencing you know the future of nursing there the roles the role development all that which I think is very important and I think nurses need to be developed too because again if you work in specialised units I think you need to have the knowledge training and experience behind you to work.		

We don't move around as much because there isn't that option to move around within the health service. I don't necessarily think that's actually good for nursing as a profession because we don't get enough people in with new ideas and the system directors within there are very business focused		
when we see the opportunity to do something obviously then through the DON, they have...they have other fora for influencing and maybe if we can't influence something we can get it influenced through the DON		Power and influence
I suppose its quite new to be in a position where you could say to the clinical director, 'listen, you're going to have to go and talk to your colleague because that's not good enough' and he'd say 'right, right I will' you know and he'd say 'right, right I will' and that's very different, that would never have happened 3 years ago unless there was something terribly serious altogether, but they wouldn't have influenced each other to come on board whereas now they absolutely do follow them up		
There is a certain level of consulting, actually now to be fair it would be a case can you live with this decision but you are more or less told it's a done deal.		
well I suppose the SDU is linked into the emergency programme so I would be involved in influencing (<i>developments</i>)		
It depends what sort of decision you are talking about so if it is a decision to redeploy nurses from one area to another that's within my remit obviously or if it's a decision about where it's best to care for a particular patient, you know, I can be involved in that but if it's more strategic then obviously it needs to go through the	Decision-making	Consulting

senior management team.		
from talking to other colleagues in other hospitals we would be listened to and asked more than other places might than people in my role in other places so from a decision making point of view to be fair to management here when we make a decision or if I make a decision and I think that we need x or y generally we get it and generally we're listened to		
I would have autonomy to make decisions directly relating to patient care by dealing with the consultants and their team. I would involve the infection control nurse with this decision making		
For us in the medical directorate, it's in its infancy but we did try to bring the whole governance thing together	Governance	Clinical
I think that nursing has been quite progressive with regards to clinical governance ah...more so than our other colleagues		
we are setting up governance committees with our directorates so that we can feed into the risks, standards of care, policies so that it is something that we are involved in		

Appendix 7B

Sample taken from the middle of the interview

MMM is the interviewer

MMM Could you tell me what you think are the competencies required for effective or influential leadership in nursing at the present time?

Participant:

You need to be a good communicator definitely, you need good interpersonal skills, they're really, really important because all the various levels that you communicate at you know, you need to be computer literate, you need to understand the importance of following up and having your hard copy, your documentation am...you need am...I suppose I would put interpersonal skills definitely at the top, communicating and interpersonal skills at the top. You need others then like time management. For some definitely it's more difficult and I can understand that and in the main... they may have to shift their day around a little bit. We don't all work the exact times, am... for some ADONs they find the evening time is their busiest time and you have to know really what's needed for that particular job and try and work your day around it. I suppose it suits me that I start early and then I finish on time then. I find that very, very important am...I suppose what other competencies? I suppose people management and interpersonal skills and am... problem solving definitely. You need to be able to think on your feet and sort of ...it's the one thing in the job that I quite like because every day is different and you could have...you could come in and think you're going to have a relatively calm day and it just takes a knock on the door or a phone call to turn things completely on its head. It's so diverse, because you're looking after people and ...environment and areas, you could get anything thrown into the mix. That's what's interesting about the job. As against a CNM 2 when the patient was always your priority, ok you had a lot of the other stuff thrown into the mix that you'd move on or move sideways or whatever, now ...you don't physically have the patients care you know. The patient is always no1 anyway but, but you have time to think about the other issues or how will we get around this, it's just a different kind of management needed. And the other competencies then I'm trying to think, am ...yea, the techno competencies. That was another challenge, I wouldn't have been totally au fait when I started in the job you know...we would have a lot of ...everything has to be applied for on line using a system like a purchasing system so if you wanted say, a laryngoscope, you have to apply, you have to put up a requisition and I have to sign off on that then as budget manager so I would never have done anything like that before so I had to learn all of that so I had to gain that knowledge, the same then with running my budget holder report, again never had to do anything like that before. If we wanted something wed always ask, I did work in an area that had a business manager so I would have gone down that route so I wouldn't have been in any way familiar with what the ADONs role in budget was whereas now I do.

MMM Do you feel there was support for you there in going into those rolls?

Participant:

Well...yes, I mean there was, I got the training which was great and I...I was I suppose reliant on the person who gave me the training to explain a lot of...well, this is what you need to do now and I'd run this report regularly and this is what you need to look at, that kind of level. I probably you know...I regularly check in with my financial partner, the person I deal with in finance, maybe every 6 months I'd say to him 'How am I doing financially?' and would organise to meet him to get more detail. Basically he'd tell me I'm overspent but everywhere is but he'll just go through it and explain it and if I had any questions or anything like that. That's a whole new side of the role that I wouldn't have been familiar with and I suppose I found it challenging and I still do but hope for the best and not deviate too far off the well worn road.

MMM How do you see your role in the wider health system overall? Like the national system

Participant:

Well...I think you always have to set yourself up there, I mean...XXX would be considered a renowned centre of excellence for what they do...and you would always have to lead by that standard so everything you do you have to do it with that in mind so there is ...there is huge initiatives being set up here in XXX that are going to be rolled out, some of them are rolled out nationwide, like the XXX is not just a XXX initiative that's a nationwide initiative and ok they might compare and contrast from hospital to hospital to see where you're at but you always want to be up there and like, this is what we're doing here you know, we've found that introducing this is going to be evolutionary in the care of the dying patient and similarly you know, you just want to be the leaders in your field. I think everyone has to bear that in mind and not to do anything that would you know...am...jeopardise it and I suppose again, the thing that I'm looking at with the communicating with the public health nurses at the early stages of the thing, that's going to impact nationwide because if we do manage to roll this out or get it out there, it is going to be ...revolutionary because I don't think anywhere is doing it or looking at it at the moment and it is going to be of huge benefit to the patient so...so its things like that

MMM How do you see the role of the Assistant Director of Nursing developing going into the future?

Participant:

I don't really know, I don't know what the future of my role is, specifically my role because I think I would be am...fearful is probably not the right word, I would be....I think there's definitely change on the cards, I know a couple of years back, they were talking about amalgamating directorates
(2nd tape, side 1 began here at 'amalgamating directorates' -rerecorded from here)

MMM You were just saying about going into the future

Participant

I don't know too much about it. I can see that the whole trust is for the amalgamation of the groups...a lot of change... and I don't know and I think because I'm in an area that's not related to any .. that my role would be in jeopardy there (*difficult to hear here*)

MMM Do you think you might get greater responsibility?

Participant:

I don't know because unfortunately, I'm in an acting post because they haven't made anyone permanent, they haven't actually...there's politics behind it I suppose and I'm happy enough to do that because I'm...ah...2 years in this current post now but its not for money I'm doing it, I'm doing it for the experience and job satisfaction and I...I would like to be rewarded, of course I would, there's those 3 years now and not getting anything other than an acting allowance but because my post is isn't secure, I could see how it could be one of the first to go and there's nothing to stop say, the wards that I look after say being amalgamated into a bigger area because they're easy to do that. So that's the role from my point of view. The role of the ADON in general I could see that changing, I could see there definitely being fewer...with maybe more responsibility

MMM Right. What do you think are the main challenges of the ADON?

Participant

The main challenges (*participant thinking for 20secs*)...well...am...the main challenges of the ADON are (laughs heartily - tape blurred here) are trying to keep everybody safe and happy but I suppose you know your patient safety is your priority and sometimes its very challenging especially when you're expected to do the same job at the same service level with you know, with the same safety but with much fewer staff. That's definitely the kernel of it and its just...and to try and keep staff motivated and you know, not fall on their knees out there, its ah... its really difficult and ah...sometimes I'd even say 'I'd love to tell you its going to get better but I don't know'. I really don't know what's going to happen. Its getting more and more difficult to...you literally have to justify as I said earlier every hour of a vacancy that you replace or sick leave that you replace because the first thing that's looked at is you know, 'you've got overtime in, why have you got overtime' yea. You know you've got overtime in because if you don't you wont be able to take the patients back from theatre you know, there's going to be a risk to the patients. What did you say, could you repeat the question?

MMM The challenges basically

Participant

Oh yes, (bleep goes off). Keeping up the ...the standards and keeping up safety is a huge challenge...am...its just with the restrictions that we're faced with and am...staff retention of course you know, even in this day and age its very difficult to retain your staff in the current climate because Australia is very appealing and Canada is very appealing and a lot of you knowthe colleagues we would have

taken in back a few years ago from India or the Philippines, they're now looking for better ...I suppose their friends and family and relations are going further afield and are having a better quality of life and we're losing a lot of them now and we haven't got any carrots to dangle in front of them. Even further education, even education incentives might have kept staff here you know...bringing them up to do various courses, you know rewarding them in some ways but the reward system is nearly obsolete now. You can't say to yourself, there's a fantastic one. and...which there is some fantastic diplomas, there's a fantastic course in palliative care, you know pick one of your staff to go on that and we'll back fill for their study leave, you can't do that anymore because you just haven't got the staff to do it. So all those little incentives that you would have given staff years ago you don't have them any more.

APPENDIX 8

PARTICIPANT INFORMATION LETTER PLAIN LANGUAGE STATEMENT

Names of researcher:

Mary Mac Mahon, Doctoral student, Dublin City University (DCU),
MBA, FFNMRC SI, RGN, RM, Nurse Tutor, Cert Onc.

Address:

Assistant Director of Nursing and Midwifery (Prescribing)
Office of the Nursing and Midwifery Services Director
Nursing and Midwifery Planning and Development Unit
Health Service Executive, Stewarts Hospital, Mill Lane
Palmerstown
Dublin 20

Research Supervisor:

Dr Pauline Joyce
Director of Academic Affairs
Institute of Leadership
Royal College of Surgeons in Ireland
RCSI Reservoir House
Ballymoss Road
Sandyford
Dublin 18

This study is in part fulfilment for the Doctorate in Education (Leadership) in the School of Education, Dublin City University.

1. Title of study: The leadership role of the Assistant Director of Nursing

2. Introduction:

Historically, nurses were not seen as having a leadership role in their own organisations as well as the wider healthcare sector. However, indications are that this has changed with nurses now involved at varying levels of corporate decision-making and governance issues. In light of this, you are invited to participate in this study which will explore the leadership role of the Assistant Directors of Nursing in Band 1 hospitals in the greater Dublin area

Aims of the study

This study aims to explore how the ADONs see their leadership role in their own healthcare organisation and also in relation to healthcare overall.

Objectives of the study are:

- to explore the perceptions of the ADONs in relation to their own leadership role
- to explore their contribution to corporate decision-making in the organisation

- to explore their perceptions of their role within the governance system, including clinical governance, in their organisation
- to explore their perceived impact of their contribution to the effectiveness and efficiency of the hospital overall

3. Procedure: The participants who return the signed consent form enclosed with this information letter will be invited to take part in the interviews or you may bring the consent form with you to the interview. The interviews will be audio-taped and facilitated by myself, Mary Mac Mahon. The interviews will each last approximately 1 hour but this time may vary. They will be carried out in a private room of your choosing or if you wish, I will arrange the place of interview. Please note that the interviews will be audio-taped and transcribed and you will be able to read the transcribed interview and edit it if you so wish.

4. Benefits: The immediate benefits are that you will have the opportunity to share your experiences and opinions. Furthermore, it is anticipated that the results of this study will provide a greater understanding of the leadership role of the ADON which can be used as a basis for further development.

5. Risks: While the study poses no immediate risk to participants, there is always a slight possibility that you or one of your colleagues may become upset during the interviews, for example, if sensitive issues arise concerning clinical practice. If this situation arises, the researcher will spend as much time as is required with the concerned individual(s) and may, if considered appropriate, provide you with contacts for further independent counselling.

6. Confidentiality:

Your identity will remain confidential. Your name will not be published and will not be disclosed. All information will be kept (safely stored) for the duration of the study. All computerised data will be password protected and accessible only to the named researcher and the research supervisor. Hard copies of transcripts will be kept locked in a filing cabinet, which will be accessible only to the researcher. On completion of the study and having fulfilled the requirements of the university in relation to the study, audio recordings and transcripts will be destroyed and disposed of in accordance with university protocol. Your name will not be included on the interview transcript. A code or pseudonym will be used. The findings of this study may be used for publication. In this event neither the research site, i.e. the hospital, or the identity of the participants will be disclosed.

As the number of band 1 hospitals in the greater Dublin area is small, there is a very small risk that the identity of the hospital may be indirectly recognised by what a participant says at interview. However, as each participant may see the printed version of their interview and edit it, this is a very limited risk. As stated previously, to maintain confidentiality, all participant names as well as the hospital names or identifiable data such as ward names or other staff names, will not be included in the interview transcripts.

7. Voluntary Participation: If you volunteer to participate in this study, please note that you are free to withdraw at any time without giving reason or prior notice and without any personnel consequences.

9. Permission: This study has ethics approval from Research Ethics Committee, DCU. Permission to contact you has also been granted by your Director of Nursing.

If you are wish to take part in the study and feel that you have been provided with all the relevant information, please refer to the consent form attached.

10. Further information: You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Mary Mac Mahon who can be contacted at 085 1424480 or email mary.macmahon@hse.ie

If participants have concerns about this study, and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Telephone: 01-7008000.

Appendix 9

Mary Mac Mahon,
Assistant Director of Nursing and Midwifery
Office of the Nursing and Midwifery Services Director
Nursing and Midwifery Planning and Development Unit
Health Service Executive
Stewarts Hospital
Mill Lane
Palmerstown
Dublin 20

Research Supervisor:

Dr Pauline Joyce
Director of Academic Affairs
Institute of Leadership
Royal College of Surgeons in Ireland
RCSI Reservoir House
Ballymoss Road
Sandyford
Dublin 18

Name of Director of Nursing
Address
XXXX
XXXXX

Date:

Dear XXX

Re: Research Study: The leadership role of the Assistant Director of Nursing

I am currently studying for my Doctorate in Education (leadership) in Dublin City University (DCU). I am in my 4th year and I am writing in relation to a research study I am proposing to carry out into “The leadership role of the Assistant Director of Nursing”.

I am requesting your permission to contact the Assistant Directors of Nursing in (XXX, name of the hospital inserted here) with a view to participating in this study. Contact will only be by post to avoid any perception of coercion. A sample of the information letter and consent form that I will be sending is enclosed for your information. I have ethical approval from DCU and I also enclose a copy of this.

Should you wish any further clarification, please do not hesitate to contact me at 085 1424480 or email mary.macmahon@hse.ie . If you wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Telephone: 01-7008000.

Thank you for your consideration
I look forward to hearing from you

Kind regards

Mary Mac Mahon

Appendix 10 INFORMED CONSENT FORM

Study title: The leadership role of the Assistant Director of Nursing

The purpose of this research is to explore the leadership role of the Assistant Directors of Nursing in their own healthcare organisation and also in relation to healthcare overall.

Please complete the following

I have read the plain language statement	Yes/No
I understand the information provided	Yes/No
I have has an opportunity to ask questions and discuss this study	Yes/No
I have received satisfactory answers to all my questions	Yes/No
I am aware that my interview will be audio-taped	Yes/No

I am free to withdraw from this research study anytime without giving reason or prior notice and without any personnel consequences.

Please note that the interviews will be audio-taped and transcribed and you will be permitted to read the transcribed interview and edit it if you so wish. Confidentiality will be maintained and the interview will not be traceable back to you. All transcripts and audiotapes will be kept securely locked and will not be viewed by anyone but the researcher. Following completion of the study, these will be disposed of in accordance with ethical guidelines of the university. All information provided is of course subject to legal limitations.

Declaration:

I have read the consent form and I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights.

PARTICIPANT'S NAME:

PARTICIPANT'S SIGNATURE:

Date:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:.....

Date:.....