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MAKING SENSE OF THE
DIRECTOR OF NURSING
STRUCTURAL
POSITIONING IN NEW
ZEALAND PUBLIC
HOSPITALS (2006-2012).

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ABSTRACT

MAKING SENSE OF THE DIRECTOR OF NURSING STRUCTURAL POSITIONING IN NEW ZEALAND PUBLIC HOSPITALS (2006-2012)

This dissertation reports on research examining and analyzing nursing leadership structures in New Zealand public hospitals, and in particular, the Director of Nursing (DoN) structural positioning. Leadership in hospital nursing is critical if the profession is to meet the challenges facing health services in the 21st century. The research has been undertaken using case study methodology and focuses on how organizational decision-making structures have impacted on nursing leadership in public hospitals. 'Sense-making' has been used as a theoretical construct to understand both the formal and informal structures that influence organizational decision-making. Phase one of the research involved examining twenty District Health Board (DHB) organizational and nursing charts. In phase two and three, the Directors of Nursing (DoNs) and the Chief Executive Officers (CEOs) were surveyed using a series of demographic and qualitative questions to draw out understanding of the Director of Nursing (DoN) role. The research has found that the constructs of power and authority influence the decision making processes at the executive level of the DHB. An analysis of the data indicates that the current structural positioning of the DoN is hindered by the existing dual accountability line reporting structures in DHBs and this is a barrier to alignment with Magnet hospital principles which provide evidence of effective patient outcomes. The focus primarily adopted by District Health Boards on professional line reporting only for nursing is not conducive to achieving effective and safe patient outcomes as it removes authority from the DoN and yet places unrealistic

expectations on accountability of how the DoN can achieve effective and safe patient outcomes within the public hospital setting.

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ABBREVIATIONS

CD	Clinical Director
CEO	Chief Executive Officer
CHE	Crown Health Enterprise
CMO	Chief Medical Officer
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
CPHAC	Community Public Health Advisory Committee
CTA	Clinical Training Agency
DHB	District Health Board
DoN	Director of Nursing
DRG	Diagnostic Related Groups
DSAC	Disability Services Advisory Committee
ELT	Executive Leadership Team
EMT	Executive Management Team
HAC	Hospital Advisory Committee
HFA	Health Funding Authority
HHS	Hospital & Health Services
ICD	International Classification of Diseases
KPI's	Key Performance Indicators
MECA	Multi-Employment Collective Agreement
MoH	Ministry of Health
NHB	National Health Board
NCNZ	Nursing Council New Zealand
NENZ	Nurse Executives New Zealand
NetP	Nurse entry to practice Programme
NZNO	New Zealand Nurses Organisation
PDRP	Professional Development Recognition Plan
QHNZ	Quality Health New Zealand
RHA	Regional Health Authority
RMO	Resident Medical Officer
SMT	Senior Management Team

CHAPTER ONE - INTRODUCTION

1.0 INTRODUCTION

The purpose of the research is to find out how organisational structures influence the decision making processes that impact on nurse leaders both in their structural positioning and their roles. Through an examination of these structures I hope to gain insight into how management decision making impacts on nurse leader positions, and this conversely impacts on nurse leadership decision making, and what this might mean for how they perform their roles and influence nursing within the public hospital structure. There is international evidence that supports the value and significance of nursing leadership in the hospital setting and demonstrates the link between effective nursing leadership and quality patient outcomes. The continual restructuring of hospitals in the health sector over the last twenty years has led to a diminishing of the positional power of nursing leadership in New Zealand.

The DHB organisation and nursing structure charts, in addition to qualitative surveys of the Director of Nursing (DoN) and Chief Executive Officers (CEO), provide a beginning to the understanding of both the formal and informal structures within the organisation. Prior to undertaking this analysis, it is necessary to understand the context of the research, how the researcher is located in relation to the thesis, the significance of the research and the research approach. After a discussion of these areas an outline of the dissertation chapters will follow.

1.1 THE NEW ZEALAND CONTEXT

New Zealand is a country that has pushed the boundaries of reform often before other parts of the world. It has been the first to initiate the vote for women in 1893 (MacDonald, 1993), and the first to provide the Nurses registration legislation in the form of the Nurses Registration Act, 1901 (Campbell, 1997). The enactment of public health legislation in 1900 also

occurred to enable the formation of a Department of Health that provided centralised oversight of the public hospitals (Dow, 1995). The unicameral system of the New Zealand government and the adventurous nature of the New Zealand make-up saw New Zealand as a country known for social government experimentation (Rosenof, 2010). New Zealand was also the first country to push through social reform under the Social Security Act 1938 which saw major changes to welfare provision. The underpinning principle of the Act was that all people should attain individual security, 'for each according to his needs, by each according to his means' (McClure, 1998, p. 81).

There were three parts to the Social Security Act 1938: cash benefits, funding provisions and health benefits. Health benefits were required as part of the focus on achieving independent security and this was seen as the precursor to creating a universal health system. By attaining independent security individuals were not indebted through overwhelming healthcare expenses. Prime Minister Savage was required to negotiate between the state and the medical profession, who were not supportive of a universal health system. This lack of support was evidenced by the 95% of doctors who voted against the scheme (Burdon, 1965). However, the universal health scheme was affirmed with the benefits including free general hospitalisation, and care for maternity and mental health cases. In 1944 free medicines and free home nursing were added to the benefits scheme (Congressional Digest, 1949). Although Savage proposed a free health care system, in principle the implementation of a fully free health care system was not implemented. The two major constraints were the full cost of implementing such a system and the opposition from the medical profession. General practitioners from 1940 were allowed to charge patients a fee for service on top of the government subsidy they were given for each patient consultation (Hay, 1989). The relationship between the government and the medical profession included the salaried hospital doctors being paid by the state, and doctors electing to work as General Practitioners being subsidised as well as being able to charge a fee for

service. This relationship between the medical profession and the state saw the continuation of medical autonomy into the 1990s (Poutasi, 2000).

The advent of a free public health service as a result of public health legislation has meant that any New Zealand citizen and resident can receive treatment free in the public hospital system. However, the autonomy granted the medical profession meant that health visits to the GP and medical specialists working in the private system incurred a charge. The free public hospital system is still in operation today, although with changing governments and difficult financial times there have been many reforms of the public hospital system. As Poutasi, (ex Director General of Health) (2000) notes 'from the 1970s it became evident that 'free' health care without queuing was impossible in New Zealand' (p. 134). The need for efficiency and reduction in delay for elective surgery, became a major driver in health care policy reforms from the 1980s.

Laugesen and Salmond (1994) and Gauld (2009a) note the predominant driver that contributed to the 1990 reforms and the commissioning of the Gibbs Report in 1988 that preceded the health reforms was the perceived inefficiencies of the health system. This was a time when almost all western developed countries were undergoing radical reform in their health systems, as they were all wrestling with the unsustainability and escalating costs and spending, and increasing percentages of gross domestic product (GDP) on health. Gauld (2009a) states that the fourth labour Government set in motion a series of reviews of the health system which included the health benefits review and the hospital and related services taskforce chaired by Alan Gibbs.

The Gibbs Report (1988) *Unshackling the public hospitals* became the blueprint for radical reform. Prior to this the management of the hospital had historically and routinely been undertaken by a triumvirate leadership group, the chief nursing officer, chief medical officer and the hospital administrator. Hospitals which were administered by a Hospital Board reported directly to the Department of Health (Dow, 1995; Gauld, 2001;

Finlayson & Gower, 2002). The changes advocated by the Gibbs Report were seen to be part of a global movement towards generic management in the public sector in an effort to find efficiencies and avoid professional capture (White, 2004). The National Government elected to power in 1990 adopted the recommendations from the Gibbs Report and changed the hospital management structures as part of the 1991 formal government response to the Gibbs Report known as the Green and White paper¹ proposal (Upton 1991). These papers were so called because of the extraordinary publication of a document which was coloured both green and white. Green symbolising the public consultation draft phase and white the final document. The publication of a single document demonstrated the government's disregard for public consultation on this change.

As Hall and Viney reflect health care reform has never been out of fashion and the phenomenon of economic rationalism that impacted political thinking in the 1980s and 1990s opened the way for another raft of health sector change. The idea that underpinned economic rationalism was one based on achieving efficient resource allocation through the deregulation of markets. This type of thinking 'promotes the use of competition, advocates consumer choice linked to user payments, rejects the use of government provision of services, and would eliminate welfare payments' (Hall & Viney, 2000, p. 51).

In the case of New Zealand the application of economic rationalism meant the government would take on the role of the purchaser of services rather than that of the provider, and would be responsible for administering contracts for service provision. Boston, Martin, Pallot and Walsh (1991) discuss the different theories, e.g. public choice theory, agency theory, transaction-cost analysis and managerialism or new public management

¹ Your Health & the Public Health was a document published by Hon Simon Upton, Minister for Health in 1991 and is commonly referred to as the Green and White papers.

that emerged in the 1980s and influenced public sector thinking. The themes that ran through these theories were economically driven and based on economic rationalism. In the case of public choice theory and transaction-cost analysis, the dominant theme was the notion of self-interest based on maximising utilities through rationalism (Boston et al, 1991; Gauld, 2009a). Agency theory was centred on the idea that all transactions were built on contracts and that this was particularly beneficial when trying to attain efficiencies through specialisation and the division of labour (Neiman & Stambough, 1998). New public management proposed management as a generic function that could be applied to public as well as private business (Brown, 2008). All of these factors combined to influence policy in the restructuring of the health system in New Zealand in the 1990s.

The dominant drive evident during the 1990s reforms was the drive for efficiencies based on economic rationalism. As an outcome of the Green and White Paper, four purchasing agencies were created, Regional Health Authorities (RHAs) with the previous 14 Area Health Boards split into 23 Crown Health Enterprises (CHEs). The CHEs were to operate competitively as Crown-owned providers to make profit as was consistent with the State Owned Enterprises Act 1986 legislation requirements (Poutasi, p. 136). It is to be noted that the State Owned Enterprises Act 1986 was not just applicable to health but to the wider public sector as it underpinned government philosophy during this time. However, it is to be noted that the company profit model as applied to the Health sector did not last as a purchaser provider market. This is because the model cannot effectively be applied to health where maximising customers is not the goal.

Subsequently the RHAs were disestablished into one central Health Funding Authority (HFA) and the CHEs were re-structured into not-for-profit companies called Hospital and Health Services (HHS) in 1996.

Restructuring of the hospitals occurred again in 2000 with the District Health Board (DHB) restructure where the HFA was disestablished and the 23 HHS were changed into 21 DHBs. This change occurred as the New

Zealand Public Health & Disability Act (NZPHD)2000 came into force, altering the mechanisms for the funding and provision of services in the health sector (NZPHD Act 2000). Following the implementation of the NZPHD Act 2000, the Crown Entities Act (CE) 2004 was also mandated. The CE Act 2004 provided the legislation for governance of the DHBs and it was through the jurisdiction of the CE Act 2004 that the DHB Boards appointed the Chief Executive Officer for the individual DHBs (CE Act 2004).

The most current restructuring occurred in late 2009 at the Ministry of Health level where the Ministry of Health now provides policy advice to the Minister and the recently established National Health Board is responsible for setting policy and targets and the provision of funding to the DHBs. The National Health Board is an appointed Board set up by the Minister of Health (www.nationalhealthboard.govt.nz).

As can be noted by the plethora of changes that have occurred in the New Zealand health sector in the last twenty five years through to the current structure with the appointment of the National Health Board, economic rationalism has not been the answer to gaining the sort of efficiencies that provides for an economically sustainable health system in the public sector (Gauld, 2001, 2009a). Alongside the changes that occurred in the 1990s and the introduction of the competitive market model, one of the significant losses that occurred was the demise of professional trust. As Boston (1991) notes,

‘public servants work in a different context to their private sector counterparts (e.g. they are bound by different loyalties and obligations, they are confronted with a constantly changing political environment, and they are governed by a range of important constitutional principles’ (p. 21).

The focus on working within a competitive environment to make profit from a health system created a culture of mistrust, and a subsequent lack of knowledge sharing, which was against all of the principles within which health professionals worked which is based on collaborative professional

relationships and trust. This meant that many senior health professionals left the health sector during this period. Gauld (2001) reinforces this sense of institutional knowledge loss with his observations of 'constant staff turnover which frustrated relationship development' and 'the reforms commenced an era of high staff turnover rates among hospital management' that occurred during the 1990s (p. 115 & p. 121). The loss of senior nurse leadership was one of the major casualties of the reforms and this loss of leadership becomes one of the factors that influences the visibility and authority of nursing leadership during the period of this research. This will be discussed more fully in the following section.

1.2 RESEARCH SIGNIFICANCE

Nursing comprises the largest component of the human resources for health budgets (Finlayson & Gower, 2002) and in times of economic constraint and rationing, the nursing staff budget is the first to be targeted (www.wellington.scoop.co.nz/?p=42567; www.tvnz.co.nz/national-news/ryall-and-union-odds-over-nursing-job-cuts-4731044; NZNO Media release 4/11/2011; North, 2011; North & Hughes, 2012). The period of health reforms during the 1990s not only decreased the nursing staff budget but also diminished, through attrition, the numbers of senior nursing staff and the institutional knowledge they brought to public hospitals (Gauld, 2001; Gower, Finlayson & Turnbull, 2003). This loss of institutional knowledge was the result of many senior nursing staff positions being restructured including those choosing not to take on positions within the hospital system. Burnout, stress, lack of organisational power to make a difference and the reforms of the 1990s are some of the reasons cited for leaving the profession (Carryer, 2001; Daniels, 2004; Jamieson & Taua, 2009).

Nursing leadership is one of the key components essential to the efficient and effective administration of a hospital within any organisation. Robust leadership is linked with the ability of leaders to empower staff to undertake their roles (Kanter, 1997) and this skill is equally important in

nursing. Nursing leaders are accountable and responsible for managing nursing workload and staffing and these factors have been consistently linked in international literature to patient safety (Sochalski & Aiken, 1999; Buerhaus & Needleman, 2000; Sovie & Jawad, 2001; Aiken et al, 2001; Korner, Jones, Zhan, Gergen & Basu, 2002; Vahey, Aiken, Sloane, Clarke and Vargas, 2004; Lucerno, Lake & Aiken, 2010; Aiken et al, 2011; Aiken & Sermeus, 2012). Studies have shown that where patients have experienced poor quality outcomes during hospitalisation, and not related to their initial admission injury, the quality of nursing care is a critical factor (White, 2002; Armstrong & Laschinger, 2006; Cummings, Hayduk & Estabrooks, 2005; Estabrooks, Midodzki, Cummings, Ricker & Giovanetti, 2005).

Maas, Johnson & Moorhead (1996) note that the study of patient outcomes is not new and has been evident since Florence Nightingale analysed health care conditions and patient outcomes during the Crimean War. They defined nurse-sensitive outcomes as 'a variable patient or family caregiver state, condition, or perception responsive to nursing intervention' (p.296). Buerhaus and Needleman (2000) refer to these nurse-sensitive outcomes as adverse nurse-sensitive events (ANSEs) as they are events potentially related to nursing interventions that can have an adverse outcome for the patient. New Zealand research undertaken on patient outcomes that are potentially nurse-sensitive (OPSNs) refer to the outcomes as outcomes potentially sensitive to nursing. These potential nurse-sensitive adverse events include but are not limited to 'medication errors, falls and patient injuries, hospital acquired infections and breakdown in skin integrity' (p. 7). These nurse-sensitive patient outcomes were further refined by Buerhaus and Needleman (2000) using algorithms that included the International Classification of Diseases (ICD), Diagnosis related groups (DRGs) and major diagnostic categories used for coding discharge records.

Barbara McCloskey undertook her doctoral study with Professor Donna Diers using the Buerhaus and Needleman algorithm to mine hospital data in New Zealand. She examined nurse-sensitive patient outcomes which led to the publication *Effects of New Zealand's Health Re-engineering on Nursing*

and Patient Outcomes (McCloskey & Diers, 2005). Significant increases in nursing-sensitive patient outcomes were identified. McCloskey and Diers then used a longitudinal statistical analysis to examine nursing workforce between 1993 and 2000. It is during this period that enrolled nurses in New Zealand were being phased out with an increase in the number of registered nurses being employed. However, the percentage increase of registered nurses employed to compensate for the decrease in nurse staffing was viewed as insufficient to address nursing workload, with McCloskey and Diers indicating that per 1000 hospital discharges there was an overall 25% decrease in registered nurse staffing. The evidence suggests that the decreased registered nurse capacity which was linked with the rise of nurse-sensitive patient outcomes was not necessarily attributable to nursing incompetence, but to problems within the organisation such as its systems and the structure of the nursing environment and nursing work (2005).

Linkages between how nursing is organised within the hospital system and patient outcomes have been identified in international research (Aiken, Sochalski & Lake, 1997). The research undertaken by Aiken, Sochalski and Lake (1997) acknowledged that even when skill mix and patient staff ratios were similar within hospitals it was the organisation of nursing that impacted on patient outcomes.

The Institute of Medicine (IOM) in the United States released the report *Keeping patients safe: Transforming the work environment of nurses* (2004), which found that the two major nursing components that were a threat to patient safety were (1) poor management practices and (2) negative working environments (Page (IOM), 2004). One of the key factors documented in the report was that the quality of patient care was directly affected by the degree to which hospital nurses were active and empowered in making decisions about the patient's care plan. Armstrong and Laschinger (2006) argue that it is also the degree to which this empowerment enables nurses to be involved in hospital organisational decision making which impacts on the quality of patient outcomes. The

American Nurses Association devised the Magnet Hospital Recognition Programme to benchmark nursing practice in the 1990s, and the Magnet hospital programme has become an international benchmarking tool that has been utilised both within American hospitals and other countries including many European countries, Australia and New Zealand. The data drawn from Magnet accredited programs worldwide, offers the most credible and evidence-based link between nursing leadership and nursing environments and how this impacts on effective patient outcomes (Aiken et al, 2001; Aiken, Clarke & Sloane, 2002; Aiken, 2008; Aiken & Poghosyan, 2009; Chen & Johantgen, 2010).

One of the critical markers used in Magnet hospital accreditation for achieving excellent patient care and retaining quality nursing staff is nursing leadership. (www.nursecredentialing.org.) Internationally, the magnet hospital accreditation programme run by the American Nurses Association includes nursing leadership as one of its five forces of magnetism, with leadership seen to be critical to leading nursing practice and supporting the professional practice environment which influences effective patient care

(<http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx>).

This programme is based around five core aspects of nurses work environment:

- nurse participation in hospital affairs
- nursing foundations for quality of care
- nurse manager ability, leadership and support of nurses
- staffing and resource adequacy
- collegial nurse-doctor relationships

(<http://www.nursecredentialing.org/Magnet/programOverview.aspx>).

Magnet Hospital status as noted by Armstrong and Laschinger (2006) is therefore characterised by high levels of attainment in nursing in the following areas:

- unit based decision making
- powerful nursing executive
- promotion of professional nursing practice
- increased likelihood of superior patient care (Armstrong & Laschinger, p. 125)

New Zealand hospital work is organised and managed by the executive leadership team within the individual District Health Boards. Having robust nursing leadership on the executive leadership teams enables nursing staff to be empowered. Through being empowered nursing leaders have authority and budgetary control which facilitates the ability for nursing leaders to create and maintain a well-resourced work environment. This in turn provides the capability to provide quality patient care.

The impetus for this research came from a meeting that occurred at Massey University in 2006. The meeting comprised Professor Jenny Carryer², Professor Donna Diers³, Dr Barbara McCloskey⁴, Dr Denise Wilson⁵, Sue Woods⁶ and me as both a registered nurse and early PhD candidate. The McCloskey and Diers (2005) longitudinal data from the *Effects of New Zealand's Health Re-engineering on Nursing and Patient Outcomes* publication formed the basis for the discussion with the findings indicating that there was a steady increase in potential adverse nurse-sensitive events coinciding with decreasing Registered Nurse staffing levels (McCloskey & Diers, 2005).

² Professor Jenny Carryer is Professor of Nursing at the School of Nursing, College of Health, Massey University, NZ and Executive Director of the College of Nurses Aotearoa(NZ).

³ Professor Donna Diers is Goodrich Professor Emerita and Lecturer in Nursing Management & Policy Leadership in programs at Yale School of Nursing, Yale University, New Haven USA.

⁴ Dr Barbara McClosky is Lecturer at Yale School of Nursing, Yale University, New Haven USA.

⁵ Dr Denise Wilson was Associate Professor for the Taupua Waiora Centre for Maori Health Research, Massey University, NZ at the time of the meeting. Dr Wilson is now at Auckland University of Technology.

⁶ Sue Woods is Director of Nursing, MidCentral Health, Palmerston North, NZ.

Carryer, Diers, McCloskey and Wilson (2011) conducted a later study that extended the period of data collection. They noted that as staffing levels rose again from 2000 onwards the potential adverse nurse-sensitive outcomes did not decline accordingly. As a result of these findings it was hypothesised that the health reforms undertaken by the government during the 1990s had impacted adversely on nursing leadership structures and that this might contribute to sustained increasing levels of potential adverse nurse-sensitive outcomes. As noted earlier the effects of hospital restructuring had led to a decline in both senior nursing staff and general nursing staff in the hospital system (Gauld, 2001; Finlayson & Gower, 2003) and had potentially created long-term damage to nurse leadership structures (Carryer et al, 2011).

Internationally, a study of nursing leadership and structures in Canadian hospitals was undertaken by Laschinger & Wong in 2006 and the report findings released in 2007. The aim of the Laschinger & Wong study was to assist with the decision making process when nurse leader role configurations and organisational structures are being designed. Research around hospital organisational design indicated that through determining the best mix of organisational structures, support and strategies, management would be able to achieve retention of nurse leaders and optimal staffing as well as quality patient outcomes (Laschinger & Wong, 2007).

A review of the literature has indicated that there is no literature available on structures that impact on decision making processes around leadership positions in public entities in New Zealand, and more specifically none in the health area. There is, however, a body of literature on organisational management that could be mined for information around the formal and informal structures of health institutions (Mintzberg, 1989; Shortell & Kaluzny, 2006; Harris & Associates, 2006). In addition, there have been a number of studies specific to nursing in New Zealand (Hughes, 2003; Bamford, 2003; White, 2004; Gower, Finlayson & Turnbull, 2003) examining the impact restructuring has had on hospital nursing. There is a

plethora of information on leadership and management focusing on hospital nursing in the United States and Canada that provides international data that can be used for aligning findings with international best practice.

There is no information on nursing leadership structures in New Zealand and minimal data on leadership within public sector corporations, and specifically health and nursing in the New Zealand context. What is valuable in utilising the range of literature outlined above is that it can be examined in conjunction with the primary data from this research to provide an understanding of how organisational structures influence nursing leadership within the New Zealand context. It is for this reason that unlike a conventional thesis structure, the majority of the literature reviewed will be referenced alongside and after the data gathering and analysis so that comparisons can be made. This dissertation will not only provide information in the field of nursing leadership in New Zealand but will also contribute insights into how nursing leaders make sense of the New Zealand hospital organisational context. The following section discusses the research approach and the research questions.

1.3 RESEARCH APPROACH & RESEARCH QUESTIONS

This thesis is predominantly qualitative and utilises an inductive and exploratory approach. An inductive approach is taken because the findings are data-driven, and an exploratory approach because the area of research is new. As the research is time bounded for the duration of the dissertation period and limited to a specific group of participants, case study methodology is used and generalizability will be restricted to the quintain of cases. There are three data phases, Phase 1 involving a review and analysis of District Health Board organisational and nursing structure charts during 2006-2012. Phase 2 and 3 comprised a qualitative survey being sent to all Directors of Nursing (DoNs) and Chief Executive Officers (CEOs) working in New Zealand District Health Board public hospitals in the period 2009-2011. The ability to group the data into 20 distinct DHB

cases not only enabled cross comparisons to be made of similarities to ensure research robustness, but also highlighted differences in the uniqueness of the cases. Underpinning the data phases three exploratory research questions were formulated:

- How are nursing leadership structures configured in the organisational structure of each District Health Board?
- How did these structures come about and, why do they differ across the country?
- How does the pattern of the New Zealand structures align with what is known internationally to be best practice?

The importance of the first question lies in the ability to create a set of current data on the participating District Health Board organisations (DHBs). The information provided descriptive data about the DHB formal organisational charts and structures. These data could then be analysed against organisational management theory on organisational structures and in particular health structures.

The second question was concerned with exploring the informal structures found within the organisations, and examining the determinants that underpin differences within each DHB. Whilst formal structures often refer to organisational charts, organisational policies, standardised processes and procedures, informal structures within organisations are often viewed as an outcome of the organisational culture that exists within the organisation. How the culture develops within an organisation also influences the decision-making processes (Daft, 2010). Organisational management constructs on power and authority were used to review decision making processes. Some of the influencing factors considered for discussion are around the historical legacies of nursing and the gendered workplace. Contextualising these factors within the dominant political discourse is essential as I seek to make sense of how the structures impacting on nursing leadership have come about.

The third question relates to both the formal and informal structures apparent in each DHB and what may be barriers for alignment with the characteristics affirmed by the Magnet hospital accreditation system. As noted in the section on the significance of the research, Magnet hospital was chosen as an international benchmark as it is well recognised in western developed countries and has been implemented in a number of countries outside of the United States, including Britain, Australia and New Zealand. The nurse leadership profiling study undertaken by Laschinger and Wong (2007), although primarily quantitative utilised a series of qualitative discussion questions with senior nurse leaders and chief executive officers in the Canadian hospital sector. Permission has been sought to utilise and adapt these questions for the purposes of this research (Refer Appendix C). Having discussed using an inductive, exploratory research approach and the research questions it is important that I now locate myself as a researcher in terms of this research.

1.4 RESEARCHER POSITIONING

Positioning myself in this research has required an examination of what being an insider and an outsider might mean in terms of the research. I am aware of having been an insider in the field of my research as I have worked quite recently in the area of patient safety within one of the New Zealand District Health Board public hospitals and have considered how these processes and outcomes affect patients. In my role I have worked in a relatively senior position advising senior management. However, I am also conscious that what I observed and reviewed during the course of this work may not be applicable to other District Health Boards. I have insight also into government as I have previously worked as a policy analyst in the health sector. Both of these work roles have been beneficial to the research as they have given me an understanding of the two different areas that influence each other in health policy, structure and decision making. As a registered nurse I understand the hospital environment and its systems

and am comfortable using health terminology; these are the benefits of being an insider.

However, my role now as a tutor, teaching health services management and policy has taken me out of the hospital environment and I am now an outsider. This, however, has also been beneficial as I am using a management lens to understand the health sector. My previous experience and working career has also given me useful links into the current health sector that continue and enable me to keep up with the informal networks that might otherwise be inaccessible. Utilising an organisational lens rather than a clinical lens, the use of informal networks has been invaluable when establishing legitimacy as a researcher, and this has proven to be the case in this research.

The use of an exploratory framework has enabled me to examine my topic area through a number of disciplinary lenses for which I have both an intellectual and working background. Intellectually I have studied nursing, policy studies, politics, economics, sociology and history through a number of university degrees. I have further studies in business and human resources and have worked as a business leader as well as the patient safety clinical co-ordinator at a District Health Board that has encompassed understanding management and organisational change processes. Again as an insider this has given me an understanding of the hospital business and budgeting processes that are not necessarily accessible to people who have not worked in public health sector organisations but also to people who work at different levels within the sector. I respect that privilege and knowledge.

Utilising an inductive method of analysis has necessitated me to be critical as I examine the data for patterns to emerge from the a priori coding utilised in the survey adapted from the Laschinger and Wong (2007) qualitative questions. To provide validation I consistently refer back to my data and what the data is saying through the use of the coding and data triangulation. My multidisciplinary academic background has provided me

with an ability to research and locate information, which in turn has meant that I have sourced literature widely for this research. This has also meant a constant need to keep focussed on the topic and what the data is saying, and using the literature to assist with a discussion of the data. I also have a passion for nursing, and understanding the health context in which nursing operates, and want to be able to constructively contribute to the nursing research field. My cross disciplinary background poses as many challenges as it does benefits, however, using both the advantages and disadvantages of working across disciplines I feel that I can bring a different and useful way of thinking to nursing matters, particularly in the current fiscally challenged environment. I now turn to how the dissertation is structured and an outline of the chapters to follow.

1.5 THESIS STRUCTURE

The remainder of the thesis is structured into eight chapters including a final discussion chapter. Chapter Two presents an appraisal of the identified literature that covers organisational management theory, nursing leadership and the New Zealand political economy. This chapter sets out to examine the texts that are available and identify the gaps in this area of research.

The theoretical view of 'making sense' or 'perspectivism' is presented in Chapter Three. The constructs of perspectivism, sense-making and the organisation and health organisation culture and nursing leadership culture are examined to form an understanding of the context in which the research is being analysed. It is important to be aware of both the perspectives and context as this is required to validate the thesis as outlined in the methodology chapter.

Chapter Four builds on the different contexts that contribute to sense-making. In this chapter a discussion on institutional theory and how isomorphism can help examine organisational structures is undertaken. Additionally the historical lens offers an important sense of what in the past

has influenced the structures impacting on nursing leadership. The dominance of women in the nursing workplace presents a rationale for examination of how the gendered workplace may have influenced nursing leadership structures.

Chapter Five provides an understanding of the case study methodology, and the rationale for case study as the most suitable methodology for this thesis. The bounded parameters, timeframe and DHB settings all provide examples of how case study research is suited to the thesis material. I then move onto to discuss the limitations of the research methodology.

Following on from the methodology, Chapter Six outlines the methods undertaken to do the research and covers data collection. This chapter outlines the research timeline, the ethical approval process, methods for data collection and how the data was coded and analysed. The inductive and exploratory nature of the thesis lends itself to a thematic analysis. Organisational management theories on organisational structure provide models that can be used for analysis with Phase one data, whilst the Magnet indicators and the Laschinger and Wong (2007) findings are aligned to explore the potential themes emerging from the Phase two & three data. This chapter also discusses using Sandelowski's (1986) method of trustworthiness to ensure that the research process undertaken is robust and credible.

In Chapter Seven the results of the data findings from the three phases are provided and Chapter Eight offers a more qualitative analysis of the data. In the first data phase the organisational and nursing structure charts have been sourced to review the formal structures of the different District Health Board public hospital configurations. A formal structure chart offers insight into the type of work that is undertaken, and how that work is managed within the organisation. These formal structures indicate the organisation of hierarchy and lines of accountability within the organisation. Through a review of the formal structure the standing of the senior nursing position, the Director of Nursing, can be ascertained in

relation to the other executive leadership positions. Examining the structure charts also provides an indication of the lines of accountability that report to the Director of Nursing position.

Position descriptions reporting to the Director of Nursing evident on the structure charts are also examined, as what appeared at first to be a plethora of positions by name were in essence similar positions. This brief exercise was undertaken to provide clarity around understanding the charts. It is from the phase one data that the first two findings emerge around the differences that are apparent in both the organisation and nursing structures and across the different DHBs.

The next step to understanding the informal structures that operated within the hospital organisation was to send a qualitative questionnaire to the Directors of Nursing (DoNs) and the Chief Executive Officers (CEOs) at each District Health Board. Understanding the informal structures within organisations is important as it assists with understanding the role that underpins that position. While a position description is formal and objective, the role is subjective and informal as it is dependent upon the perception or 'making sense' of the stakeholders that communicate with that role within the organisation. Utilising (with adaptation for the New Zealand context) the Laschinger and Wong (2007) qualitative questions provided a survey tool that could be used to understand the informal processes that influence the DoN role. Findings three and four that emerged from the dataset were related to nursing leadership reporting lines and visibility, and the degree to which the authority of the DoN role has diminished over time.

Using the Magnet hospital criteria as an example of internationally accepted best practice, and the findings from the Laschinger and Wong qualitative component of their nursing leadership project (2007) the data responses were examined for alignment. Findings five and six indicate a further erosion of nursing leadership authority as ambiguous financial accountability and dual nursing accountability becomes evident. In the

Magnet hospital model, it can be argued that responsibility as well as accountability for the nursing budget and subsequent nurse to nurse reporting is viewed as critical to achieving effective patient care as these two factors empower nurses. Armstrong, Laschinger and Wong (2009) argue that the characteristics of the Magnet hospital programme are a reflection of conditions within a hospital that support professional nursing practice. Further studies by Aiken, Smith and Lake (1994) and Aiken, Clarke & Sloane (2002) have also established the connections between nurse work environments and patient safety. The findings in this research indicate that whilst the DoNs have increasing informal responsibility for nursing they are not given the mandate of formal accountability and this becomes very evident in the dual accountability process seen in the majority of the DHBs. All six findings provide evidence of how in combination with fragmentation and perceptions around authority, senior nursing leadership has experienced diminished authority over time in New Zealand public hospitals.

The final discussion in Chapter Nine, returns to the three research questions and looks at the implications of these findings for nurse leaders and for future nursing research. One of the issues raised as a result of this exploratory research is the gap between the narrative and the reality and what this means for nursing leaders in terms of real authority. I will also draw on the contextual factors discussed in chapter four, and how institutional isomorphism and the gendered world of health work has contributed to this continual struggle and look at potential ways in which nursing leaders can increase their visibility and gain back authority. I will now move onto chapter two and provide an overview of the literature.

CHAPTER TWO – UNDERSTANDING CRITICAL CONTRIBUTIONS TO THE LITERATURE

2.0 INTRODUCTION

Hart (1998) notes there are a number of pertinent reasons for reviewing the literature that include but are not limited to ‘distinguishing what has been done from what needs to be done’, providing a method for ‘synthesising and gaining a new perspective’ and ‘placing the research in a historical context to show familiarity with state-of-the-art developments’ (p. 27). This quote reflects the rationale for a review of the literature. There have been a large number of narratives on nursing leadership internationally, but none have been found on the influence of structural positioning or autonomy, authority of the leadership position and therefore influence in organisational decision-making. It is this gap in this literature that has been identified and therefore becomes ‘a need to be done’. There is a paucity of information directly relating to organisational structures and nursing leadership, particularly in the New Zealand context and the literature review provides an avenue for synthesising literature on both organisational culture and nursing to gain a different and new perspective.

The historical context is also critical to examining the literature as it provides not only a timeline of changing ideas, but also places the research within a timely context. Finally, it is important to acknowledge that this literature review does not cover the entire breadth of material available on nursing leadership nor on organisational structures as it would be impossible to do so. What it does cover is some important seminal works from authors Morgan, Weick, and Kanter from the organisational field and draws on more recent literature from the nursing leadership field.

The first section of this chapter focuses on the search strategy utilised, as this assists with establishing what has already been written. The keywords

in any search provide the expanders and limitations within which literature can be explored and it is important that the keywords are focussed on the research area. This is achieved through funnelling and focussing in on detailed keywords that can then be expanded to broaden the search as required (Aveyard, 2010). Using keywords, such as nursing leadership, nursing management, and nurse executive, the search has then been expanded or limited using additional words such as organisational structure, decision-making and New Zealand. The use of this type of search strategy is in keeping with the inductive and exploratory nature of the research.

Literature that is relevant to this thesis is found in two dominant search sections, the first in the areas of nursing leadership and nursing leadership structures. The second critical area is that of organisational management, organisational structures and organisational culture and behaviour, and in this area the institutional approach and the constructs of power and authority will be examined. As noted earlier there has been a plethora of literature on nursing leadership, but very little examining the actual structures that relate to nursing leadership. There have also been a large number of articles and books on organisational management and specifically health services management but limited contributions to the New Zealand context. I can say this with some authority as I teach a postgraduate health services management paper and am well abreast of the relevant available teaching materials and literature.

Reviewing the relevant literature suggests a large number of different potential exploratory pathways. In an attempt to determine the gaps in the literature, some of these pathways have covered empowerment, bureaucracy, economics, political history, the gendered workplace and legitimacy. This has made examining the literature exciting and quite difficult at the same time. Examining the diverse nature of some of the literature was kept in check by reaffirming what the research questions were trying to identify, and focussing on literature that would assist with understanding nursing leadership structures.

The gaps became obvious when overviewing the literature on nursing leadership in New Zealand public hospitals. There was nothing overtly available on how leadership structures influenced decision-making authority, for example, how had the nurse leader positions come about in the current structures? And, what did being a Director of Nursing mean within the organisation, what influence did this role have in the organisation? Literature on nursing leadership was available on different types of leadership styles that worked best for nurse leaders, such as transformational leadership. However, there was minimal information that portrayed instances of how these leadership styles had been applied to New Zealand nurse leaders and whether understanding this style of leadership was linked with any organisational structural processes that influenced the specific role, function and influence for senior nurse leaders.

There has also been information available on how the constant health and hospital reforms have impacted on nursing and this reveals that for nursing one of the critical impacts of the 1990s health reforms was the loss of senior nurses in the hospital setting and the consequent loss of institutional knowledge, leadership and influence (Finlayson & Gower, 2002). However, whilst some literature acknowledges that the loss of leadership is an important issue for nursing there has been minimal empirical research undertaken in this area. There is a lack of published research on nursing leadership structures in New Zealand and given the significance of nursing leadership in international benchmarking practices such as the Magnet accreditation process used to define Magnet⁷ hospitals, suggests that research in this area is important.

Having briefly outlined the relevant areas of literature and the gaps that became obvious I will now discuss the search strategy that was utilised in reviewing literature for this dissertation.

⁷ Magnet and Magnet hospitals has been defined in Chapter one.

2.1 SEARCH STRATEGY

A Google scholar and an Ovid database search were performed on keywords such as nursing leadership; health services leadership, and health services management. The keywords New Zealand and nursing were added to narrow the search using the broader health services terms. Additional keyword searches were performed in relation to organisational management, decision-making and organisational structure. In addition to keyword searches, the McCloskey and Diers (2005) article provided a starting point for looking at re-engineering and restructuring health services in New Zealand.

There is a plethora of information on Magnet nursing and nursing leadership in the international literature, however there is very minimal information on organisational structures and how they might influence nursing leadership. The Laschinger & Wong (2007) Canadian nursing leadership profiling research was the first quantitative study that has examined a variety of environmental factors influencing senior nursing leadership and the structure of nursing leadership internationally. On the New Zealand front, a study on nurse leaders in relation to the 1990s hospital restructuring and nurse retention had been conducted by North et al. (2005). In this study nursing turnover was found to be a significant issue for most DHBs. During the course of the research it was reported that DoNs were held accountable for nursing workforce in the areas of 'nursing skill mix, scope of practice, clinical practice and professional development and policy' (2005, p. 29). It was also noted that not all DoNs had control of the nursing budget, and where some DoNs reported being in a line management role, others reported being in an advisory position. This study was important in that it provided background data on DoN positioning in the DHBs. Another study internationally comparing nurse's perceptions of hospital care, which included New Zealand as one of the countries, was undertaken by Finlayson, Aiken & Nakarada-Kordic in 2001. Nurses work environment was one of the key areas studied in this research and the findings drew comparisons with international findings and New Zealand

findings on how nurses reported on their work environments. The findings indicated that New Zealand nurses felt they were not supported by management within their working environment. This lack of satisfaction with their work environment raises the question of whether nursing leadership is influential in being able to make changes to the nurses work environment. References to Nurse Leaders in New Zealand hospitals were also highlighted in a publication by Finalyson, Gower and Turnbull (2002) and a chapter in Gauld (2003). In both of these articles one of the key findings was around the disruption and change that impacted on nursing during the 1990s health reforms and the consequential impact on nursing leadership.

Other important New Zealand contributions to relevant nursing research have been from Francis Hughes (2003), Anita Bamford (2004) and Jill White (2004). Hughes thesis (2003) *Policy, Politics and Nursing: a case study of policy formation in New Zealand* offers insight into the policies and politics that were impacting on nursing in the late 1990s, and how nursing organisations were coping with the pressures of 'competition, managerialism and the new labour relations'(p.2). Hughes thesis raises the importance of the nursing voice in influencing government policy.

Leadership for culture change: generating new growth from old, Anita Bamford's thesis, provides awareness into the disempowerment nursing leaders felt following the 1990 health reforms and suggested the concepts of 'breakthrough leadership, shared governance and action processes' can be used through action research to bring about culture change in nursing (Bamford, 2004, p. xiv). The information in this thesis is important to the literature review through the findings from its central research question which looks at 'the leadership function and role of a Director of Nursing in a contemporary healthcare climate' (2004, p. 10). Bamford provides a detailed account of the difficulties encountered by DoNs as a result of the health reforms and how the role changed. *The Commodification of Caring* (White, 2004) explores how the effects of the political and organisational

changes of the 1995 health reforms impacted on nursing practice and the nursing profession.

In all of these theses one of the sub themes that is evident has been the 'invisibility of nursing' as a result of the reforms, and as White notes, one of the consequences from the reforms on nursing was the 'subversion of authority' (2004, p. vii). Exploring the extant New Zealand research and taking note of the relevant referenced literature provided the basis for further refinement of the literature search.

Returning to my first research question on establishing what nursing leadership structures were evident in each District Health Board in New Zealand, a gap was emerging in the literature as there was no such published data. This lack of information led to further keyword searches incorporating the organisational lens, as organisational structures are part of organisational management and organisational culture literature. It was far more difficult to find pertinent and relevant information that was specifically related to New Zealand health systems and health organisational structures.

However, it was in the review of this literature that the first critical building block became evident to understanding how to make sense of nursing leadership structures using an organisational lens (Weick , 1995, 2005). Weick provides a pathway by which sense-making is examined and shows how this concept can be applied to different organisational frameworks. He notes that sense-making occurs when unusual activity is noticed in a usual pattern of activities or happenings. Reviewing the unusual activity becomes retrospective as the individual attempts to make sense of the discrepancy in the normal patterning (1995). However, because organisations are controlled through a series of measures and incentives how individuals within the organisations make sense of unusual activities is influenced by these measures and incentives. Therefore individuals can become constrained in their sense-making by the pervading organisational culture. Mintzberg (2001), Shortell and Kaluzny (2006), and Harris and

Associates (2006) all provide invaluable information around health services management structures that offer a scaffold from which to view the research data. Mintzberg (2001) offers ways of viewing organisational structures and how they have come to be shaped such as breaking down the organisation into components and arranging the different components into different types of structures. The professional bureaucratic structure is one structure that is still evident today in public hospitals in New Zealand and it is this structure that provides a starting point for examining the DHB organisational structures. This is because the public hospital structures have remained relatively unchanged and a model of bureaucracy since their inception over 100 years ago. Shortell and Kaluzny (2006) discuss the health management structures that are apparent in the United States health system and offer explanations and case studies of how these systems are structured and managed and this information can be used to understand New Zealand health system structures. Harris and Associates (2006) also look at health systems and how they function in the Australian context, again this information provides a closer understanding of the New Zealand health system as both health systems have evolved from the British health system. Both texts offer more contemporary views on healthcare organisations, however also draw on the early organisational theorists and use Mintzberg (2001) to examine professional bureaucracy.

Finally, the work of Buerhaus and Needleman (2000), Aiken, Clarke and Sloane (2002), Aiken, Clarke and Sloane (2004), Aiken, Buchan, Ball and Rafferty (2008), Aiken et al (2011) and Aiken and Sermeus (2012), the American Nurses Association (ANA) information on the Magnet recognition program, Cummings (2006) are just a few of the sources that provided information that established parameters for examining the alignment or misalignment of nursing structures in New Zealand, with an internationally benchmarked best practice structure such as those in the Magnet hospital research. Buerhaus and Needleman (2000) discuss and refine the indicators that are potentially nurse sensitive and impact on patient outcomes. Linda Aiken is well known for her research on magnet hospitals

and their contribution to both better nursing and patient outcomes. Aiken, in conjunction with other nurse researchers has undertaken work not only in the United States but also in a number of other countries including Great Britain, Europe, Russia and New Zealand and has found during the course of her research that having empowered nurse work environments in the hospital setting can be influential towards positive patient outcomes . Cummings (2006) has also contributed to the nursing literature on magnet hospitals through research on the positive attributes that working in a magnet hospital environment can bring.

2.2 RELEVANCE OF THE LITERATURE

Having identified the two dominant areas of literature that influence this research this section is structured into the following headings nursing leadership and organisational structure literature. As noted earlier the literature on nursing leadership covers a plethora of other topics where the literature has been examined for linkages with nurse leaders in general and then more specifically the nurse leadership research area in New Zealand. At the tail end of the discussion information is provided specifically around the New Zealand health sector context. The organisational management literature has been explored primarily in the areas of organisational structure and organisational behaviour to ascertain what might contribute to decision-making in organisations, and specifically health services organisations.

2.2.1 NURSING LEADERSHIP LITERATURE

The examination of the relationship between nursing leadership and effective patient outcomes became the first of a series of exploratory pathways in the literature. The pivotal document for starting this research was (as noted in the introduction), the McCloskey and Diers study (2005) which suggested that nursing leadership was potentially one of the unexplored variables that influenced patient outcomes in New Zealand hospitals. Buerhaus and Needleman (1999) had undertaken research into nurse sensitive patient indicators, with these indicators becoming one of

the benchmarks that are used as part of the magnet hospital accreditation process. The indicators serve as a set of measures that hospitals can use to determine effective nursing practice. Aiken, Clarke and Sloane (2002) have undertaken a number of magnet related studies on hospitals both within and outside of the United States to try and determine whether magnet practices improve the quality of nursing care. The studies looked at what the characteristics were of workplaces that attracted and retained nurses and held a certain 'magnetism'. The Revised Nursing Work Index (NWI-R) has been utilised to capture the characteristics of what constitutes a professional nursing practice environment. In using the NWI-R tool researchers have been able to ascertain the organisational traits of different hospitals to distinguish those hospitals with magnet characteristics (Aiken & Patrician, 2000).

INTERNATIONAL LITERATURE ON NURSING LEADERSHIP

Research supporting the influence of environment on the quality of nursing practice is found in the Institute of Medicine Report (IOM), (Page, (IOM), 2004) *Keeping patients safe: Transforming the work environment of nurses*. It was in this report that empowerment of nursing was also noted as a contributing factor to patient safety (Armstrong & Laschinger, 2006). As Redman notes, the IOM report identifies 'evidence-based leadership practices' as integral to guaranteeing a safer patient care environment (2006, p. 292).

Laschinger and Wong (2007) provided a quantitative study that profiled nursing leadership across Canadian Hospitals. The aim of the Laschinger & Wong study was to examine the decision making process that influenced nurse leader role configurations in health organisational structures. Through determining the best mix of organisational structures, support and strategies, it was considered that management would be able to achieve retention of nurse leaders and optimal staffing as well as quality patient outcomes. The executive summary for this research puts forward six key areas that can influence decision making around nurse leadership: nursing

leadership succession; sphere of influence; empowerment; spans of control; good working relationships and adequate resourcing (Laschinger & Wong, 2007). As these areas addressed both the internal and external issues influencing nursing leadership, I have adopted these three areas as a lens for understanding nursing leadership structures in this dissertation. The three areas are: spheres of influence, empowerment and spans of control.

More recent literature on nursing also points out the need for a greater emphasis on nursing leadership. In 2011 the Committee on the Robert Johnson Wood Foundation Initiative on the future of nursing at the Institute of Medicine published the *Future of Nursing: Leading Change, Advancing Health* report, which calls for nurses to take a greater role in the American health system and acknowledges that leadership is fundamental to advancing the nursing profession. In this report it is acknowledged that there is a greater need for nursing leadership across all healthcare settings and this is evident in the third key message, 'nurses should be full partners, with physicians and other health care professionals in redesigning health care in the United States' (2011, p. 4). To achieve this partnership it is highlighted that the 'nursing profession must produce leaders throughout the system from bedside to boardroom' (2011, p. 7).

In the United Kingdom the Department of Health published *Frontline care: the future of nursing and midwifery in England. Report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England*. The focus of the report is on meeting changing healthcare needs through nursing and midwifery delivering high quality care, and in addition the report also acknowledges that 'in return policy-makers, service commissioners, employers and managers will support them' (2010, p. 4). Minister, The Honourable Ann Keen chair of the Prime Minister's Commission on the Future of Nursing and Midwifery in England also notes in the overview that a positive workforce culture has to be provided so that nurses feel valued.

The Canadian National Expert Commission has recently reported on the need for change to support the Canadian changing healthcare system in its 2012 report *A Nursing Call to Action*. One of the key messages in this report suggests 'strengthening the voice of advocacy for and by nurses' (2012, p. 30). One mechanism for achieving this strengthening advocacy is through increasing effective nurse-led interventions. Nurse led model of care structures with changed funding would 'free up the time of other health professionals, improve outcomes and rein in costs' (2012, p. 31). However, for this to occur, nursing leaders need to be leading the advocacy role as outlined in the Magnet hospital accreditation guidelines in Chapter One. Understanding what strong nursing leadership looks like is one way in which to identify whether there is the capacity within the system for nursing leaders to advocate and lead, rather than manage and this has been the predominant theme in the recent international literature. One of the issues that keeps arising is the lack of opportunity for nurse executives to be transformational leaders as they are often tied up with transactional based management concerns.

SPHERES OF INFLUENCE

Nursing 'spheres of influence' may be defined by the degree to which senior nurse leaders view themselves as influential members of the senior management team. The main factors influencing spheres of influence is inclusion as part of the senior executive structure, a reporting relationship with the Chief Executive officer and the use of a title reflecting their seniority in the organisation such as chief nursing officer (Laschinger & Wong, 2007). Having a powerful nurse executive participating in decision-making in hospital affairs at the most senior levels was critical within the magnet hospital process, as indicated earlier.

The perception of influence became critical to the data when making sense of the informal and formal relationships New Zealand Directors of Nursing have within their own healthcare services. Studies in New Zealand (Finlayson & Gower, 2002; Gower, Finlayson & Turnbull, 2003; North et al, 2005) all found that since the disestablishment of the Principal Nurse

position in the hospital in 1988, there had been a variety of positions with varying accountability and responsibilities to replace this position. Gower, Finlayson and Turnbull (2003) provide a snapshot of the changes that occurred between 1988 and 1999. Looking at 16 public hospitals during this period, six of the hospitals had between two to six years where there was no centralised nursing leadership position since the Principal Nurse position was disestablished. The principal nurse had previously been charged with the authority to ensure the delivery of nursing services met the hospitals requirements. During the period 1988 to 1999, 13 nurse advisor positions were established and then disestablished to be replaced by Director of Nursing positions. As these senior nursing positions were gradually replaced with Director of Nursing positions it was noted that whilst Directors of Nursing were professionally accountable for nursing staff, they had 'no management authority over the delivery of nursing services' (Gower, Finlayson & Turnbull, 2003, p. 130).

The importance of having influence at an executive level is noted in the literature and forms the basis for empowerment as a leader (Kanter, 1997). Following the reforms of the 1990s, White (2004) notes that by 1994 nursing was a profession that was 'tired, emotionally exhausted and dispirited' and it had 'an almost silent professional voice, a fractured leadership group and experienced nurses were leaving nursing' (p. 4). The relevance of this cluster of literature addressing nursing influence at senior management level, is critical to this research, as what is evidenced as best practice internationally and what has occurred in New Zealand and continues to influence the New Zealand nursing environment appears to be quite different.

EMPOWERMENT

A salient point found in the 2007 Laschinger and Wong study, relates to the impact organisational structure had on the quality of the environments in which nurse leaders worked. Where there was a perception that nurse leaders were involved in the decision-making processes from a very early stage, the greater the feeling of empowerment and being valued by the

organisation. This in turn led to feelings of professional nursing practice being supported by the organisation, and ultimately a perception that there was a higher quality of patient care delivered. This perception also filtered down to middle and first-line managers. Mathews, Laschinger and Johnstone (2006) note from a study that reviewed staff nursing empowerment from both a staff organisational structure and line organisational structure perspective that staff nurses who reported to a chief nurse executive through a line structure, felt more empowered in their work environment than those who reported to chief nurse executives working in an organisational staff structure. Organisational staffing structures differ from line reporting structures as the staff nurses report through the organisational lines of reporting, for example the staff nurse may report through to the service manager rather than through a nursing reporting line. McGillis Hall, Doran and Pink (2008), Lake (2002) and Stordeur and D'Hoore (2006) all note the importance of the nursing work environment and that one of the influencing factors that contributed to a healthy work environment was organisational and managerial support. Stordeur and D'Hoore (2006) focus on the organisational configuration of hospitals and note that whilst the structural characteristics of either 'attractive' or 'conventional' hospitals were not the influencing factors in how nurses perceived whether a hospital was more attractive than another, the relationships with nurse managers were perceived as better in hospitals that attracted nursing staff (p. 45).

SPANS OF CONTROL

The collection of narratives on the span of control and line authority in nursing in the international literature provides a way in which to compare the data from this research with both organisational theory and international practice. Lines of authority and reporting are related to both the relationship and the span of control that the nurse manager has with staff and this was viewed as another key finding in the Laschinger and Wong (2007) research. The size and management of the span of control that a nurse manager has, is also aligned with the Magnet hospital concepts

of managerial support of nurses and unit based decision making. Getting the balance right between managing the tension of autonomous decision making within the individual unit and the number of direct reports can affect the relationship between nurse managers and their staff (Pabst, 1993; Meyer, 2008).

The constant change in healthcare services with the amalgamation of roles and the financial pressures has created scenarios where nurse managers have had to adapt to large spans of control. There was also a general recognition that the spans of control need to be reduced. In the Laschinger and Wong (2007) study first line managers averaged 71 direct reports with Chief Nursing Officers working in hospitals averaging 49 direct reports. What was noted from these large spans of control was 'managers who reported a large span of control had higher levels of staff turnover and lower patient satisfaction' (2007, p. 13). Arnold et al (2006) and Sanford (1994) provide discussion on the overarching span of control for which Nurse Executives are expected to be responsible and suggest where some of the limitations lie in having such a wide ranging span. The literature on span of control is important, as some New Zealand DoNs have a span of control that covers the wider District Health Board and includes the public hospital within that jurisdiction, whereas some DoNs have a span of control that only covers the public hospital⁸. Using the international literature to define what the span of control actually means is important for nursing in an organisational context. Having accountability and responsibility for people through the span of control gives the position a direct budget line and financial accountability. This point, is linked to the following section on adequate resourcing.

⁸ New Zealand District Health Boards by statute cover a geographically defined location and provide health services to that location. The health services cover hospitals, primary health care and all other health care providers. Some Directors of Nursing are responsible for all nursing services funded by the District Health Boards, whereas some Directors of Nursing are only responsible for hospital nursing services.

ADEQUATE RESOURCING

Focussing on adequate resources is highlighted due to the fact that resourcing remains an ongoing issue for all healthcare organisations (Laschinger & Wong, 2007, Executive Summary). Studies undertaken on Magnet hospitals highlight having adequate resources as being an influential factor within the nursing work environment that impacts on patient outcomes (Aiken, Smith & Lake, 1994; Aiken, Sochalski & Lake, 1997). One of the consequences of the reforms both in New Zealand and internationally has been the effect of cost cutting in hospitals and the economic impacts on resources. In New Zealand the Health & Disability Commissioner (HDC) report (1989) on Canterbury DHB highlighted the issues with patient outcomes and the high mortality that occurred when nurses were not able to work in adequately resourced work environments. White (2004) also notes the disillusionment nurses felt in being unable to control and provide the level of care they were required following budget cuts in both staffing and resources. The discussion on staffing and resources leads onto discussing the New Zealand context and the application of economic rationalism to health services.

LITERATURE ON THE NEW ZEALAND CONTEXT

Understanding the external environment is important to understanding organisational structure as the health services in New Zealand are government funded and therefore responsive to government politics and policies. As indicated in the introduction, the move to implement new public managerialism led to both changes in leadership structures and policies on economic rationalism in the public sector.

HEALTH RESTRUCTURING

The Arthur Anderson Report commonly referred to as the *Gibbs Report*, 'Unshackling the Public Hospitals' (1988) signalled the start of fundamental changes to hospital organisation and inherently within such a change the leadership of the organisation. The election of the National government to power in the 1990s and the subsequent health reforms saw the

implementation of the suggested changes in the Gibbs report. Easton (1997) uses the health reforms as a case study to examine what he refers to as the *Commercialisation of New Zealand*, and it is in a similar vein of thinking to White's thesis (2004) on *The Commodification of Caring: a search for understanding of the impact of the New Zealand health reforms on nursing practice and the nursing profession: a journey of the heart* examines the political impacts on nursing and nursing practice in New Zealand.

The significance of the health reforms in New Zealand was such that an international peer reviewed journal *Health Policy* devoted a special issue to Health care reform in New Zealand (July/August 1994). The issue covers the background to the provision of public health care in New Zealand with the introduction of Social Security legislation (1938) which saw the government involvement in health care increased through the passing of the Social Security Act 1938 (Laugeson & Salmond, 1994; Gauld, 2001; 1994; Belgrave, 2004). The chapters on 'the 1990s reform of the New Zealand health care system' (Scott, 1994); 'The management of health care: A model of control' (Jacobs, 1994) and 'A reflection on the New Zealand reforms' (Mooney & Salmond, 1994) are of particular pertinence for this research. These three chapters provide the health context in which nursing leaders were working, and the subsequent impacts of the health reforms on the provision of public hospital services.

The introduction by the National party of 'The mother of all budgets' by Finance Minister, Ruth Richardson in 1991 (The Dominion Post, 8/12/1997) did little to change the negative perception evident within the health services following the lead up to the 1990 election. This different budget combined with the implementation of Simon Upton's, (Minister of Health) Green & White Paper (Upton, 1991) cemented the purchaser/provider split and the subsequent competitive market funding model in health. In the New Zealand Institute of Health Management (NZIHM) monographs we have a reiteration of the changes to leadership modelled on the Gibbs report, 'The step from a triumvirate to general management was a big one' (Upton, 1991, p. 3). The move away from

clinical leadership involving senior nursing to a generic style of management is promoted as providing a clearer accountability, and a move away from what had been seen as 'professional capture' by doctors and nurses. However, to date I have been unable to find any New Zealand literature that provides evidence that clearer accountability was achieved as a result of implementing the reforms.

Internationally, Weinberg (2003) describes a similar scene of reform impacting on nurses in the United States. In 'Code Green' Weinberg examines the merger of two highly regarded hospitals in Boston, the Beth Israel and the Deaconess. Individually both hospitals performed well and yet when they were merged the combination of the two different organisational cultures with an imposed top down managerial culture left the merged institution struggling to find staff. Weinberg provides a comparative insight into the impacts of health reforms in nursing that were undertaken during the 1990s in the United States and how similar effects have been experienced by nursing during the New Zealand health reforms. The loss of institutional nursing knowledge and nursing leadership positions have occurred across both countries despite the differences in the provision of health care services.

Somjen (2000) notes that during this period of rapid economic change New Zealand was one of twenty-four countries in the Organisation for Economic Co-operation and Development (OECD) that was in the process of planning or implementing health reforms. The rationale for these reforms was based on three goals: (1) controlling health costs (2) improving access to healthcare services and (3) maintaining the quality of healthcare (p. 54). Although it is noted that until the mid-1980s New Zealand's health cost per capita was one of the lowest in the OECD, the global economic recession was starting to impact on the New Zealand economy. As health was publicly funded through the government, reforms in this area were viewed as necessary to gain economic efficiencies as noted in Simon Upton's 'Green & White' Paper (1991).

Gauld (2001) discusses the impact of the health reforms in the New Zealand health sector in *Revolving Doors: New Zealand's Health Reforms* and summarises the period of reform under seven generalisations. The first being that since the 1990s whenever there has been a change of government a change to the health sector structure has occurred. The second flows on from the first in that the health sector is just coming to terms with the changes when change occurs again, therefore there is no period of bedding in the changes. Gauld says the third generalisation that applies is around the consequences of the changes which are 'enormously disruptive and largely a negative process' although it is noted that if change is given time to bed down the process can result in positive benefits (p. 213). Fourth, having continuous change does not always provide better health services it simply provides a re-organisation of the health care structures in which the services are still to be delivered. In the fifth, Gauld comments that concepts are much easier to design and it is in the implementation of the concept where the issues arise. The sixth broad generalisation that is made highlights the notion that whenever changes occur to 'fix' or 'realign' the sector this change invariably creates other issues. Finally the seventh focuses on the fact that the historical context is often ignored as policy makers focus on the ideal rather than the reality of historically occurring issues. These generalisations are very useful to understanding the healthcare sector in New Zealand and how nursing leaders have had to work within these parameters to attempt to influence and provide a voice for nurses.

Continuity amid Chaos (2003) edited by Gauld outlines the issues associated with the management and delivery of health services that were faced during the health reforms. In this book, Gower, Finlayson and Turnbull, in their chapter 'Hospital restructuring: The impact on nursing' provide data on nursing management during the 1990 reforms that can be used to supplement the current research data. The lack of nursing leadership positions available in the public hospitals, due to both restructuring and a loss of senior nurses from nursing, provides evidence that during the health

reforms hospital nursing structures were not aligned with international best practice, and this did not appear to change as the decade of reforms continued.

The election of a Labour Government in 1999 signalled yet another change to the health services, and a new raft of health policies and changing structures. The four Regional Health Authorities established under the 1990 National government to fund health providers were disestablished. To replace this model 21 District Health Boards were legislated and created through the New Zealand Health & Disability Act (2000). In line with Labour policies additional funding was granted to Vote Health and an increase in the staffing of clinical staff in the public hospitals occurred. However, research undertaken by Carryer, et al (2011) to 'analyse adverse patient outcomes that are potentially sensitive to nursing (OPNS)' between the period 1998 and 2006 found that although registered nursing staffing had increased, adverse outcomes potentially sensitive to nursing interventions had not decreased. The results of this study suggested that the consequences of the health reforms experienced during the 1990s were continuing to have a negative effect on nursing leadership possibly through the previous dismantling of leadership structures, as clinical leadership was replaced by generic management.

Further insights are provided into how the reforms evolved in both countries in the text *Health reform in Australia and New Zealand* (Bloom, 2000). In the foreword to this text Christopher Lovelace (a previous New Zealand Director General of Health) notes as Gauld (2001) did 'health reforms as planned often bear only passing resemblance to the actual changes implemented (p. xvii). The difference between the ideal and the reality is one of the challenges. Poutasi herself as past Director-General of Health, alludes to this difference in the chapter 'The Evolving Role of Government in Health Sector Reform'. One of the challenges lies in the 'balance of government intervention' and getting the right degree of intervention to stimulate innovation and provide the right level of regulation in the New Zealand health sector (p. 133). North and Hughes

(2012) look at productivity and nursing in the current economic environment and argue that nursing has been regarded as a unit of labour and thereby a cost to the organisation. Their findings indicated that although nursing productivity rose during the reforms there was a consequential negative cost to both patient safety and nursing. Differing levels of government intervention and getting the balance right in the current economic environment impact on how organisations respond and it is timely to turn the dialogue to reviewing the literature on organisational structure and organisational culture.

2.2.2 ORGANISATIONAL STRUCTURE AND ORGANISATIONAL CULTURE

“Making sense” is the term used by Weick, who is a seminal author in the field of ‘sensemaking’ and is used to understand how organisational structures influence decision making processes impacting on nursing leadership, and is a term used often in this dissertation (1995, 2001 and 2005). It is from this sensemaking that people build their world views of the organisation in which they work (p. ix-x). Using this construct to understand organisations and how they may be viewed from a sense making framework, offers a pragmatic perspective that is critical for this dissertation.

MAKING SENSE OF THE ORGANISATION

In the introduction to his book *Making Sense of the Organisation*, Weick (2001) points out that people are fallible, and organisations do not proceed along linear and uninterrupted pathways. It is in recognising that being human is to be fallible and that problem solving to meet the constantly changing dynamics within the organisation is usual rather than a shortcoming that Weick explores how people make sense of their organisation (2001, p. xi). He provides an interesting insight to support his discussion using a study by Alan Meyer in 1982 that looked at the impacts of doctor’s strikes on hospitals. What was noted was how the doctors adapted and influenced the outcomes of the strike through formulating a collective identity. One of the key attributes that came out of the doctors

collective identity was that they were able to articulate a series of commitments that led to justification of their actions. This articulated justification then became redefined as the 'collective intention' of the organisation and provided a sense of coherent identity and legitimisation (2001, p. 7). This ability by the doctors to influence the organisation through the use of identity and legitimisation was critical to achieving the outcomes they wanted. Identity and legitimisation as anchors for making sense are critical to groups trying to influence outcomes and these two factors are evident in this research.

Progressing through the literature review on organisation structure and culture that has influenced the analysis in this dissertation, Mintzberg (1989) provides a view of organisational identity through reviewing organisational structure. Mintzberg has long been regarded by organisational behaviouralists in the United States as an eminent writer in the field of organisational culture and behaviour and the text *Mintzberg on Management* provides further exploration and analysis of not only how organisations are structured but also what these organisations mean to society. Incorporating Mintzberg's ideas provides sound basis for understanding in looking at both the formal (organisational structure) and informal (organisational culture) structures found in organisations and furthers the sense making theme through trying to understand how these structures are influenced and influence the societies in which they are located.

Bennett (1997), Hatch and Cunliffe (2006), Shortell and Kaluzny (2006) and Daft's (2010) recent analyses of theoretical narratives on how organisations are structured, have utilised, but not changed the theories that Mintzberg first formulated. The above authors currently contribute to the organisational management field in the study of organisations and support the seminal work of Mintzberg. What has altered over time, are the organisations that were first used as exemplars to understanding organisational behaviour. As the business and corporate world has changed due to the ongoing global recession, and become more unstable

and uncertain, the behaviours of those organisations have adapted to survive. The organisational management changes over time are explicated in the first two sentences in the preface of Kanter's book (1997) *Frontiers of Management*, where Kanter postulates the following question, 'What do shamrocks, symphony orchestras, gazelles, federations, astronauts, atoms and molecules, schools of sharks, virtual networks, whitewater rafting, jazz bands, diamonds, and ant colonies have in common?' with the response being 'Not much. But all of them have been invoked to describe the properties of a new organisational model that is replacing top-down bureaucratic machines' (p. xi).

Rosabeth Moss Kanter, previously a Harvard University Professor, and still a high profile figure on the Harvard Business Review Journal, is well known for her innovative approach to organisations and her discussion on best practice for organisational management.

Morgan (2006) in *Images of Organisations* provides another way of viewing social identity and how individuals define themselves within the context of the organisation. He uses the notion of a *psychic prison* where individuals become 'trapped in webs of their own creation' (p. 207). This is another construct that can help us understand how individuals make sense of their world and in particular how this idea impacts on the decision making processes around Director of Nursing leadership roles. Morgan goes on to discuss the concepts of 'groupthink' where ways of thinking that have been favoured for some time are detrimental to the different groups moving forward (p. 211). The links that are made with bureaucracy and hierarchy as a form of social control that traps individuals into a particular way of thinking, and continues to foster organisational rigidity were evident back in the 1900s when Weber first examined the consequences of bureaucracy. This social control brought about by bureaucracy is in conflict with the current way innovative and organic organisations are successfully emerging. This issue becomes apparent in the emerging public hospital structures as they become complex adaptive organisations but still caught

up in historical modes of bargaining and hierarchical government financial structures.

Hurst (2002) uses the concepts of two group types, bushmen and herders to explain adaptation and change in organisations. Over time as society evolved bushmen (nomadic, non-hierarchical groups) have acquired characteristics of herdsman (settled, hierarchy based groups). Organisations, Hurst argues, have acquired these same types of characteristics, however, herdsman groups only work effectively when the environment is stable. What Hurst questions is the ability to reverse the shift from herdsman back to bushmen in times of crisis to be able to adapt or has the change to herdsman been so great they are 'possessed by their possessions and quite unable to summon the cultural memory of the hunting skills that ensured their survival in a turbulent past' (p. 29). In this discussion we again see the organisation being caught in a 'web of its own making'. Kanter (2000) furthers this argument discussing the common assumptions people use to make sense of their organisation.

In an earlier article on knowledge workers Kanter (2000) discusses three common assumptions that people make within organisations that can lead to reinforcing the notion of being trapped in a web of their own making. The first assumption is that senior leaders always have more information because of their rank and seniority in the organisation, that they should be 'the first to know'. The second assumption is that people in senior positions always have the most experience based on the seniority of the position and therefore have 'all the knowledge', and the third assumption is that as you become more senior in an organisation fewer people will disagree with you. These assumptions can in themselves create a culture within the organisation that can disempower people and make them less likely to have a voice within their organisation.

Kanter (1997) also provides an organisational theory approach to looking at the informal changes that occur within organisations. In relation to this research 'empowerment, participative management and employee

involvement', the terms that Kanter uses to look at the changing frontiers of management, have had a significant influence on the health sector and nursing leadership in particular. Empowerment, participative management and employee involvement are areas that have not been particularly visible in nursing leadership history and it is possible that the legacy of this invisibility has had far reaching effects on the current nursing leadership structures. Kanter's theory around empowerment, where she suggested that when control over working conditions is attained there is a subsequent increase in feelings of psychological empowerment (Laschinger, Sabiston & Kutscher, 1997; Laschinger, Gilbert, Smith & Leslie, 2010) provides one of the threads that entwines with Weick's discussion on identity and legitimacy as without these variables empowerment is difficult to attain.

Daft (2010), views the concept of empowerment as 'power sharing' or, as the delegation of power or authority to delegate. Through empowering employees, there is a sense of value which increases motivation to perform work (p. 503). This lack of delegation and sharing of power Kanter (2006) argues is why leadership in big organisations is now perceived with a sense of distrust and fear. The lack of trust by employees has been partly attributed to the increasing managerialism of the 1990s and the 'arrogance of success' as a result of not delegating and sharing. The changes that occurred in the New Zealand health system in the 1990s as a result of wide sweeping management changes globally are a reflection of the growth of management roles as opposed to a growth in professional leadership. Subsequently through her research, albeit through a different theoretical proposition, Kanter's work also supports Morgan's notion of the psychic prison and in doing so provides another thread to weave into the theoretical understanding of sensemaking in this dissertation.

This line of thinking has been developed further from the literature on Social Identity Theory (SIT) and the organisation where Ashforth and Mael (1989) review social identity theory in relation to organisational socialization, role conflict, and intergroup relations. The authors argue that individuals socialise into the organisation in an attempt to belong and

establish a shared identity with the organisation, however the same individuals will have loosely coupled identities with different groups within the organisation and will compartmentalise and buffer these identities in a way that will make sense. The final debate is that intergroup conflict will exist, even when discussing the same issues due to the need to retain the group identity and its distinctiveness (p. 35). Foster (1983) remarks that the phrase 'loose coupling' has been notated originally by Glassman (1973) and March and Olssen (1975) and is intended to 'convey the image that coupled events are responsive, but that each event also preserves its own identity and some evidence of physical and logical separateness. Both the DoNs and CEOs/COOs surveyed in this research provide a good example of having multiple and loosely coupled identities within an organisation that are further explored around reporting structures and diminished authority.

I return to the literature by Weick (2005) on sensemaking, and the different threads linked to sensemaking of identity, legitimacy and empowerment. Critically analysing the data to determine whether the responses from the Director of Nurses (DoNs) and the CEOs'/COO's indicate an environment that encourages empowerment becomes important in light of the overall research. Making sense of the structural influences that have impacted on the DoNs ability to provide nursing leadership for the organisation is reinforced by the international benchmarking criteria provided by the magnet accreditation process. The literature on Magnet hospitals advocates that nurses being empowered to lead, and their level of autonomy provides one of the hallmarks of a hospital that has achieved magnet accreditation status. The ability to be empowered further reveals the theoretical threads of having an identity as a profession and the legitimacy to make decisions. The impact of being able to make decisions in an empowered environment is important for nursing leaders who have a mandate to keep patients safe in hospitals.

Weick (2005) provides a case study that illustrates how a nurse in a particular situation is unable to garner the attention from medical staff she needs for treatment to a deteriorating baby. During the course of this case

study the nurse in question approaches another nurse who she perceives has more experience and is able to get the treatment she requires. As noted by Weick 'this particular nurse really knew what she was doing [The Attending (Physician)] knew she knew what she was doing.... She knew exactly what button to push with him and how to do it' (p. 413). This provides an example of where empowerment and legitimacy is lacking. A number of articles that Kanter has written (1998, 2003, 2004 and 2006) reflect the need for CEOs to attain support from their staff if they are to make the organisation successful. Attaining support is being able to empower people to assist with the decision making and fostering a culture of trust. Laschinger, Sabiston & Kutzscher (1997) use organisational empowerment as a key word to understand how Kanter's theory of structural power in organisations can be examined. Their study looks at how nurses perceived informal and formal power in light of feeling empowered within their work context. The Laschinger and Wong study (2007) is also important as it provides a way in which to examine how nurses and nursing leaders can be involved in both the realms of professional and organisational decision making within the bounds of the institution.

EMPOWERMENT, NURSING LEADERSHIP VISIBILITY AND NURSING VOICE

Mintzberg (1997) undertook a study in hospitals that examined the different components of managing a hospital. In this study credentialing and visibility are the two components directly related to nursing and in particular the visibility of Directors of Nursing on the hospital floor. Mintzberg (1997) acknowledged that whilst visibility of the senior nurse executive can provide a successful method for the management of nursing in the hospital structure, it is in achieving the visibility and subsequent availability by the nurse executive that proves difficult. The inability to be both on the operational floor and the strategic boardroom is not new to senior managers and creates a difficult position for the senior nurse executive. The tension in managing this workplace scenario is through

leadership and empowering leaders. This is achieved through fostering leadership skills and delegating to senior nurse leaders. However, historical nursing structures and positioning of nurse executives has not made this empowerment of other leaders easy to achieve. Gordon (2010) argues that nursing can often disempower itself as a profession through the way nursing conveys itself, and it is utilising appropriate voice that enables visibility. Nursing leaders need to be seen and understood as people who are knowledgeable and have authority within their organisation. Gordon (2010) uses the examples of how nurses and doctors are portrayed in organisational media where nurses are often portrayed as smiling at patients or at technology and doctors portrayed as serious with an expression of concentration. The imagery from these pictures diminishes the authority of the nurse and contributes to increasing invisibility in a hierarchical setting where being visible is important.

When the 1990s changes to the health system, and in particular the public hospital system, were implemented in New Zealand, leadership and organisational approaches for addressing perceived failures were in direct contrast to what was arguably best practice for efficiently managing organisations. Top down restructuring approaches that did little to involve individuals in the change created a culture of mistrust and demotivation (Finlayson & Gower, 2002).

Kanter (1997) argues that when failures occur in organisations the last thing organisations need is for the senior management to take a top down approach 'worked out in bureaucratic detail and staffed by dozens of complex self-perpetuating task forces' (p. 69). Empowered leaders look at the failure and find information and details to improve the outcomes. In addition leaders do not necessarily start a whole new program of change but build on platforms already existing through defining the 'strengths and potentialities in existing resources, experiences and bases' (p. 71). Nelson and Gordon (2004) find that nursing does exactly the opposite of what Kanter (1997) defines as empowered leadership. They argue that nursing continually denies its previous professional existence in an effort to 'recast'

itself (p. 255). This continual recasting in response to change provides a sense of negativity associated with nursing that devalues earlier nursing skill and competence. This constant need to re-position itself as a profession also undermines the authority of the nursing leadership voice.

Drucker (1990) notes that leadership is usually a discredited quality until a leader is required. He discusses that the experience of the leader is to anticipate the crisis and to be coming up with innovative ways of trying to be ahead of the crisis. An example of anticipating a crisis is found in 'Weathering the Perfect Storm'.

This catchphrase became a focus for the Michigan School of Nursing when they were faced with shortages in nursing staff impacting on patient safety between 2004-2007 (Hinshaw, 2008; Talsma, Grady, Feetham, Heinrich & Steinwachs, 2008; Smith, 2008). Hinshaw (2008) discusses the factors that impacted on the staff shortage during this period. She noted that where there were strong positive work environments, such as in magnet accredited institutions, nurse retention was highest and that within the umbrella of the magnet program nurse, empowerment was a critical characteristic of a healthy work environment.

This type of transformational and visionary leadership by the chief nurse executive was viewed as one of the key factors to ensuring that nurses felt valued as professionals and subsequently empowered to have control of their practice and the resources to provide evidence based care (Hinshaw, 2008). Aiken, Clarke & Sloan (2002) and Haven (2001) also provide substantial evidence to support this premise.

Linda Aiken noted for her many contributions on magnet hospital research also reviews the economics of nursing (2008) and how this has impacted on the nursing shortage. In essence the nursing staff shortage is shaped by economic and political influences where nursing schools are unable to recruit students because they have capacity limitations, yet at the same

time the nursing workforce is unable to adopt innovative changes because they cannot meet nurse staffing requirements in hospitals.

The impact of the new public sector management model has not only disempowered nursing leadership but increased the perception that nursing is a cost rather than revenue, or has a positive financial value (Aitken, 2008; North & Hughes, 2011). As mentioned earlier, New Zealand suffered from the same cyclical, budgetary cuts and subsequent lay off of nursing staff as the United States, as health reforms were implemented universally in Western developed countries to reduce spiralling healthcare costs. This perception of nursing as a cost has been seen as equally applicable to New Zealand healthcare reform policies (Gauld, 2001). Directors of Nursing in the New Zealand public hospital system have therefore had to rebuild the visibility and voice of senior nursing in a health system that had sidelined clinical leaders (Gibbs, 1988, Upton, 1991). To understand how this occurred it is important to gain a sense of how institutional structures operate and adjust to their internal and external environments.

THE INSTITUTIONAL VIEW & ORGANISATIONAL STRUCTURES

The institutional view provides a way to examine organisational structures and builds on the elements found in the bureaucratic and hierarchical models that are defined by Weber and Mintzberg. Di Maggio and Powell (1983) argue that one of the key features of bureaucracies is found in the isomorphism of the different public services and this is evident in the hospital bureaucracy. Isomorphism is often referred to as organisations taking on similar appearances even when they have different origins. The three types of isomorphic elements, coercive, mimetic and normative provide a way in which to understand how the divisions of work have been structured within the DHB and how in turn they can shape and influence the organisational structures and culture. Boxall and Purcell (2011) discuss the different influences that enable organisations to respond to external challenges and note that it is through using rational economic policies in response to the external influences that create differences in the

DHB organisational structures. The literature on institutional theory and how organisations respond in unstable environments provides a way in which to examine the data on DHB organisational structures.

In another arena of sense making that impacts on the organisation, Johnson (2009) notes the influence global factors have had on the health area in the past decade that include the rise of terrorism, financial recession and a number of major natural disasters. These factors have culminated in a push for universal health care and reinforcing the guarantee for safety of patients in hospitals. In the text, *Health organisations, theory, behaviour, and development*, McDaniel and Jordan (2009) provide the tenets that underpin the complex adaptive system emerging in healthcare services to meet these global challenges. They argue that using the theoretical lens of complex adaptive systems can 'illuminate critical issues such as history dependence, dynamic structures, inevitability of change, and issues of power' (p. 78). In essence I agree with McDaniel and Jordan's general discussion on complex adaptive theory, and that the current configurations that are evident in New Zealand hospitals are primarily evolving into complex adaptive systems. However, one constraining factor that hinders this evolution is the lingering impacts from functioning as a professional bureaucratic system inherent in the public hospital system prior to its inception in the mid-1800s where New Zealand public hospitals were predicated on the British hospital system. This further supports Kanter's (1998) concept around 'bureauspace' and the impact this has on organisational thinking when trying to adapt and manage change in what may be perceived as a predetermined set of parameters for change. Networking and communication follow on from making sense of change and adapting to different parameters of thinking, as these two factors are vital for understanding and feeling empowered within a change process.

NETWORKING AND COMMUNICATION

Hoff, Jameson, Hannah & Flink (2004) in a discussion examining the literature on linkages between organisational factors, medical errors and

patient safety in hospitals in the USA, note that there are three levels of analysis that can be undertaken within organisations: (1) individual, (2) group or team and (3) structural. Individual level factors include leadership, training, performance feedback and quality information. Team integration, membership, effectiveness and communication are the factors that can be reviewed at the group or team level, whilst standardisation, co-ordination and formalisation of health care processes can be analysed at the structural level (p. 4). As communication requires engagement with others, it is the engagement of nursing leaders and their engagement with others that is important to understand. There are a number of limitations in the communication literature on nursing leadership as the literature is not directly written specifically on or about nursing leadership communication. Review of the literature has had to encompass articles written on, inter-professional collaboration, physician-nurse communication, clinicians and the new managerialism (where the emphasis has been on the medical clinician) to name a few. However it is also in the absence of defined literature that narratives can be identified, as where nursing leadership is strong the communication for nursing as a group, in the narratives will be easily identifiable.

Riley and Manias (2007) focus on the nurse and surgeon relationship in the operating room and the communication struggles that ensue in this environment. Their argument focuses on the nurses positioning in the operating theatre environment and how it is subject to both the organisational time and efficiency requirements alongside the hierarchical dominance of the surgeon. This critique is useful in that it provides understanding of how nursing is positioned within certain areas of the hospital environment that are analysed for nursing leadership influences in the data analysis chapter. Interpretation of organisational language based on their professional culture is one of the variables that can impact on how the operating nurses and the surgeons interact.

Hatch and Cunliffe (2006) note that where there are different languages used in the same environment conflict and misunderstandings can arise.

This is also evident with the introduction in the 1990s of new managerialism and the rise of generic management to replace clinical management. Depending on the degree of hierarchy between the vertical levels of the relationships in the DHBs, the greater the chance of communication problems, and this is exacerbated, or can cause message distortion if the language is on a continuum that oscillates between clinical to financial (Dawson, 1996; Shortell & Kaluzny, 2006). Shortell and Kaluzny (2006) discuss the environmental barriers to communication in addition to the personal barriers that impact on how relationships within the hospital are managed and effective. It is within the environmental barriers to communication that power/status relationships can inhibit effective communication. The power/status barrier has been observed in scenarios where information provided by experienced nurses to resident doctors has been dismissed (Shortell & Kaluzny, 2006, p. 256). Kanter (1997) also discusses the difficulties women in the workforce face, when information they are privy to or provide is viewed by others as unimportant, providing the example that 'people assume they can afford to bypass women because they *must be uninformed* or *don't understand the ropes*' (p. 141). She further notes that although there may be respect for the competence and expertise of women, they are not perceived as going beyond the understanding of the technical requirements of any work. One way in which 'not knowing the ropes' may impact on nursing and how it makes its decisions as a profession is the notion that lacking technical expertise can be linked to the curing and caring differentiation between nurses and physicians.

Glouberman and Mintzberg (2001) illustrate the issues nursing face in the workforce as 'care' which is undertaken by nursing staff is viewed as subordinate to 'cure' which is undertaken by physicians. They point to two journal notes that were written by physicians 100 years apart that show little has changed in the nurse-physician role. The communication aspect becomes critical as the degree of specialisation of both the curing and caring tasks decrease. Highly specialised roles are seen to have higher

differentiation and therefore the lines are not blurred, the operating theatre is used to illustrate this high degree of specialisation between nurse and physician. Using this concept of differentiation it can be seen how the Director of Nursing roles can be blurred as the degree of specialisation is not evident. Mason, Leavitt and Chaffee (2012) who have written a widely cited American text on policy and politics in nursing and health care also look briefly at inter-professional communication. Chaffee in *Chapter 11 – Communication skills for success in policy & politics* focuses on how nurses need to review conflicts that result due to a lack of effective communication. Chaffee, utilises a Centre for American Nurses (CAAN) study to identify that 53% of the nurse respondents in that study reported having experienced conflict with managers or peers (p. 118). This conflict has been noted in Harris and Associates (2006) as being due to the tension that clinicians face when they are given managerial tasks and have to resolve the tension between the 'welfare of the organisation as their highest priority and the conditioning of clinicians to place the patient as their highest priority' (p. 31).

The perception that nursing leaders do not see beyond patient care becomes a disabling process for nursing leadership. By utilising the organisational lens and the literature by Mintzberg (1997, 2001), Tobin (1993) and Prideaux (1993) on the differentiating or blurred roles that clinician managers have to undertake, we can see some of the issues that arise for the Director of Nursing in their role as both a clinician and a manager. The focus by nursing on patient care can sometimes be seen by management to obscure the organisational focus. This perception creates a sense that nursing leaders do not see beyond patient care and are therefore not attuned to the broader organisational needs.

Chiarella and McInnes (2010) provide another reason why nursing falls prey to this perception of 'not knowing the ropes', and this is through the changing organisational infrastructure. As noted in the historical influences on nursing there is a strong tradition of hierarchy evident within nursing which has provided an over-bounded system. The two authors

base their understanding on the concept by Alderfer (1980) of over-bounded versus under-bounded systems and find nursing may be struggling as a profession to adapt to the changes that are needed to work in an under-bounded system. As mentioned over-bounded systems have evolved from a traditional hierarchical system and tend to work in stable environments. On the other hand under-bounded systems are more suited to complex adaptive environments where the lines within the organisation are flatter and there can be a blurring of authority and responsibilities. The current unstable healthcare environment has placed pressure on nursing which can lead to marginalisation as the blurring of role definitions occurs. This concept is discussed further in the analysis chapter as it is integral to making sense of how the structures influence decision-making within the organisation and where this makes an impact on Director of Nursing roles. Finally, to address gaps in the literature it is useful to review the historical context as this adds a depth to the sense-making of the dissertation.

2.3 ADDRESSING THE GAP

Following the thread of exploring different pathways that have been examined to establish the relevant literature, the review now follows through another entrance to the maze of narratives to identify the literature knowledge gaps. Continuing the theme that was evident in the New Zealand context on health services understanding the history is critical to making sense of influences that may have shaped nursing leadership.

The first area of consideration is that of history, followed by a discussion of different narratives in the literature that cover the informal organisational processes of networking and communication and lastly literature that highlights some of the issues that have arisen for nursing leadership in the area of empowerment, nursing leadership visibility and nursing voice. These areas of literature help to fill in the gaps of making sense of the research material.

2.3.1 HISTORICAL CONTEXT ON NURSING LEADERSHIP

History provides us with a sense of time and context and reviewing both the primary and secondary historical sources that have influenced nursing leadership is critical to understanding this context. Tosh (2006) refers to two meanings of history, the first being what happened in the past and the second being how that is represented through historical interpretation and writing. Tosh (2006) outlines the three important principles in understanding and portraying history as difference, context and process. It is in understanding difference that we gain insight into an experience we can never be part of as individuals living in this current time. Likewise, context is also critical, as to interpret or try and make sense of an historical event or behaviour out of context is to provide an inaccurate representation of that event or behaviour, and therefore it becomes a misleading representation (Tosh, 2006; McDowell, 2002). The final principle, process helps guide us to make sense of the world we are exploring (2002, p. 33-41). Interpretations of the past influences on nursing leadership therefore need to take into consideration these principles to ensure that the history or its lessons is not anachronistic and is sensitive to the time (2006).

Social history provides the most appropriate genre for the study of nursing leadership history. As Tosh (2006), Marwick (1998), and Jordanova (2000) point out the use of social history enables an approach rather than a precise subject matter to the research being undertaken. Jordanova (2000) refers to the study of social theory which 'examines structures and patterns across society' and how this is able to provide an inclusive approach of all the constituents being explored (p. 38). The use of an inclusive approach through social history also enables the voice of the participants in this research to be examined (Tosh, 2006). To explore the historical impacts and look for evidence of nursing leadership voice a sequential chronological approach has been undertaken using four distinct periods. The first period covers the 1850s to 1920, the second covering 1920s through to 1960s, following on a brief look at the 1960s through to the

1980s. It is during the late 1980s that the narratives become political and economic and the rhetoric of understanding contemporary nursing history is enmeshed with these considerations. The literature covering this fourth period will therefore be examined in the following section under political and economic influences. A review of the literature has revealed dominant themes that appear in the narratives during the chronological periods that distinguish them from one another these will now be examined.

THE NIGHTINGALE INFLUENCE

A review of secondary history texts written on the 1800s through to the early 1900s of nursing in Britain and a study of the influence of the eminent figure of Florence Nightingale provides the starting point. In the précis of Lynn McDonald's text (2005) *Florence Nightingale on Women, Medicine, Midwifery and Prostitution* we learn that Nightingale was the daughter of wealthy English parents who subsequently, through both familial connections and being well educated, had quite an influential circle of people around her. As noted in McDonald 'Nightingales own network of colleagues and advisors was impressive and she continued to add to it as newer, younger, experts, MPs and officials came into office' (p. xv). In addition to this ability to influence the people that could support her policies and public work was Nightingale's renowned ability with statistics and the instigation of evidence based healthcare and nursing. Brief backgrounds of Florence Nightingale's life by Bostridge (1998, 2003, 2005), van der Peet (1995), and McDonald (2005) also indicate the importance of religion in Nightingale's nursing and how these views differed from the conventional mores of the day. The influence of religion is also evident in the reproduced text of Nightingale (1980) herself on, *Notes on Nursing, What it is and what it is not*. Nightingale felt that nursing was a duty to God, but differed from being a calling such as that found by the religious orders. Her convictions were based on both personal and Unitarian beliefs as she adhered to the principle that everyone deserved the same level of health care whether they were rich or poor. In addition to her religious beliefs Nightingale was also a great believer in miasmas being responsible for ill

health. Miasmas were seen to result in illness where people were exposed to stagnant air. Porter (1997) points out Nightingale was involved with the redesign of the St Thomas's Hospital where the pavilion ward was built to enable cross ventilation – as Nightingale believed 'stagnant air bred disease' (p. 375). Her focus on miasmas and natural causes, where bad air was the major source of all diseases, underpinned her writings on nursing care in which nursing was based on being able to provide good ventilation, proper nutrition, quiet, cleanliness and hygiene and in monitoring the patient. Nightingale believed by having the above aspects in place the patient would be placed in the best position for the body to heal itself.

Nightingale's strong religious beliefs coupled with the societal overtones of the time were highly influential in the way women as nurses were perceived. 'Religious zeal and utilitarian science' were key drivers that influenced the reforms of such institutions as school, work houses, hospitals and prisons (Porter, 1997, p. 376). Hospitals had previously been considered as disorganised and ill-run as evidenced by the satirical figure of Dickens' Nurse Sairey Gamp. The need for formal nursing training was evidenced through the catholic and protestant nuns where the term 'nursing sister' first became known. It is at this point that Nightingale trained through the Kaiserwerth Deaconess order and then spent time with the French catholic order, the Daughters of Charity. The images of nursing changed with Nightingale becoming regarded as a nursing leader (Porter, 1997; Bostridge, 1998; McDonald, 2005). One of the positives of this perception was that nursing was beginning to be regarded as respectable and nursing work was a formally recognised occupation. The negative tension that sat alongside this perception was that nursing and caring work still belonged in the home and therefore public nursing was to remain invisible. In the Nightingale system two tenets ran side by side, one was that nursing was an honourable vocation, the other tenet emphasised service and subordination (Porter, 1997). Both of these tenets generate a tension in nursing that in turn supports a level of public invisibility which is

explored further in both chapter four and the discussion chapter where the historical influences are reviewed for their impact on nursing leadership.

NURSING LEADERSHIP IN COLONIAL NEW ZEALAND

The treatise written by Nightingale provided the basic tenets for formal nursing as it was implemented in England in the early 1800s through to the implementation of nursing practice in the colonies in the late 1800s in New Zealand. The religious and moral overtones that were clearly apparent in the original document were subsequently influential when translated into the New Zealand context. This is not surprising given the immigrants brought their own cultural and moral mores from England. New Zealand historians Tennant (1989), Dalley and Tennant (2004), Brookes, MacDonald and Tennant (1992), McClure (1998), Bryder (1991) and MacDonald (1990) all cover various aspects on what colonial women's lives were like when they reached New Zealand in the 1850s onwards. Supporting an overarching theme of the expectations of women is the title by Macdonald (1990) 'A Woman of Good Character', this thinking dominated colonial moralists and was very influential in determining which women were suitable to nurse in the colony. Orchard (1997) uses this very title 'Women of Good Character' to examine the reasons why women chose to emigrate to New Zealand and of those which women sought nursing as an occupation. Parallel with this historical theme of good moral character, is the medicalization of disease, increasing influence of the medical model and the 'paradigmatically passive' patient (Burney, 2007). This becomes important as it highlights the influences on the invisibility of nursing and the nursing voice. Nursing as a profession becomes both a representation of the medical model, and the 'passive' patient in the context of medicalisation. Porter provides eloquent reading on the institutionalising influences of the medical model in his text *The Greatest Benefit to Mankind* (1997).

The following quote from Porter (1997) highlights the deeply embedded historical influences on nursing:

By 1930... the typical features of modern nursing had taken shape, combining female subordination to the male medical hierarchy with a deep and quasi-religious sense of duty. This, while confirming gender divides, made the nursing staff not just indispensable but guardian angels, imparting to the modern hospital an essential aspect of its characteristic ethos. (p. 380)

This line of thinking is continued in the article by Helmstadter (2008) who overviews the concept of the gendered division of male and female spheres in the industrial working world of 19th century Britain and how this influenced nursing. As with Porter, Helmstadter (2008) notes in her results of a classical historical examination of both secondary and archival sources on 19th century British hospitals that 'success in delivering a highly competent nursing service depended on the matron's leadership and legitimate authority but she also had to have the support of her hospital board to gain access to allocation of scarce resources' (p. 4). New Zealand secondary text narratives on the different public hospitals also impart a sense of the gendered division of labour. Belgrave (1991) and Bryder (1991), both New Zealand historians, offer insights into the New Zealand health context and the gendered division of labour apparent their analysis of early New Zealand health professionals. These insights are further reinforced by the different hospital histories where the first two to three chapters are solely focussed on the men in the public sphere, those male doctors and administrators that were at the helm of decision making in the hospitals. The only mention of women in the early part of the history was often a brief name of who the housekeeper/matron was at the time (Angus, 1984; Bennett, 1962; Barber & Towers, 1976).

As the 1900s progressed nursing became visible in the public arena through the need for medical doctors to have trained nursing staff and it is in the New Zealand hospital histories that the influence of the medical profession was evident when voicing their needs for public hospitals (Brown, Masters & Smith, 1994; Bennett, 1962). Although hospital histories are often 'narratives narrowly focused on a particular institution, frequently commissioned to celebrate special anniversaries' (Risse, p. 175), they provide both a view of the dominant discourse of the day and by

default the lack of voice of 'others' (Goubert, p. 46) in this case nursing leaders during this period. Primary sources also offer insight into the first nursing leaders and their thoughts on nursing in the colonies with insights offered from Grace Neill's son, a text written about his mother and her work in New Zealand (1961) and Hester Maclean penning her own thoughts in 1932. *Kia Tiaki* (1908 onwards) also provides interesting insights as the first Nursing Journal in New Zealand founded by Hester Maclean. The journal was originally funded by Maclean to make public what she perceived the issues in nursing were at the time.

The focus on historical writings on women who were nursing leaders, is primarily found in a limited number of autobiographies or biographies. This has led to an exploration of a number of New Zealand social history texts to find gems of information on nurses and health in New Zealand in the early New Zealand period. As noted earlier Charlotte MacDonald, Margaret Tennant, and Barbara Brookes, all noted New Zealand historians, have proved invaluable for their insights on women and women's work in New Zealand, and through examining these social histories I have been able to look through the lens of the gendered work place.

NURSING LEADERSHIP IN THE INTERWAR & POSTWAR YEARS

The next historical period examined, the 1920s through to the 1960s covers the aftermath of war, depression, the second world war and the aftermath of World War II. The impact on nursing leadership during this period is dominated by two aspects, the first, the continued legacy of obedience and duty that was expected of nurses, and the second is the advances in medicine and surgery.

A review of a number of nursing journals provide evidence of a masculine, medically dominated world where nurses were viewed as 'doctors handmaidens' and this view far from being challenged was supported in a social world that accepted this role of nursing (Helmstadter, 1997; Peate, 1998; Manias & Riley, 2006). In the text *Nurses of Auckland*, Masters (1994) in her chapter on 'the 1950s' notes the Auckland 'School of Nursing was

still operating within the archaic model of entrenched attitudes of loyalty and obedience, coupled with military discipline. Nurses lacked the power, the managerial skills and the expertise to facilitate change, and there were probably few who could even visualise any alteration to the existing system' (p. 167).

Kendall and Corbett (1990) also offer explanatory insights into the influence of military nursing on nursing as a profession. Kendall who examines narratives from military nurses in World War One notes the difficulties matrons had when working on the war ships, as the demarcation between military officers, medical staff and nursing was less evident in that environment, 'The matron, an appointed senior nurse on each sailing, held control over nursing duties, but in reality doctors held more power' (p. 62). In addition nurses were often treated as second class citizens, although their status as nurse accorded them officer status, their request for better accommodation often went unheeded, first class accommodation often given to the male officers, as Kendall notes in some instances nurses met barriers because of their sex (p. 63).

Corbett (1997) follows the theme of military nursing into the World War Two period 1939-1945 and remarks on the increasing profile nursing is given as a result of their involvement in the wars. Interestingly it is noted that the nurses who were nursing in New Zealand were less likely to achieve similar recognition, 'The publicity given to their [war nurses] deeds raised the profile and credibility of New Zealand registered nurses both at home and in Europe. Less lauded were those nurses who served their country at home, maintaining an essential service despite the exigencies of the war years and the ensuing conditions of austerity' (p. 67). It is during this period that a sense of feeling disenfranchised makes itself evident amongst nursing.

The shortage of nurses available for both overseas nursing work and in New Zealand, in addition to the opening up of other occupations for women as a result of the war, provides an impetus for change. As Masters (1994)

noted, 'Since the war, the status of women had changed, women had learnt new skills, and there was a greater variety of occupations available – ones less arduous and restrictive than nursing'. The discipline and regimentation found in the hospital was in contrast to the greater independence and autonomy apparent in other occupations available to women (p. 158). The implementation of the Social Security Act also exacerbated the shortage of nurses due to the availability of free hospital health care. Lambie (1947) cited in *The American Journal of Nursing* 'Although the government has introduced a nursing service benefit in connection with the Social Security Act which gives free district nursing to the population as a whole, this cannot be put into effect totally. There are not enough nurses available...' (p. 217). A recruitment drive was launched by the Department of Health to promote nursing as a career in 1938. As a result the concept of nursing as a career rather than a vocational 'calling' was met with mixed reception (Kendall & Corbett, 1990, p. 68). The narratives during this time impart a sense of crisis regarding both the nursing shortage and how nurses perceived themselves and their role. A change to the perception of what nursing was and how it was regarded is reinforced by Mary Lambie, the Director of the Division of Nursing in the Health Department, as a review of nursing as a profession is put forward in 1939 in the House of Representatives (AJHR, 1939). Again primary sources such as Mary Lambie's autobiography (1956) and her text on 'Historical development of Nursing in New Zealand' (1951) provide a sense of both what was expected of senior nurse leaders during this time and what they felt was appropriate.

In her appointment as the Director of the Division of Nursing, Lambie notes that although the position was to be originally advertised, she was appointed without any advertisement made, and that the manner in which senior nurse leaders were appointed rather than selected from a group of interviewees had always been conducted in this manner (p.72). Both the process for the appointment of senior nursing staff and the representation of nursing within the Department of Health changed with the advent of the

State Sector Act 1988. The precursors and impacts of this legislation are discussed in the next section on political and economic influences.

NURSING LEADERSHIP & NURSING EDUCATION

The 1960s through to the 1980s are best represented in the literature for the changes to nursing education and changes to nursing conditions. Narratives during this time are drawn from Kai Tiaki and articles published by the New Zealand Nurses Organisation as well as Department of Health reports. This period is important for nursing leadership because it marks endeavours for the profession to be able to become fully autonomous and set its own education standards and agendas that are nursing focussed and separate from medicine. The first attempt at providing higher education for nurses had occurred in the 1920s at the University of Otago, however this had not proceeded. Nursing training remained 'primarily an apprenticeship system' (Angus, 1984) and whilst two nurses Janet Moore and Mary Lambie (Hughes, 1978) had been sent overseas to be trained in advanced nursing training, on their return, the Department and Health and the University of Otago could not agree on funding for the course and the tertiary courses did not progress until the 1970s. The significance of this course was that it was to have been the first higher education training for nurse focussing on nursing training as opposed to the 'service needs of the hospital' (Hughes, 1978, p. 18).

The next attempt at gaining higher education training for nurses was a recommendation by Alma Reid in 1966. Reid, a Canadian nurse, supported by the International Council of Nurses and the World Health Organisation provided a report on nursing education to the University Grants Committee recommending a basic degree programme for nursing be implemented, however the recommendations were not implemented (NZNA, 1984). Five years later, Dr Helen Carpenter, also a representative of the World Health Organisation, produced a report for the Department of Health (1971) focusing on getting nursing education into higher education and out of the hospital setting. Again the report and recommendations became highly political due to economic circumstances and the subsequent cost to

hospitals as a result of losing student nurse labour. Carpenter (1971) commented on the tension the medical superintendents have between balancing the training of nurses to meet population needs and the current strictures on changes which impose an economic cost to the public hospital. She also discusses the concerns Matrons have expressed regarding both the quality of care and the dependence they have on students to staff the wards. They (the Matrons) also note the lack of upward mobility for registered nurses and their fear that recruiting registered nurses may become difficult due to this lack of career structure. Another comment that was particularly noteworthy, 'There is little recognition that patient care is the essence of nursing' (p. 20). Again I return to the sense that nursing was regarded as a cost and this perception hindered the evolution of nursing education. The progress in medicine and disease management only increased the perception that nursing was an adjunct to medicine, not a profession in its own right.

I note this as important because this has been a constant and on-going source of frustration for nursing leaders and nursing since Nightingale tried to differentiate nursing from medicine, and is expressed throughout the narratives on nursing. The response to the Carpenter report by the Government was lukewarm and resulted in a very cautious change to introducing nursing into the Polytechnics, as opposed to the Universities, which is what had been proposed. The costs associated with taking student nursing labour out of the hospitals historically provoked an animated discussion by hospital boards. It is at this point that political and economic rationing start to dominate the narratives with the Gibbs Report (1989) and the Green & White Paper (1991) and the change to the leadership structures in public hospitals in the late 1980s becomes a pivotal point for nursing leadership.

2.4 SUMMARY

In summary, nursing leadership and the nursing leadership structures and the organisational lens are used to frame the analysis of this dissertation

and are driven primarily by understanding the constructs of sense making. These narratives are used to provide a platform for illustrating and understanding the primary research data collected from the twenty District Health Boards from both a formal and informal organisational structure aspect. The literature on nursing leadership and nursing leadership structures provides us with four key areas that require examination in the New Zealand context utilising the research data. The first area concerns the spheres of influence DoNs operate within, the second area is empowerment, the third span of control and the fourth revolves around the adequacy of resourcing. I have then discussed the different accounts that help inform the research in the area of nursing leadership, both locally in New Zealand and internationally. The use of magnet as an international benchmark to align nursing narratives and processes has helped provide a series of influencing factors impacting on nursing leadership that have been supported by the Laschinger and Wong (2007) study. The use of New Zealand studies has assisted in ensuring the relevance of the literature as the magnet factors and the Laschinger and Wong profiling summary have been used to draw comparisons with New Zealand and what is happening overseas in America and Canada.

Utilising the organisational lens through the use of literature on the institutional view, we can examine differences and similarities in the DHB & nursing structures and move onto understand how the narratives of power and authority have come to influence both the structures and the positioning of the DoN role within the organisation. The gaps in the literature become further evident as we explore nursing history to understand the context in which past decision making around nursing leadership has occurred and the possible influences that have impacted on the structural positioning of DoNs. I will now progress to the next chapter covering the theoretical assumptions that support this research.

CHAPTER THREE-THEORETICAL ASSUMPTIONS

3.0 INTRODUCTION

Having examined the different types and context of literature that have influenced this research and thus provided a picture of the landscape it is important now to explore the theoretical assumptions that underpin the research analysis. The theoretical assumptions provide scaffolding for understanding how the data is analysed, and are based on an exploration of the organisational structures that influence the decision-making processes of the two participant groups, the Chief Executive Officers (CEOs) and the Directors of Nursing (DoNs). It is through understanding and examining these organisational structures that influence the roles the participants play, their structural positioning and the influence of those roles and structures on nursing leadership within the New Zealand public hospital system that we gain greater insight into this area of research. The social construct of 'sense-making' is explored through the social constructivist ontological perspective within the interpretive paradigm (Weick, 2001).

'Sense-making' or 'perspectivism' is based on the idea that 'our knowledge of the world is inevitably shaped by our perspectives and, consequently, can never be objective or enduring' (Connolly, 2011, p. 487). Connolly (2011) proposes two views of how perspectivism can be interpreted, the first is that perspectivism is reductionist and provides only one view among many, whilst the second view counters that perspectivism also provides a method through which people can manage their interpretations of different scenarios. Whilst both views are valid and have equal application to understanding how individuals make sense of their world, the second view offers a way in which participants can gain a sense of control through managing their environment by organising their perspectives, and by appreciating that perspectives can be many. Martin (2010) argues that health care systems are complex environments that involve 'human

systems where phenomena are unpredictable and need to be managed' and it is through making sense of the 'options and dilemmas in a realistic time frame' that decision making can be undertaken in an informed manner (p. 990). The change from stable organisational health environments pre 1990s to the complex adaptive systems that have emerged since that period also supports the notion that individuals need to make sense of their environments as the environment is constantly changing.

There have been three different approaches used with 'sense-making' as an area of study (Martin, 2010). The first approach focuses on communication using mathematical and computer modelling to understand communication patterns in real world systems, Dervin (1998) leads this field of inquiry. The second approach is that of intelligence and multi-ontology sense-making and is usually applied to military or business units to make sense of their strategic environment (Martin, 2010). The third approach and the one applicable to this thesis is that of Weick (2001) and organisational sense-making. Weick (2001) explores the organisation and how participants make sense of their organisational environments. Following the organisational viewpoint of sense-making Kanter (1997) also provides a way of exploring this sense making through her constructs on power and powerlessness within organisations. It is therefore through using the lens of organisational sense-making that we understand the importance and relevance of this construct to this dissertation.

In the first section of this chapter I discuss the social constructivist perspective and '*perspectivism*'. This is followed by an exploration of sense-making within the organisational culture. I then look at health organisational culture and nursing leadership culture to gain an appreciation of how influential these factors have been on participant sense making.

3.1 SOCIAL CONSTRUCTIVISM & 'PERSPECTIVISM'

Creswell (2009) states “social constructivists hold assumptions that individuals seek understanding of the world in which they live and work” and that they (constructivist researchers) “address the processes of interaction among individuals” (p. 8). This thinking is echoed by Schwand (2000) where he asserts that “human beings do not find or discover knowledge so much as (they) construct or make it” (p. 197). A number of arguments have been espoused about social constructivism and its value as an ontological theory of meaning. Descriptive social constructivism is claimed to provide a discourse and language that enables the representation and description in meaning of the area being studied, and without the discourse and language used in descriptive social constructivism the meaning becomes “agnostic and mute” (Schwand, 2000, p. 198). In utilising a sense-making perspective, how meaning is arrived at becomes the essence through which we understand the perspectives of the participants.

In this research, social constructivism is used not only to describe, but also to explore the meanings the two groups of participants give to the organisational structures that influence decision making-processes around nursing leadership. Through analysing the meanings of the participants not only as individuals, but also as represented through the opinions of professional groups, and then using cross analysis to determine any relational information will offer a deeper understanding of the context of their working world. As Semin and Gergen (1990) propose ‘everyday understandings exist in the language of culture’ (p. 14). Taking this proposition further it is also the ‘social interchange’ in which people are involved that provides primary meaning to the words they use.

The construction of this social interchange by the researcher is also critical, therefore taking cognisance of an insider /outsider view is essential. As an insider the researcher socially constructs individual interpretation of their health organisation through a shared language and culture of health care

and healthcare service provision. As an outsider the researcher needs to draw upon a number of different data inputs to interpret what is being constructed. Individuals give meaning to a frame of reference to make sense of the world they live in, and political, historical and cultural factors are critical components of the context in which they live and work. This sense-making or application of a frame of reference by individuals to their worlds has also been called *perspectivism* (Schwand, 2000).

To gain an understanding of the perspectives that may have been influential in how the participant groups have constructed their working worlds, a number of different concepts have been examined. In order to gain an understanding of the working world, organisational theory is reviewed and in particular, health organisational theory. Health organisations are the broader context in which the participants in this research are involved. By examining the different theories that apply to organisations we can gain a greater understanding of the diverse influences that impact on how the participants make sense of their organisational environments.

3.2 SENSE-MAKING & ORGANISATIONAL CULTURE

Perspectivism can also be individual, group or organisational sense-making. Gergen (1994) places this process of pulling together multiple perspectives or 'generating realities' as a central tenet of any organisation and states that "Without people coming together and determining what they are doing and why it is important, there is no organisation" (p. 144). Morgan in his seminal work *Images of Organisation* (1988) views this form of sense making as describing the "culture" of the organisation. Following on from attributing sense-making by individuals to organisational culture Morgan questions how this culture is created and furthermore sustained and constructed (p. 134).

Organisational behaviouralists (Morgan, 1998; Weick, 2001) propose that life within any given culture will follow a smooth path as long as individuals follow a set of unwritten rules. In following the ascribed social norms and rules the individuals in that society will construct a social reality that is acceptable to other individuals within that society. However, just following rules does not necessarily constitute culture, as the context for different perspectives change in any given situation (Weick, 2001).

This idea is captured in the literature review in the examination of the historical texts on nursing leadership, where Matrons utilised the culture of the time to promote the image of nurses and nursing, that in the current context would not necessarily be viewed as acceptable for nursing today. It is in utilising late 19th Century ideals around women's roles, cleanliness, hygiene and purity as the symbols reflective of nursing in the past and noting that they are not viewed as appropriate nor are reflective of nursing culture today that is important.

This changing perspective is what Morgan refers to as the enactment of culture, where individuals shape the culture of the organisation through a series of everyday points of reference. Organisational rules, policies, goals, and job descriptions are some of the routine functions that organisations construct to act as a point of context from which individuals can work from to gain a shared sense of understanding (Morgan, p. 139). However, it is the ability to construct a shared sense of understanding that creates a cohesive organisation, and conversely where organisations have multiple interpretations of their understanding, fragmentation occurs.

External influences also impact on the shaping of this sense-making. Political decisions, workforce fluctuations and environmental economics are some of the factors that can influence how individuals make sense of their organisation and how the organisational culture can shift and change. The economic hardships of the 1990s reflected in the health sector provides an example of how nursing workforce was affected and patient

outcomes were negatively impacted on as a result of the reforms (Gauld, 2001).

The shift in the political decision making to a competitive market health model combined with the reduction in the nursing budget shaped a different health culture that negatively impacted on nursing and client well-being. Adverse patient outcomes during this period have been well documented by e.g. (McCloskey & Diers, 2005; Davis et al; 2003) with the Minister of Health now publishing annual District Health Board adverse event reports through the Quality and Safety Commission. The observed political and economic factors that contributed to these adverse patient outcomes resulted in multiple realities that did not lead to a shared organisational cultural view of healthcare services. Government sense-making was underpinned by a competitive model of health with economic efficiencies as the key driver and this model differed from consumer and health workforce realities. The competitive model was based on a combination of free public access, privatisation and user pays, and New Zealand consumers and health workers were still operating in a system that was based on free publicly funded access (Upton, 1991). Additionally, legislative requirements of the health organisations were in conflict with the political economic demands placed upon them. Having to provide 24 hours free public access to healthcare for consumers year round and yet manage specified targets on the numbers of consumers that accessed healthcare was unmanageable (Gauld, 2001). One interpretation of the above scenario is that fragmentation was occurring in the New Zealand health sector in the 1990s with the multiple realities of different agencies contributing to a series of sense making by individuals that appeared to be in conflict. This conflict in turn created a lack of 'sense-making' that added to the confusion.

The lack of sense making resulting from ongoing conflict between multiple realities is consistent with the changing wider health environment and the unstable and complex systems in which healthcare services are operating.

Blomme and Bornebroek-Te Lintelo (2012) refer to this type of behaviour in complex adaptive organisations as occurring when structures dissipate due to the constant push for change and the subsequent inability to embed a repetitive cycle. Prior to the change in the leadership structure in the hospital system in the 1990s triumvirate leadership was embedded which included the hospital administrator, the senior medical officer and the matron. This structure was repeated in all of the public hospitals in New Zealand and the resulting organisational environment was one of hierarchical stability.

The changes to the hospital management structure in the 1990s came about as a result of a theoretical shift in political thinking. The paradigm that politicians began following has been described as the 'new managerialism' and was the introduction of the 'generic manager' to many workplaces in the state sector (Boston, Martin, Pallot & Walsh, 1991). This shift removed clinical leadership from the hospital management structure and replaced the traditional triumvirate structure with a single Chief Executive Officer (Gibbs, 1988; Upton, 1990). The constantly changing political paradigms since that time have led to a constant stream of change imposed on the healthcare system within the New Zealand environment where healthcare entities have had to become adaptive to survive. The ability of the organisation to adapt, impacts on how the individuals working within the organisation make sense of that organisation and its culture. The change in the management structure of the New Zealand public hospital has had a marked impact on nursing leadership structure and to understand this impact it is essential to appreciate how organisational culture has been interpreted.

3.3 HEALTH ORGANISATION CULTURE & NURSING LEADERSHIP CULTURE

As discussed, the sense making of organisations is influenced by the culture of those organisations and how well that culture manifests as a distinctive character of the organisation. As noted in the previous section not only are

the external factors influential, but we also have to be cognisant of the internal factors that impact on how the organisational culture is enacted. Examining the two participant group's, Directors of Nursing and Chief Executive Officers, perceptions of organisational structures that influence decision making processes and how this has impacted on nursing leadership provides an interpretation of leadership culture at a senior decision-making level in New Zealand Health organisations that occurred at the end of the first decade of the 21st Century.

Like many bureaucratic organisations, the Ministry of Health and its associated District Health Boards have constructed a series of everyday norms to provide a sense of shared cultural values. These normative functions are represented in the use of formal management systems that provide guidelines for care, policies and procedures; in attending meetings and, being a player in the hierarchical frameworks that are historically part of professional bureaucratic organisations (Daft, 2010). It is through these everyday norms that the individuals working in these institutions socially construct their understanding of the organisation.

In making sense of the understandings of the participants, Schwand (2000) points out there are three on-going issues that have to be addressed. Defining the meaning of 'understanding', and validating the written expressions of participant understanding is the first issue. How the research is framed within a broad, interpretive context is the second issue, and the location and relationship of the researcher to the participants and the research material is the third point. The first issue requires further exploration on how 'understanding' or 'making sense' is understood within the worldview of social constructivism and how it is applied in the context of this thesis.

Contemporary debates on 'understanding' are informed by two sets of consequences, 'strong holism' and 'weak holism' (Schwand, 2000). Advocates of strong holism argue that everything is constructed from

interpretation and there is no correct or incorrect way to interpret meaning. Supporters of this view (Denzin & Lincoln, 1994; Richardson, 2005) maintain that where there is no universal measure of plausibility of the interpretation, then there is no rational way for one interpretation to be better or worse than others. Debates around weak holism lead to a discussion on whether there is a rational way to justify interpretation where Schwand (2000) notes that there are common themes around justification of interpretation using the narrative form of practical reasoning. Through acknowledging prior bias and pre-conceptions the researcher forms an understanding by using these prejudgements to establish an on-going narrative with either the text or information.

The relevance of understanding the different debates is that I am aware that both sets of holism are being used in the search for understanding the meanings that the participants convey through the data. For accuracy strong holism is utilised to portray the meanings the participants attribute in the data as the recording of the conversations is neither correct nor incorrect. However for the researcher the holism is weak as prior biases and pre-conceptions are taken into account as the data is being interpreted. Practical reasoning also plays an important role in understanding the context in which the data is not only recorded but also in the interpretation of the data. This way of thinking is best captured in the following quote, 'Aristotle's description and formulation on the method of practical philosophy acknowledges that morality and politics are not susceptible to a detached theoretical interest but presuppose education and maturity' (Gadamer, 1975, p. 312).

In the article *Language and Understanding (1970)*, Gadamer (2006) posits that 'the general process of reaching an understanding between persons and the process of understanding *per se* are both language-events that resemble the inner conversation of the soul with itself' (p. 13). Here Gadamer acknowledges that to state that language is the only form of understanding may appear provocative, however he goes on to provide a

perspective of language as not just spoken and includes language that is silent. Furthermore, Gadamer theorises that 'language leads its tension-filled life in an antagonism between conventionality and revolutionary awakening' (2006, p. 18). This becomes evident as the 'powerful economic interests' in organisations are harder to control leading to 'a form of alienation of the common citizen from public affairs, and why the reaction against this power or "the establishment" is so strong' (Gadamer, 1975, p. 314). We see evidence of this in nursing as professional tensions compete with organisational tensions. Drawing from both tenets of strong and weak holism, I will use the language of the participants in the data results chapter to indicate an open interpretation of the participant meaning. However, for interpretive purposes weak holism is applied to deconstruct the participant meaning as practical reasoning based on the context will apply to an analysis of the research data.

3.4 SUMMARY

Making sense of the processes that have influenced nursing leadership structures in the New Zealand public hospital system requires both an understanding of the organisational structure and the culture through which it operates. This chapter has covered the theoretical assumption around sense-making which facilitates our understanding of how the participants in this research come to understand their organisation and the decision-making processes that have an impact on their working environment. Sense-making as a philosophical underpinning informs the analysis and assists with the structuring of this dissertation.

The focus on language and interpreting the language or culture of an organisation is very pertinent to this research and will be discussed further in the next chapter when I look at the organisational context and its relationship to nursing leadership roles, structural positioning and influence. The concepts of power and powerlessness are an intrinsic part of understanding organisations and provide an extension to making sense

of the organisational context and its culture and will also be discussed in the next chapter. These concepts will assist with interpreting the analysis around how the participants make sense of how the structures influence their roles and position within the organisation. Additionally the gendered world of work is also explored in the next chapter as power and powerlessness underpin gendered workplaces and have the potential to impact on the structuring of nursing leadership in New Zealand.

CHAPTER FOUR- THE CONTEXTS OF SENSE-MAKING

4.0 INTRODUCTION

This chapter now seeks to discuss how organisational theory on structure, history and the gendered world of work have been influential in making sense of the organisational structure and the subsequent role positioning of the DoN. These areas provided a context from which to understand the research. Having collected and considered the data it was essential to look for a theoretical context or explanation to make sense of what was being captured. Organisational theory on structure provides the framework for examining the District Health Board and nursing structures. History and the gendered world of work offer insights into how the nursing leadership environment has been shaped and how these facets have the potential to influence the structures.

4.1 USING ORGANISATIONAL THEORY TO EXAMINE ORGANISATIONAL STRUCTURE

The starting point for making sense of the organisational structure lies with Max Weber and his views on bureaucracy. Understanding the influence of bureaucratic structures is important in this dissertation as it underpins the confusion that is at the heart of the structural differences found in the data. I will look first at understanding bureaucracy and how the hospital structures have come about, progressing to using Mintzberg to look at the traditional hospital structure with their divisions of work and then focus on how the changes in the late 1980s have impacted on these structures.

Weber (1864-1920) a German sociologist is best known for his work *The Protestant Ethic and the Spirit of Capitalism*. Weber founded his theories based on the context of the time which was the rise of industrialism and capitalism, and the growing interest in Marxist literature (Parsons, 1947). Weber's theories (which have been translated) are used to understand how

bureaucracy influences the division of work within the organisation. Weber also wrote *The Theory of Social and Economic Organisations* (English Translation by Parsons, 1947) which provides a way to look at bureaucratic structures, and it is this text I use to inform my understanding of organisational structures and how work within an organisation was controlled, through focusing on how social order in organisations was rationalised through bureaucracy. This seminal text also examined how within bureaucratic structures technical efficiencies could be produced.

The distinctive characteristics of bureaucracy have been redefined by Hatch and Cunliffe (2006) in their text *Organisational Management* into the following eight areas: (1) a fixed division of labour (2) a clearly defined hierarchy of offices, each with its own sphere of competence (3) candidates for office are selected on the basis of technical qualifications and are appointed rather than elected (4) officials are remunerated by fixed salaries paid in money (5) the office is the primary occupation of the office holder and constitutes a career (6) promotion is granted according to seniority or achievement and is dependent upon the judgement of superiors (7) official work is to be separated from ownership of the means of administration, and (8) a set of general rules governing the performance of offices; strict discipline and control in the conduct of the office is expected (p. 103). The predominant idea that is reinforced about bureaucracy is that through its entrenchment it becomes one of the hardest social structures to destroy (Weber in Eisenstadt, 1968).

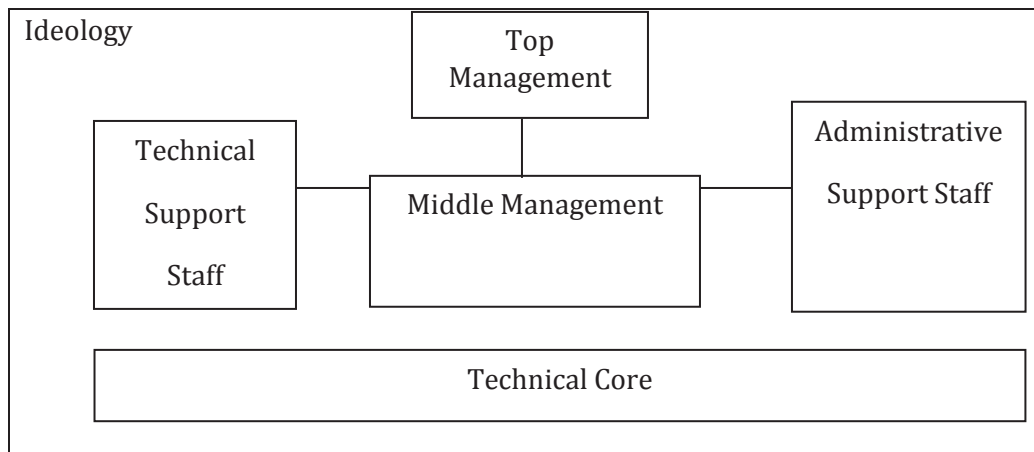
The list of characteristics used by Weber (Secher, 1964) and redefined by Hatch and Cunliffe(2006) that underpin his ideal bureaucracy, are required to be broken into two groups to fully explore the impacts on the organisation. The formal and informal components of organisations are quite different and through separating out these two areas we can gain a better understanding of formal and informal power structures that impact on organisational structures and decision making. The fixed division of labour and the hierarchical structure, the first two characteristics of Weber's ideal bureaucracy provide a way of formally examining

organisational structure charts. The characteristics numbering three to eight form part of the informal structure of the organisation and the data for these characteristics can only be ascertained through a general overview of District Health Board information.

The division of labour and the clearly defined hierarchy of offices are evident on the DHB organisational structure charts as ways of analysing the formal organisation. Examining these two characteristics in relation to each different District Health Board organisational structure chart made available it can be seen that both characteristics can be found on the organisational charts. The depiction of the division of work through the named service configuration provides a key to understanding how the organisation is structured and how that organisation subsequently might work. Using the definition of a large professional bureaucracy, as described by Mintzberg (1989), it is the clinical activities that can be seen as providing the predominant services of work within the hospital setting.

Mintzberg (1989) is noted for his work on different organisational types and proposed that organisations comprised six parts. Refer Diagram 4.1

Diagram 4.1. Mintzberg's Six Parts of an Organisation



(adapted from Mintzberg, 1989, p. 99)

Mintzberg (1989) viewed the directing and co-ordinating of the organisation as the primary role of top managers. The individuals located

in this part set the direction, the strategy, goals and policies for the whole organisation. Middle management emulated top management individuals at the department level and acted as the mediators of communication between top managers and the technical core. Administrative support staff functions were involved with a combination of human resource issues such as the recruitment and education of staff, and facilities staff maintaining the physical buildings, equipment and grounds. Technical support comprised a combination of information technology input, engineering support and research, and these individuals were viewed as the innovative component. The fifth part was the technical core where individuals or groups of people were responsible for transforming inputs to outputs. An example of this can be seen in the health system where in a public hospital the technical core comprise the staff that provide clinical activities (Daft, 2010). Some examples of clinical activities include the treatment and care undertaken in a number of different areas such as ambulatory care, accident and emergency departments, medical, surgical and specialty wards. Other areas where clinical activities occur include pharmacy, radiology, and physiotherapy which often fall under the clinical support services group. The final and sixth component of the organisation was the ideology that underpinned the organisational culture (Mintzberg, 1989).

The arrangement of the different components provides further insight into how the organisation is structured. Utilising the five staffing components in different arrangements five organisation types have been put forward by Mintzberg. *Entrepreneurial structure, machine bureaucracy, professional bureaucracy, diversified form and adhocracy* are the proposed types which each one structured differently based on the size and importance of each component (Mintzberg, 1989; Daft, 2010).

The professional bureaucracy can be seen as the type that fits the majority of public hospital organisations, as the main feature found in this type of configuration is the 'size and power of the technical core which is made up of highly skilled professionals such as found in hospitals and universities'

(Mintzberg, 1998, p. 29). The technical support staff numbers are small as the technical core make up the largest staffing of the organisation. There is also a large number of administrative support staff to support the professionals and administer the routine activities of the organisation.

An example that supports the Mintzberg professional bureaucracy configuration is noted in the District Health Boards New Zealand (DHBNZ) Report of 2002:

Healthcare is labour and knowledge intensive. So even relatively small progress in workforce development can make a big difference in costs, the volume and quality of services, and ultimately and crucially, the health status of their (DHB) populations (DHBNZ, (NZIER), 2002, p. iii).

This comment reflects the labour intensive composition of the technical core found in hospital organisations. The impact of a labour intensive health workforce is also reiterated in the OECD report *Health Workforce and International Migration: Can New Zealand Compete?* In this report the health workforce accounts for “70% of the costs of delivering public health services and 5.5% of the workforce” in New Zealand (Zurn & Dumont, 2008, p. 8).

The dominant workforce in the DHB is its technical core comprising medical, nursing and allied health staff. As noted in the New Zealand Nursing Council Report 2010 over 39% of the nursing workforce registered to practice in New Zealand is working in the acute hospital setting (NCNZ, 2010). A number of public documents provide further examples of District Health Boards full time equivalent (fte) workforce staff that make up the technical groups. In the majority of District Health Boards the technical staff composition would be between 75-76% with nursing around 42-43%, medicine 12-13% and allied health 19-20% (Southern DHB, 2011; Canterbury DHB, 2011; MidCentral DHB, 2011; Waitemata DHB, 2010). All of these examples support the view that the hospital setting fits Mintzberg’s professional bureaucracy of organisational structure type. The importance

of defining the type of structure is that it enables a formal view of the organisation to be understood. Through understanding how people are organised within the organisation we can look at how their work is defined.

How that work is departmentalised or divided offers further insight into how the formal structures within health organisations are explained. Gibson, Ivancevich, Donnelly, and Konopaske (2009) provides insight into four distinct types of departmentalisation and a fifth hybrid design. The first area, functional departmentalisation, structures work to what the organisation does. Using a hospital as an example the key functions that are necessary for it to undertake its day to day work may include ambulatory care, surgery, outpatients, accident and emergency, pharmacy, nursing, human resources and catering. The structure chart will then reflect these specific departments and a broad indication of the type of work they undertake. The reasoning behind this type of departmentalisation is around the achievement of efficiencies. The functions are performed by specialist groups and this in itself is considered more efficient as groups who have similar backgrounds and interests share their expertise. However, it is noted by Gibson et al (2009) that the negative aspect of this type of departmentalisation is that the specialisation may be achieved at the cost of the organisation's goals.

Organisations that work across a number of different physical areas may use geographic departmentalisation. This type of departmentalisation is applied to groups who are usually working across a number of defined geographic areas. Various activities with a specific location may be assigned to one manager to manage that region. The advantages with this type of plan are seen when managing people and business activities across different physical spaces. Disadvantages can occur when standardisation is not cross referenced across the departments and silos ensue.

Another aspect of which structural design is through divisional organisation where the divisions are based on the products or services they

are selling. Gibson et al (2009) note, that the divisions can be independent units within the organisation through their ability to 'design, produce and market their own products' (p. 398). The positive aspect of this type of departmentalisation is through the ability to self-manage the business within the organisation and thereby have a degree of autonomy and control. The negative factors are often found in the duplication of generic activities such as research, financial expertise, human resource input and legal support and the costs that are usually associated with providing the same activities in multiple areas. The fourth approach is to group work around clients, and this is often found in educational organisations to meet the needs of specific groups of students. Customer focussed work groupings are better able to provide targeted services as they are often oriented towards what the client or customer wants.

The final design that organisations may use is the matrix which combines any of the above to create a hybrid structure. Often the matrix organisation is:

Typically seen as a balanced compromise between functional and product organisation and between departmentalisation by function and by product'. This is usually achieved by overlaying 'a horizontal structure of authority, influence, and communication on the vertical structure (Gibson et al, 2009, p. 401).

Dawson (1996) notes that this is usually evident where a number of specialists work in the same product or service area reporting to that product or service manager but will also have a formal relationship with the functional manager.

Although the hospital as an organisation has been provided as an example of functional departmentalisation, this is perhaps more evident of past traditional structures. A current overview of the organisational structure charts indicates that New Zealand public hospitals will more often fit under the fifth hybrid structure using a matrix of functional departments and

service organisation to meet their service needs. Whilst the majority of clinical activities are evident in all of the public hospitals, the size and composition of clinical groupings differ. These groupings are structured in relation to population size and needs, financial constraints, human resource constraints and policies and localised strategies of the individual District Health Boards. The fifth hybrid structure is evident where the organisations have a number of divisions representing clinical activities and support of clinical activities across the top of the organisation. These divisions then feed down hierarchically into middle management and technical core and both administrative and technical support staff. However the different divisions also have horizontal reporting through their professional advisory support which includes the Chief Medical Officer, Director of Nursing, Director of Allied Health and the Kaumatua⁹. The constant restructuring of the DHBs over the last thirty years has meant continuous change that has been subject to political directives, subsequently the organisation must be able to adapt to continue.

Having covered how the formal DHB hospital organisational structures and divisions of work can be made sense of, I now look at the changes that have impacted on these traditional hierarchical structures and use the institutional view to look at the differences and ultimately what are the perceived mechanisms for survival or adaptation of the organisations. The institutional view has been selected as one of the ways to makes sense of the organisation in the current environment as it provides a way of understanding the organisation and its responses to external/environmental impacts in order to survive. Daft (2010) states that 'the institutional view believes that organizations adopt structures and

⁹ Kaumatua are Māori elders, have many important roles in their families and tribes, including preserving traditions and knowledge, providing leadership, and nurturing the younger generations (<http://www.teara.govt.nz/en/kaumatua-maori-elders>).

processes to please outsiders, and these activities come to take on rule-like status in organisations' (p. 192). Furthermore because the institutional view comprises two essential elements – the technical (day to day work and operating requirements) and the institutional element (the visible to the public persona), it is the institutional element that overrides the technical element as external environmental expectations override technical efficiencies. It is through the institutional view that we recognise that the formal structure is a facade that is disconnected from the actual operation of the organisation but is the required mechanism through which the organisation obtains legitimacy and authority (Daft, 2010). The need for legitimacy becomes one of the reasons why there are differences in the formal organisation and nursing structure chart data in the research, and this is further discussed in chapter eight.

The disempowerment of clinicians has come at a time when previous bureaucratic structures were no longer seen to be effective, and combined with a political movement against 'big governments' the emphasis was placed on 'corporatising' or 'transferring private sector management techniques' into the public sector (Brown, 2008, p.4). The disempowerment of the triumvirate management group therefore not only de-legitimised their authority but also altered the perception of how traditional health sector authority was perceived. The political changes that occurred in the public health sector therefore, was not only a change in who was managing, but also to how the sector was being managed. Brown (2008) discusses the transfer of management practices from the private enterprise sector to the public sector, which in turn shifted the administrative functions to management functions. This shift in administrative functions to management was evident in the health sector with the recommendations made by the Gibbs report (1988). The changes were viewed as necessary to meet not only the rising consumer demands in healthcare, but also a perceived need to decrease health expenditure and reduce health budget deficits. As Brown (2008) notes the components that characterised new public managerialism were 'managing for results,

performance measurement, corporate planning, user pays, devolution of authority, decentralisation of activities and risk management' (p. 4). This model was to be flexible and market oriented so that reliance on government spending would decrease.

It is through the flexibility and response to market requirements that the different structures started to emerge in the District Health Boards. As noted in the institutional view we can see the DHB institutional arrangements start to change in response to the external environmental pressures. The 1991 restructuring of the DHBs, and the main thrust of the government policy meant that they had to operate in a competitive market. One way in which organisations that are service oriented can become competitive is to promote a form of diversity and this can be undertaken by making the organisation 'look' different (Boxall & Purcell, 2011). In line with this thinking, organisations try to differentiate themselves through offering a niche market or specialist services, whilst all the time utilising cost drivers to keep the cost down. Boxall and Purcell (2011) argue that the 'achievement of economic viability is clearly the fundamental priority of management' and through attaining sustainable economic viability they will succeed. In this discussion the term 'economic viability means that a firm (organisation) generates a return on investment that its shareholders consider 'acceptable' or which meets the obligations it has to its bankers and other lenders'(p.12) in this research the shareholders, bankers and lenders are one and the same, the government. Remaining viable is linked to having a sustainable competitive advantage and in the DHB organisation and the hospital services this is achieved in having resources that are difficult to imitate. It is therefore in the diversity of the use of its resources that the DHB can sustain its competitive advantage and it achieves this through the legitimacy of restructuring how it looks to its stakeholders.

The external environmental pressures on the DHBs and the hospitals therefore alter the legitimacy of the traditionally accepted management structures and offer an explanation as to why the District Health Board structures have evolved over the last twenty years in such different ways.

The difference in nursing structure charts requires further examination as these structures are the result of nursing leadership also trying to respond to these changes. The need for difference in an initially competitive market continues as following the disestablishment of the market driven health model between DHBs, funding still remains contestable both within and between DHBs in the continuing drive for efficiency. Differences can be accounted for as individual clinical units within the DHBs compete for scarce resources and capped budgets. The constant cycle of change in structures occurring in hospitals are a response to try and be innovative and 'manage more with less'.

However, the embeddedness of the bureaucratic structure in the hospital setting and the underlying technical elements found in the divisions of work create both confusion and a tension at odds with the institutional element. The technical elements found within the hospitals are representative of a homogenous group of health services that are being provided as a result of government directives and historical health servicing. Homogeneity is also found within nursing structure charts in the types of broad roles that nurses have been assigned on the different charts and in the additional information sourced from nursing job descriptions. As mentioned earlier sustained competitive advantage results in an organisation maintaining its viability in the market place, and gaining a competitive advantage is achieved through providing services that are difficult to imitate or have different looking services (Boxall & Purcell, 2011). Political and economic changes have always been the catalyst for the differences in organisational and nursing structure charts historically and through re-configuring the services within the public hospitals a point of difference is made not only between the different DHBs in what they might provide and contest funding for, but also the way in which the re-configured services in the hospitals argue their case for additional funding. The continual re-invention of how services can be provided which are delivered more efficiently ensures that the labour supplying those services is also subject to constant change. Yet at the heart of the confusion lies the

inescapable fact that these organisations are all supplying a similar group of health services. Di Maggio and Powell (1983) argue that the reason why the institutional view is so apparent in public sector organisations is because in trying to make their organisations different, the mechanisms they use result in making their organisations very similar. Whilst differences may become evident in the organisational structure and nursing structure charts, this is an indication that the organisation has reverted back to what is referred to as the early life stages. These differences can occur even when a high degree of homogeneity has occurred through constant restructuring of the organisation. Often these changes are in response to the external environmental demands overriding the technical elements within the DHB organisations.

Di Maggio and Powell (1983) comment that 'in the initial stages of their life cycle, organisational fields display considerable diversity and form' and it is this beginning life cycle stage that also contributes to the explanation as to why the structures are so different. However, the similarity of the services they provide is accounted for through reviewing some of the technical elements and the isomorphic mechanisms that exist within the organisations. Coercive, mimetic and normative isomorphism offer a way of making sense of why the services provided in the DHB public hospitals are similar and the structures delivering them so different. Coercive isomorphism also occurs in organisations as a result of external pressures on the organisation that results in the organisations delivering similar services. As the word coercive implies the organisations begin to have similar features as the same legislative frameworks and policy directives apply. Evidence of coercive isomorphism in the DHBs become apparent as they change in response to government mandates for example the efficiency drivers that DHBs are subject to found in current key performance indicators (KPIs), and the need to innovate and change to meet government targets within prescribed budgets (MoH, 2012a).

In more recent months coercive isomorphism has also been evident with the establishment of the Regional Clinical Networks as the DHBs are

required by the Minister to work together to find solutions over achieving common health targets and providing more vulnerable services (MoH, 2012b). In addition the medically driven model of health has also acted as a coercive mechanism that has created homogeneity amongst health services. The legitimacy and authority of the medical field has been very influential in determining what the major priorities are in the provision of health services.

Homogenisation of services is also characterised by coercive isomorphism as the structuring of the services are an outcome of the constraints imposed on nursing leaders by the medical field, statutory bodies and the government to meet the current health policy objectives. Mimetic isomorphism occurs when organisations copy or imitate other organisations as they try and achieve certainty in an uncertain world. In the current health arena communication and having collaborative partnerships is echoed in many government documents and DHB reports (NHB, 2011; MoH, 2012a). There is a sense of both coercive and mimetic isomorphism occurring as the nurse leaders try to meet the expectations of working within a collaborative workforce.

Further evidence of mimetic isomorphism is found in the CEO position where there are generic attributes and requirements associated with CEO roles in any organisation. The whole movement of new public sector managerialism which incorporated the corporate CEO can be viewed as a mimetic isomorphic process. Weinberg (2003) in *Code Green* highlights the mimetic isomorphism that occurred in the United States hospitals as the hospitals were merged and nursing 'dismantled' as OECD countries applied the principles of new public managerialism across the globe. In an attempt to cut costs and gain efficiencies 'hospitals adopted a common set of practices to cut costs and increase revenues' (foreward). This common set of practices was found in restructuring in an attempt to increase productivity. Again confusion and tension are evident as the differences in the structures increase through the pressure on the institutional elements and how they override the technical elements where the divisions of work

being performed are still the same. The mechanism of mimetic isomorphism is also reinforced where there is uncertainty and subsequent modelling on other organisations occurs, where certain practices are perceived to be more legitimising than others.

This is where the professional bureaucratic model that Mintzberg (1989) first formulated still applies to the public hospital as the technical elements of the hospital still comprise the largest group and the technical/professional services being delivered are still based on similar service demands. The requirement for nursing to provide 24/7 nursing services in the hospital has not changed, they are still the main provider of care and therefore they are still the largest professional group within the public hospital setting. Normative isomorphism reinforces the homogeneity of the nursing profession within the DHB organisations.

Di Maggio and Powell (1983) argue that normative isomorphism occurs in organisations as a result of professionalisation. Their interpretation of professionalisation is 'the collective struggle of members of an occupation to define the conditions and methods of their work, to control "the production of producers" and to establish a cognitive base and legitimation for their occupational autonomy' (p. 152). Progressing through the thesis the data from both sets of questionnaires reinforces both the normative and mimetic isomorphic mechanisms at work. This is discussed further in chapter eight.

It can also be argued that 'professional power is as much assigned by the state as it is created by the activities of the professions' and the Nursing Council of New Zealand (NCNZ) and the Health Practitioners Competence Assurance Act (2003) are evidence of the highly legislated and regulated nature of the profession. These regulatory bodies define what the normative rules are around organisational and professional behaviour. As a result of these regulatory mechanisms, 'a pool of interchangeable individuals who occupy similar positions across a range of organisations' is created (p. 152). Again there is evidence of homogeneity occurring within

the DHBs as a result of the normative isomorphic processes as the primary professional groups are represented as an interchangeable pool within their professions. The Multi Employment Collective Agreements (MECA) also reinforce this interchangeable pool of resources within the nursing profession as nurses recruited are subject to a standardised process across all of the DHBs in relation to job description and salary. However, whilst the positions as a function are interchangeable and provide a form of normative isomorphism, the argument for gaining a competitive advantage would see the people in the role as difficult to imitate or copy and this is where the confusion and tension between the institutional elements and the technical elements are most apparent.

Mintzberg (1981) argues that in trying to rationalise, standardise and formalise hospitals, the government causes devastation. The basis for his argument is that organisations are not a collection of component parts that can 'be added to and deleted at will, a sort of organisational bazaar' (p.104). He goes on further to add that effective organisations achieve this effectiveness through coherence, by working through all of the component parts to overview the flow on effects of change. As noted on page 80 Mintzberg's organisational configuration that applies to the DHBs over time has been that of the model of professional bureaucracy. However one of the key factors in the application of this model has been that the environment has been both complex and stable.

The lack of stability and constant uncertainty in the health environment that has become apparent since the late 1980s has subsequently impacted on the DHBs and the public hospitals and how they organise their resources and deliver their work. The underpinning homogeneity of the health services that has been intact for over one hundred years with a medically disease driven model is now subject to adaptation and the need to be structured differently. The core professional groups that make up the dominant resources in a professional bureaucratic model are required to meet the changing environment and with nursing comprising over half to two thirds of the workforce resources across the New Zealand public

hospitals this group is noticeably affected by the confusion and resultant tension between the differences found in the structures (through restructuring) and the similarities required in the technical elements (the health services still required to meet public expectations).

The response by DHBs and nursing to meet the challenges of an uncertain and unstable environment in providing diverse structures to manage their work, has created both a confusion and tension for DoNs between managing innovatively using the institutional elements that support differences in the DHB and hospital structures and being constrained by the isomorphic mechanisms that influence the technical and professional elements within the public hospital. The institutional pressures continue to enable the DoN to manage and lead over the professional lines of nursing, but the requirement for innovation and change in a political climate of new managerialism has disempowered the DoN role through the removal of the operational line of reporting and its associated components of budgeting and decision making. Furthermore the historical factors and gender influences, which are discussed next, also act to perpetuate this way of thinking.

4.2 HISTORICAL INFLUENCES

History provides a contextual understanding of the issue being explored as noted in chapter two in the literature review. In this dissertation it is the social history that is of particular interest as it enables an historical approach to be considered rather than a precise subject matter. The historical influence in both health and nursing has played an important role in determining how nursing has evolved over time and it is through history I will look at how the potential differences of organisational and nursing structures have come about. The history relevant to the change in health organisational structures has only come about since the late 1980s. As noted earlier in the introduction, prior to the 1980s, public hospitals had a triumvirate management style and a strong hierarchical organisational structure both within the governing organisation and nursing. This

hierarchical organisational structure had evolved from the English hospital system and the Nightingale model of nursing. Religion and military influences were important in the shaping of the public hospital system and these influences have been reported in the texts of Porter (1997), Bostridge (1998) and McDonald (2005). The hierarchical structures within both religious and military institutions provided the organisational structures for hospitals until the late 1980s. This hierarchy was evident through the rank and insignia of nursing uniform and the expected subordination of nursing staff to medical staff (Porter, 1997).

New Zealand society approached hospitals with a different view to England and this also formed a legacy that was to pervade how hospitals were funded and managed over time. MacDonald (1990), and Brookes, MacDonald and Tennant (1992) discuss the abhorrence in New Zealand towards the English Poor Laws and in not wanting to implement such a law, but recognising there were people in need instituted the Hospital & Charitable Institutions Act (1885). The public hospitals were therefore begrudgingly funded under an act of charity. With the advent of improvements in medicine, the nursing model of care began to change (Porter, 1997; Lupton, 2003).

The two world wars saw not only changes to how patients were diagnosed and treated but also to how the nursing role was regarded. The nursing role has often been portrayed as the 'handmaiden to the doctor,' as the role of nursing became more entrenched in the disease driven model of care rather than a holistic health model of care. The focus during the two world wars did little to reduce the military style of hierarchy evident in the public health system (Masters, 1950; Kendall & Corbett, 1990). The combination of the changes in medicine and the focus on the disease driven model continued to entrench the view of a hierarchical hospital structure, and managing and overseeing these structures was the Director General of

Health¹⁰ who until 1993 had always been a medical doctor. In the early 1980s, changes to the Health Act 1956 were first mooted with the legislation amended in 1983 so that the Director-General of Health and deputies were no longer required to be medical doctors (Dow, 1995). This signalled the start of significant changes to the New Zealand health structure, as the traditional hierarchical model based on the dominance of the medical profession now altered. Politically this change was viewed as the correct action to take so that 'administrative structures should reflect today's broader picture of the health field' (Dow, 1995, p. 209). In 1991, Christopher Lovelace was appointed as the Director General of Health, and was the first to have been appointed without a medical background.

The establishment of the Department of Health in the 1920s saw reporting through to a central government department and the Director General of Health as the most senior government official. It is to be noted that the Department of Health had also established a Division of Nursing by which the Hospital Matrons reported through to the Chief Nurse at the Department of Health (Dow, 1995). It was in the 1980s following the recession of the 1973 oil crisis and the ongoing global economic issues that restructuring of the developed countries health systems started to become a major focus. In this context following the appointment of Lovelace, the Department of Health was restructured into the Ministry of Health in 1993 and as Dow (1995) comments, the first major task for Lovelace 'was to prepare the Department for its demise and replacement by a new Ministry of Health' (p. 211). Political and economic rhetoric around rationing started to dominate the narratives in health and the Gibbs report (1988) recommended that the triumvirate style of leadership and the current hospital structures be disestablished in favour of a 'new managerialism' style of management. This recommendation was followed up by the Hon Simon Upton in his Green and White papers (1991) when he unveiled a

¹⁰ The title has changed over time, during the late 1800s and 1900s till the establishment of the Department of Health the title had previously been known as the Inspector of Hospitals & Asylums.

competitive health model for New Zealand (Upton, 1991). The Green & White papers (Upton, 1991) reinforced the disestablishment of the traditional hospital triumvirate management and in place appointed a DHB Board who elected to appoint a corporate CEO. The CEO held accountability for the DHB which included management of the public hospital. So the late 1980s became the turning point for the changes to both the hospital organisational and nursing structures.

Prior to the changes in the late 1980s nursing authority was seen to be achieved through the triumvirate management of the hospitals where the Principle Nurse role was closely linked with the Medical Director and the Hospital Administrator in the decision making processes for the hospital (Gibbs, 1988). Gibson et al (2009) note that the position of an individual as located in the organisational structure denotes the level of authority, and subsequently formal power of that person. This form of authority is recognised as 'legitimate authority' and premised on a number of characteristics where other individuals feel bound to acknowledge the authority based on custom and a normalised 'validity' (Weber in Secher, 1964, p. 72).

It is the combination of rational/legal and tradition conventions of authority that are of interest in this research because of the linkages of these conventions to the differences and similarities found in the structuring of the DHBs. Rational/legal authority is tied in with the individuals' job description as 'it extends to the persons exercising the authority of office under it only by virtue of the formal legality of their commands and only within the scope of authority of the office'. Evidence of this becomes apparent in one of the case studies where the DoN notes that they are only able to make decisions within '*delegated authority level*'. Whereas when traditional authority boundaries are applied, it is the person who occupies the role in authority who garners obedience, which is given based on the 'traditionally sanctioned position of authority' (Weber in Eisenstadt, 1968, p. 46). This traditional authority is linked to all three

constructs of isomorphism and reinforces the historical underpinnings of nursing authority.

Reading historical accounts of when the early nursing leaders in New Zealand through the twentieth century presided over nursing, traditional authority is apparent as the 'Matron' was viewed as in a sanctioned position of authority. The sanctioning of this position can be seen as coercive isomorphism where the norms and morals of society sanctioned the type of role and positioning of this role. Add into the mix the influence of medicine and the medical model of health in combination with the scientific rational organisational structures that were evolving from the industrial revolution and there are quite a few social, political and economic structures that shape and coerce how the nursing profession in the industrialised countries is evolving in very similar ways. In particular it is the reliance on the 'mother country' (Great Britain) and Florence Nightingale that shapes New Zealand nursing during this period (Belgrave, 1991; Angus, 1984; Lambie, 1956; Neill, 1961; Campbell, 1976). This shaping in turn sees the mimetic isomorphic process occur as nursing practices and processes are moulded and shaped on Nightingale nursing practices. In addition the normative isomorphic process is unmistakable by the professionalization of nursing as nurses set about establishing themselves as a profession. The nursing uniform has also played a key part in identification of the profession, the nursing veil is particularly important as it continues the perception of the profession as pure and chaste and linked to strong moral beliefs. These moral beliefs also play an important role in the similarities found in nursing as it establishes itself as a profession (Nightingale, 1980 [Translation]; McDonald, 2005; van der Peet, 1995).

In the context of the pre 1990s nurse leaders were seen to be in a position of power and authority as structurally their positioning placed them close to the top of the hierarchy and in a strong relational link with the Hospital Administrator and the Medical Director. This structural positioning within the organisation becomes important to nursing leadership as it denotes the line of command under which they are given authority to act (Gibson et al,

2009; Fineman et al, 2010). However, a deeper reading of the historical accounts would also indicate that empowerment was not readily forthcoming to nurse leaders as they were always fighting for more resources to be able to undertake the work they were tasked (Barber & Towers, 1976; Angus, 1984; Bennett, 1962). Without access to the resources and information required to carry out the required tasks there is a certain sense of powerlessness as nurse leaders did not have the leverage to be empowered (Kanter, 1997). This 'powerlessness' created a different culture within an organisation, which resulted in a sense of 'bossiness' as opposed to leadership (Kanter, 1997, p. 135). It is also a culture of powerlessness that causes frustration and a sense of failure as individuals are held accountable for work for which they do not have the resources. The combination of frustration due to the lack of power and resources to do the work can often lead to a 'desultory and petty, dictatorial, rules-minded managerial style' (p. 135). Consequently whilst the role of the nurse leader pre-1990s although viewed as structurally in a position of power, it is argued this was not the case and that the isomorphic mechanisms supported an apparent tension between a perceived level of attributed power and actually being empowered. The fact that the nursing workforce is comprised mostly of a female workforce also raises the issue of power and a gendered workforce and I will now discuss the influence this has had on the positioning of nursing leadership in New Zealand.

4.3 THE GENDERED WORKFORCE

Theories that support the gendered world of the workplace can be seen to be derived from a Marxian view of economics and in this particular research I refer to Meillassoux (1981) and his theory of production. Meillassoux (1981) argues that from an economic perspective that 'the reproduction of human beings is..... production of labour power in all its forms' (p. xi). His discussion centres on the domestic community with its ability to manage labour reproduction through women. This notion of 'through women' stems from an earlier theory on kinship, where women

were exchanged amongst tribes to continue the race. Women are therefore a commodity that can be exchanged and their value is reproduction. Further to this concept are the political connotations of such exchanges, 'Reproduction depends on the political capacities of the communities to negotiate an adequate number of women at all times' (1981, p. 25). Although it is acknowledged that Meillassoux's work is primarily aimed at pre-capitalist and African developing countries, and that survival was perpetuated through continued labour production, in context this differs very little from the 19th and 20th century worlds in which women worked, and a century from which nursing as a working occupation and profession evolved.

Although exchanging women was not directly on the political agenda as was found in tribal societies, the concern with labour reproduction was. The industrial revolution that occurred in Britain was noted for its child labour and sweatshops and like Britain these practices were perpetuated in New Zealand to the extent that a Royal Commission to inquire into Sweating in the colony of New Zealand 1890 was undertaken (*Report of the Royal Commission appointed to inquire into certain relations between the employers of certain kinds of labour and the persons employed there-in*, AJHR, Vol 3, H-5, 1890). The increased need for labour was a direct result of demand for industrial production in a capitalist world centred on profit. The political agenda initially premised by Meillassoux based on biological survival was now an agenda of survival based on making profit at all cost.

The two wars provided political impetus time and again for reproduction as means of future labour power and was evidenced in the following political adage that 'Population means power. The nation that has the babies has the future' was still very evident in the first half of the twentieth century (Mein-Smith, 1997, p. 1). It is in this context of women being valued primarily for their reproductive capacity to produce future generations that the theoretical considerations underpinning the gendered world of work are examined, with the two dominant themes being domesticity and medicine.

Starting with the theme domesticity, Ann Oakley is noted in the field of gender, housework and domesticity and it is her work that I use to review this theme.

4.3.1 DOMESTICITY

Oakley (1985) notes in her text *The Sociology of Housework*, that 'women are conspicuous for their absence as data in the sociology of industry and work' (p.19). In areas traditionally considered female occupations such as food and clothing manufacture, retail work, clerical work, teaching, nursing and domestic work there is a lack of available studies on these occupations. Where women in these occupations have been studied it has been part of a study combined with being married. One of the focal questions in these studies women have been asked has been 'why are you working?'. The normative view during this period is clearly expressed as one where women's roles were primarily confined to the home and the marriage. Nursing considered an 'honourable' profession was confined to the hospital and marriage to the profession. This is reinforced by the fact that nurses were not allowed to be married whilst nursing and this status did not change until post world war two (Camslibs, 2004; Bailey, 1968).

Joseph (1994) in the chapter, women, health and nursing discusses the fact that women still experience inequalities in their working lives, and much of this is premised on what characterises woman's work. Ironically, as Oakley (1985) has pointed out the experts who have characterised women's work over time have been predominantly male and therefore, the view of work has not only been influenced by male views, but also examined by male views. How women's work is characterised is therefore against male occupations and their earning abilities. Subsequently the ability to earn a higher income is considered a benchmark for different occupations. An analysis of British households undertaken by Joseph showed that in 1991 women were still fighting for equal pay and that women were the prime owners of domestic work. Looking at New Zealand statistics in the report *Focusing on Women 2005*, a similar situation is noted 'women have the

higher rates of participation than men in all categories of unpaid work, both within and outside the household' (2004, p. 9). Although women's labour force participation had increased from 39% to 60% over the 30 year period (1971-2001), it was still lower than men's participation in the labour force at 74% (2004, p. 9). As can be noted the discussion on labour force statistics for women in both countries was not dissimilar. As the nightingale nursing model and the first trained nurses came from Britain to New Zealand the discussion reflecting labour force work amongst the two countries reflect the shared heritage of both domestic and workforce patterns.

The consequences for women as a result of this view of women's work and domesticity, is embedded in Meilassoux's theory. Women in their reproductive capacity are of value for this very capacity (reproduction) as they provide the means for future labour force production. Supporting this concept James and Saville-Smith (1994) argue that the suggestions around women developing a career, and men taking up domestic duties and child rearing, endangers reproduction of the future labour force and the accepted existing social order (p. 78). Therefore to change the social order is perceived as threatening the means for survival of the human race. Continuing the social order and promotion of the women's role in society as responsible for child rearing and domestic activities subsequently disempowers women in a world perceived by this male sense making.

Subsequent socialisation of girls is based on societal perceptions that have come about through male sense making and Salvage (1985) argues that it is women who nurse or look after sick family members and ill people, whether through the family unit or a larger network, and that 'most nursing continues to happen outside institutions, carried out by women with no special training' (p. 2). Understanding the difficulties on gaining recognition for formal nursing is evident in the conclusion in *Notes on Nursing* where Nightingale proposes the following caution to how nursing is perceived,

“It seems a commonly received idea among men and even among women themselves that it requires nothing but a disappointment in love, the want of an object, a general disgust, or incapacity for other things, to turn a woman into a good nurse. This reminds one of the parish where a stupid old man was set to be schoolmaster because he was ‘past keeping pigs’. Apply the above receipt for making a good nurse to making a good servant. And the receipt will be found to fail” (1980, p. 110).

The link between domesticity and trained nursing becomes evident in the notes written by Nightingale (1980) through her arguments to try and differentiate nursing from domestic duties and her focus on observation and understanding those observations through statistics as paramount to patient care.

“The most important practical lesson that can be given to nurses is to teach them what to observe – how to observe – what symptoms indicate improvement – what the reverse – which are of importance – which are of none – which are the evidence of neglect – and what kind of neglect” (Nightingale, 1980, p. 88).

It is with the refining of her nursing notes in 1882 that Nightingale qualifies her definition of nursing the sick as nursing proper (van der Peet, 1995). Due to these constant efforts to define nursing Nightingale is a well-known nursing theorist and it was through her nursing theory that she was able to differentiate how nursing was clearly different from medicine, but also not subservient to medicine (Selanders, 1993). It was also through Nightingale and the subsequent Nightingale Fund set up to honour her Crimean War efforts that nursing established its first formal training as a profession. However, although the establishment of this formal training provided a start for nursing to become a profession, the social mores of the time also restricted nursing as a profession.

Salvage (1985) argues that even when nursing training was introduced in the mid-19th century it was as a result of meeting the needs of the medical profession rather than through the notion that caring for a patient as a nursing skill should be developed. This line of thinking is further supported through the different New Zealand hospital histories that have been written, where doctors were pushing for nurses trained through the

nightingale system to assist them in their medical duties (Bennett, 1962; Barber & Tower, 1976; Angus, 1984). In a reply to Dr Whyllie, Bellevue School, New York State, in 1872 about how to differentiate nursing training and duties from medical training and duties, Nightingale states 'Nurses are not medical men. On the contrary nurses are there, and solely there, *to carry out the orders of the medical and surgical staff*, including, of course, the whole practice of fresh air, diet etc.' (Nightingale, 1911, 362). Selanders (1993) and van der Peet (1995) have both attributed this statement as being a political response to the time as Nightingale was well aware of the political power of the medical profession. The social context of the period in which Nightingale lived was marked by rapid industrialisation, change and reform, however although this was a time of rapid change, women in Britain were still restricted by gender (Selanders, 1993).

Domesticity as part of the gendered workplace was also evident as the Nightingale training model was established in the New Zealand colony and nurses were only employed if they were 'women of good character' (Macdonald, 1990). However, it is the adaptation to colonial life that strengthens the domesticity role rather than removing it, as nurses in colonial New Zealand initially found work hard to come by and were often employed in governesses or domestic work. Where work was available nurses were required to be capable of a number of duties that extended outside the hospital nursing scope with the domestic component viewed as a natural extension to the nursing role (Maclean, 1938; Orchard, 1997). At this point it is timely to consider the medical influence and how this has contributed to the theory that nursing has evolved through a gendered workplace.

4.3.2 MEDICINE

Both Salvage (1985) and Porter (1997) discuss the growth of scientific medicine during the nineteenth century, however, as Porter notes this growth contributed more to medical knowledge than to actual health improvements. Porter (1997) details the continuing growth of medical

equipment that enabled physicians to build their medical knowledge from the microscope through to the modified thermometer devised by Clifford Allbutt in 1867 and also comments that 'such measuring devices were incorporated into the more enterprising hospitals which lent themselves to routines, had trained nurses and paramedics to take the readings, and were often keen to accumulate data for research' (p. 346). It was during this period of medical technological growth that the Medical Registration Act in Britain in 1858 provided a formally established medical profession (Hardey, 1998). The link with rational scientific knowledge that medicine could offer gave the medical profession authority and inherent in this authority, legitimised power in providing medical care.

As noted before the 19th century was a period of rapid transformation and industrialisation, and these factors were the drivers underpinning the theory on rational scientific knowledge (Stone, 1983). The use of scientific knowledge in a functional manner was viewed by Weber as fundamental to ensuring a stable environment. The stability of these environments was imperative for bureaucratic structures to function (Hardey, 1998). At the beginning of the chapter Weber's different types of authority was discussed as being one of the factors that enable bureaucratic structures to work. The rational/legal authority awarded to physicians and surgeons through legitimizing their registration provided the first step in creating a powerful and autonomous profession that operated in a highly bureaucratized environment. Here we have organisational perspectivism where organisations are making sense of their environment in what has previously been a period of rapid change, and into this mix, the British medical profession as a group are portrayed as a professional authority legitimised by the Medical Registration Act 1858. Hardey (1998) provides a list of characteristics that are associated with what being a profession might include:

'A knowledge base that informs professional practice.

The control of entry to the profession through a long period of training and examinations.

A self-regulating code of ethics.

A professional statutory body that is relatively free of lay involvement.

A professional culture that is orientated to public service and which members usually belong to for their lifetime' (p. 68).

Hardey (1998) points out that it is easy to identify the medical profession as a professional body through the use of these characteristics, but other professions such as nursing do not seem to fare so well. Salvage (1985) argues that nursing was viewed as an extension of the home to enable legitimisation of the caring role. As was earlier noted the comments made by Nightingale in relation to nursing being subservient to the doctors was viewed as a political move to ensure acceptance by the medical profession, 'by presenting themselves as skilled domestic managers, [nurses were] less likely to be seen as a threat to medical power' (p. 5). To make sense of their world, nursing leaders had to shape the world they lived and worked in, as much as it shaped them. Lupton (2003) in reviewing power relations in the medical world notes that nurses are 'far lower in the medical hierarchy than doctors, often treated by both doctors and patients as little more than servants' (p. 131). The other constraining factor for nursing as a profession has been the power medicine has had over nursing education.

Historically nursing education has been a combination of domestic duties that have been overseen by the matron, and limited medical understanding mentored and overseen by the medical profession and it has only been since the 1970s that Nursing has been able to determine its own educational pathway. One of the reasons why this has been the case has been the legacy that nursing is regarded as a resource cost to the hospital. The view that nursing is a cost raises questions around the value attributed to nursing which is examined in chapter nine.

4.4 SUMMARY

Chapter Four provides a discussion of the organisational, historical and gender factors which contribute to making sense of the context that frames this research. Sense-making is not made in isolation and is based on understanding data within a frame of different contexts. In alignment with the theoretical assumption of sensemaking in chapter three and the contextual factors contributing to sensemaking in this chapter, case study methodology is discussed in chapter five. The use of case study as a research design provides a consistent approach with understanding the settings and the context of the participants in this research.

CHAPTER FIVE- METHODOLOGY

5.0 INTRODUCTION

The previous chapters explored the theoretical framework of 'perspectivism' or sense-making and the different contextual factors that influence the sense-making which informs this research. The aim of this chapter is to discuss the case study methodology that underpins and structures the research using an interpretive and exploratory stance. As noted by Stake (1995), who is seen as the seminal figure of this methodology, research questions in qualitative studies 'typically orient to cases or phenomenon, seeking patterns of unanticipated as well as expected relationships' (p. 41). Case study is utilized for this dissertation, as it can provide an in-depth understanding, through the analysis of the two participant groups' narratives, of the outcomes related to the structural positioning and accountability impacting on nursing leadership at senior level in District Health Boards. Decision making processes that involve how care is delivered, impact on patient care and safety. As nursing leaders are perceived to be responsible and accountable for the nursing group within the hospital, and nurses provide for the care of patients, negative impacts on patient care and safety will have adverse consequences for patients, nurses and health care institutions.

Stake (2006) states 'We can use the case as an arena or host or fulcrum to bring many functions and relationships together for study' (p. 2). In this research the case study covers a number of functions and relationships that are interconnected. To understand how the participants make sense of the organizational structures that influence decision making processes that impact on nursing leadership the arena of the case covers two very different participant groups both operating at a senior decision making level. It also includes the myriad of external influences on not only health policy and District Health Boards but also the legacies that the participants have inherited from the past, and may use to make sense of where they are

now. The methodology, using single complex case study accommodates both the inside components of the case, and the outside or external contexts of the case, that enables the researcher to make sense of the data (Stake, 2006).

The single complex case study usually incorporates several research questions. Questions used to inform this study were:

- How are nursing leadership structures configured in the organisational structure of each District Health Board?
- How did these structures come about and, why do they differ across the country?
- How does the pattern of New Zealand structures align with what is known internationally to be best practice?

The research questions are critical to the case as they are the 'conceptual infrastructure for building the study' (Stake, 2006, p. 9). This is exemplified in the above questions where the first question lays the foundation for the study and the next two questions build up the layers of the study.

The logic of case study fits well with the research questions as the data on the different district health boards provides a natural setting for a complex case study of 20 different cases with participant responses bounded both within the individual DHBs and across DHBs to form a quintain. A study of the case entity is referred to by Stake as a 'quintain' pertaining to both the study of the individual cases and collection of cases (2006, p. iv). All data including organisational structure charts, nursing charts, participant responses can be used to inform the different DHB cases to provide both individual cases and a collective case study across the DHBs. This chapter now details the case study methodology used and is structured into four sections: (1) case study methodology and rationale, (2) research limitations and (3) summary.

5.1 CASE STUDY METHODOLOGY & RATIONALE

Lunenberg & Irby (2008) note that case study is a useful methodology for research that may have political significance and Stake (1995) states that 'case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances' (p. xi). The reason for using case study method is that it can 'offer detailed insights into mechanisms, motives of actors, and constraints they face at particular moments which no other method - statistics, experiments, biographies, or even more systematic comparative analysis can offer' (Hancke, 2009, p. 61). As Cresswell (2007) notes cases studies in smaller qualitative studies provide an understanding of the complexities of the case rather than a generalisability that is often associated with large¹¹ qualitative studies.

Case studies are often drawn from multi-disciplinary areas such as law, medicine, social sciences and have as a unit of analysis the study of an event, program, activity or a number of individuals (Cresswell, 2007). Researching leadership requires a multidisciplinary approach as there are two distinct participant groups being investigated that form the unit of analysis of the study. It is important to understand why case study is applicable, and there are three defining characteristics justifying its use in this research.

The first characteristic of a case study is that there are defined boundaries and timescales. In case study research a unique phenomenon is being studied within a particular context over a specific period of time. In this dissertation I am seeking to understand or make sense of the organisational structures that influence decision making processes that impact on nursing leadership within the hospital structure. In doing so the research becomes bounded as the setting is confined to the hospital and the positions and roles are confined to the two senior leadership roles that impact on each

¹¹ Large qualitative studies are usually seen to involve more than 100 participants (Cresswell, 2007).

other, CEOs and DoNs. The time period is also confined within the period of the dissertation, between 2006 and 2012. The use of case study design therefore is enabling in this research as it assists with identifying the unique phenomenon, the organisational structures impacting on senior nursing leadership within the context of the two senior leadership group participants in the hospital setting, over a specified period of time – the dissertation timeframe.

The second defining characteristic is that the case is located in a real world context. In this research both the New Zealand health sector and the District Health Board environment provides a real world context. As the health sector environment within New Zealand is funded and managed by central government it is in a state of continual flux and transformation due to changing political ideologies as a result of electoral outcomes.

Undertaking research within the health sector offers a real world context as the organisations and participants involved in the research provide information and responses that relate to the context of the organisation in which they work. The responses of the participants involve both the internal and external influences on their organisational working world. The combination of the data from the organisational and nursing structure charts and the participant responses is a reflection of both the organisations and the participants' perceptions of what is happening at that particular time. The data are therefore unique to the bounded timeframe but set in a real world context within that timeframe. Sandelowski (2011) offers further support for this thinking in her article "*Casing*" the Research Case Study as she notes that cases are 'constructed' and are never closed during the duration of the case study period, but remain open as new data comes to light. Through being responsive to new information during the case study period a real world context is achieved.

Finally the case has to have a relationship with the theoretical approach to which it is connected. 'Perspectivism' or sense-making has a natural synergy with the case study phenomenon being examined. Understanding

the participant's sense making of their organisation and their relationships provides a way in which we can understand how the organisational structures influence the decision making processes that impact on senior nursing leadership. Case study is used to deconstruct the sense making that the two participant groups undertake to understand the organisational structures that inform their working world (Stake, 1995; Cresswell, 2007; Hancke, 2009) through being able to review each case in detail using both typical and atypical responses to inform the analysis in the research. The ability to deconstruct the data using case study method is noted by Hancke (2009) as a powerful instrument providing rich detail around the causes that may converge with the theoretical approaches. In deconstructing the research data, understanding is gained as to how gender, and in turn legitimacy and authority have had an impact on the organisational structures that influence decision making processes in the DHB workplace and more specifically on nursing leadership. Having discussed the rationale for case study and its applicability to this research it is also important to note that the case study design is a multiple case study.

Stake (1995) uses individual and collective case study design. Individual and the collection of individual cases studies into a collected case are used for complex case studies and referred to as quintains. A single complex case study incorporating multiple individual cases is used in this research to examine how the two participant's roles and positions, Chief Executive Officers (CEOs) and Directors of Nursing (DoNs) relate within the organisational structures. Using this type of case study methodology enables examination of the two participant group's responses not only unique to the 20 District Health Board sites but also across the DHBs. The use of single complex case study design is also fitting as it applies to instrumental case study.

Stake (1995) differentiates between the use of intrinsic and instrumental case study, where intrinsic case study is based on the need to understand a particular case. A potential example of this type of case study in the context

of this research area would be to look at the way a particular nursing leader works within a DHB to promote a clinical governance program. The focus is on the individual and how he or she promotes the program. An instrumental case study covers the need to understand a research question or a puzzling phenomenon where the case study is 'instrumental' in facilitating the researcher to understand other factors. In the context of instrumental case study research, the case study is seen to contribute to the understanding of the broader context. In this research this is seen as the influence of the two participant groups and the DHB organisational structures that impact on nursing leadership. An examination of the DHB cases therefore facilitates an insight or as Stake states "This use of case study is to understand something else" (1995, p. 3).

One of the issues arising from studying a single complex case study is through understanding the possible tensions between the individual case and the collection of individual cases. An example of the tension in this research is when reviewing individual participant responses where the atypical response will highlight the individual case but create complexities for the collective set of cases. Stake (2006) poses the question 'What is more important for understanding the quintain – that one thing is common to the cases or that another is dissimilar among them?' and posits that this becomes a dilemma for the researcher (p. 7). In this research one of the strategies to deal with this dilemma is found in using an indigenous or local sense making as this offers a way of understanding what is particular to the case that can be explained within a collection of cases. Indigenous concepts are discussed further in chapter six.

As referred to in the literature discussion in chapter two, New Zealand research on the organisational structures that influence decision making processes impacting on nursing leadership is limited and this exploratory, descriptive case study provides a baseline of knowledge in the area of New Zealand nursing leadership, which may offer a springboard for further research. Case study methodology is used in the research design as it

covers a variety of data collection techniques that lend themselves to the nature of the research. This research uses a number of data collection methods which include (1) the use of primary and secondary data sources, (2) DHB organisational and nursing structure charts and (3) semi-structured surveys incorporating both interviews and postal/email surveys. The historical, political, economic and cultural perspectives from which the research is drawn, are also well suited to case study method, with information being able to be drawn from primary and secondary source material to explore and examine the background context of the organisation and the roles within the organisation (Hakim, 2000).

Being able to draw on a variety of sources assists with characterising the phenomenon, and as part of collective case study research it is essential to show how the phenomenon is portrayed from different perspectives (Stake, 2006). The phenomenon in this research as stated previously are the organisational structures that influence the decision making processes impacting on senior nursing leadership, and how this is perceived by the different participant groups informs the research. The use of multiple sites enables an increase in the confidence of the data through contextualising similarities and differences in the participant's viewpoints. Hentz (2012) notes that the 'concept of replication is key in multiple case study design' and the 'rationale for multiple case study or collective case study is to enhance the credibility of the findings and its trustworthiness' (p. 365). Comparability is one way in which case studies can be analysed and using comparability is particularly pertinent given the time-bound nature of the case study. One of the ways in which comparability may be noted is through the strategic formal processes of the organisation, as all DHBs collectively, are funded from central government with specific legislative and policy requirements. Comparability is further discussed in the methods chapter on applicability and how it relates to qualitative research.

As noted earlier the ability to use different types of evidence and data collection methods has enabled the use of multiple sources of information.

The survey questionnaire in this study has two components, a demographic component and a thematic set of questions. These questions have been based primarily on the Laschinger and Wong questions used in their nursing leadership profiling exercise in Canada (Laschinger & Wong, 2007). Whilst the Canadian Nursing profiling exercise has primarily been a quantitative exercise, Laschinger and Wong utilised a qualitative questionnaire with both their senior nurses and the CEOs that was used with permission as a base for the qualitative questionnaire in the New Zealand research. The use of this questionnaire is discussed further in the methods chapter and the findings and comparisons are detailed in chapter seven (Data Findings) of the dissertation. The use of the Canadian nursing leadership research in combination with New Zealand District Health Board primary sources has enabled comparisons and this has aided in the generalizability of the data.

Hakim (2000) argues the use of a case study methodology for exploring organisational structures influencing decision-making processes also offers the ability to describe similar characterising features of the relationships involved within the structures, and a subsequent examination of the tensions that exist in these relationships. Overlooking multiple organisational sites that are set up under New Zealand statute, and have the same functions and accountabilities for delivering health care to the New Zealand population enables a contrasting and comparative examination of the top most senior relationships to occur.

Examining contrasting and comparative aspects has also been recognised as useful in the Hecllo and Wildavsky 1974 study of Whitehall in the UK as providing an almost invisible 'co-author' approach to the research through underlining similarities in approaches of the participants while noting key differences in their 'purpose and perspective'. The Whitehall study reviewed the expenditure process practices of British Central Government as well as highlighting the actual operational process (Hecllo & Wildavasky, 1974). Whitehall provided a 'window into the reality of British political

administration' (Hakim, 2000, p. 68). The ability to take a broad perspective through a comparative and contrasting lens, not only of the process practices at a strategic level but also the operational processes enabled the researchers to present a view that was different and provided trustworthiness in the research. Due to my own background and experience within the DHB setting the ability to use comparative and contrasting views has been valuable, although I am mindful that there are limitations which are discussed in the following section.

5.2 LIMITATIONS OF THE RESEARCH

As Hakim(2000) notes, one of the limitations of using qualitative inquiry and case study design is through the diversity and flexibility that allows it to be used in social science research. The subjectivity that is associated with using diversity and flexibility is seen as providing a lack of 'intellectual rigour' through positing the case study as purely descriptive and exploratory research without achieving sound analysis (p. 70). However, as Stake points out 'Qualitative inquiry is subjective. New puzzles are produced more frequently than solutions to old ones' (1995, p. 45). In this research the human participant and researcher element will always contribute to a subjective inquiry. As a qualitative researcher I agree with Stake as the contribution made by case study enables the research to be undertaken in greater depth and the ability to interpret participant responses unhindered by a specific hypothesis.

The purpose of the research is to find out how organisational structures influence the decision making processes that impact on nurse leaders both in their structural positioning and their roles. This in itself will elicit various responses because the individual nurse leaders and CEOs will interpret the survey questions differently. Although subjective inquiry may have its limitations regarding tangible, scientific evidence, its benefits lie in the rich detail and understanding researchers gain from the area of research through the participants. The responses from the participants

help inform me how they are making sense of their working world. It has been acknowledged that one of the areas of concern with such a human interpreted study is in the validation of not only the data but the analysis of the data and this is covered in the methods chapter on how the methodology can be applied in a trustworthy manner.

Researcher bias is another limitation that Stake (1995) calls miscommunication between the researcher and the reader, as research results can be influenced by the researcher's interests and views. To manage this bias I explore the insider/outsider views that impact on interpretation of the data and the subsequent results. As noted in my positioning statement in the introduction this helps me to provide an honest appraisal of my background to the participants and how they understand the perspective from which I am researching. The knowledge that I am also a registered nurse enables a relationship to be formed with the participants through a shared understanding of both the clinical and non-clinical aspects of their working world. To try and mitigate any bias as a result of my insider knowledge the use of the organisational lens and the theoretical framework of sense making provides a counterbalance to the insider view.

The theoretical framework of sense making to explore the research area and analyse the responses provides a way to not only interpret the responses, but also provides a holistic and observable approach that is consistent with case study as a methodology. What might be seen as a limitation in terms of this research is the variability of the size of the District Health Boards. The size of the organisation can impact on the relationships and culture within the organisation. Traditionally and historically health organisations have been structured hierarchically and the larger the organisation the greater the levels of reporting and subsequent different spans of control within the organisation. Over time more informal reporting structures have developed and this has been particularly evident in smaller DHBs. Reasons for this change in reporting

structures range from having a smaller base of staff to carry out the same functions as a larger DHB but not with the same capacity or load, to physically geographical structures being smaller and people being within reach of each other. However, whilst variability amongst the DHBs is viewed as a potential constraint for generalisability, the ability to provide unique case studies becomes a benefit to the research. This has been discussed in terms of the quintain and the tension between the individual case and the collection of individual cases utilising the indigenous or local concept as a strategy.

5.3 SUMMARY

Utilising case study methodology as a research design provides a flexible and creative construct with a bounded timeframe and setting, a connectedness to nursing leadership and sense making theory as well as examining an issue that has implications for the current healthcare context. The research design provides the signposting through case study and the use of a single complex case study framework. The use of instrumental case study enables the research to facilitate an understanding of 'something else' outside of the case, which is harmonious with the theoretical assumptions of 'perspectivism' and sense making. This chapter has covered the methodology and the rationale for using case study as a methodology. This chapter also links chapter three and four with the next chapter methods and provides the connective pathway through which the research has progressed.

CHAPTER SIX - METHOD

6.0 INTRODUCTION

The aim of this chapter is to detail the data gathering and data analysis methods used within this research. This chapter also provides the rich descriptive audit trail utilizing work of Sandelowski (1986, 1993, 2011) and presents the logical pathway that has been followed in this dissertation. The research, as indicated in the introduction, was constructed in three phases. The first phase provides the starting point for understanding each organization through a review of the organization and nursing structure charts. This phase aligns with understanding the formal organizational processes of the District Health Boards and provides the locational context for the participants. Phases Two and Three are aligned with understanding the informal organizational processes of each of the two distinct participant groups. This chapter begins with a research process timeline and is then structured into five further sections: the preparatory stage which includes ethics, choice of case study participants and the recruitment process and its response rates; secondly the data gathering methods; thirdly data analysis methods which included coding and analysis; fourthly the audit trail; and finally the remaining chapter summary.

6.1 RESEARCH TIMELINE

The timeline of the research outlines the key events that occurred during the course of the research. This is presented in table format for ease of reading. The research began with preliminary discussions between March and June 2006 with my prospective supervisor Professor Jenny Carryer which culminated in my enrolment as a part-time PhD student in April 2006.

Early in my candidature the thesis discussions broadened to engage a larger group discussion during the month of June 2006 as a result of the

outcomes of the research undertaken by McCloskey and Diers when they mined New Zealand inpatient data for potential adverse nurse sensitive patient outcomes (refer chapter one for participants). The total period for which the research runs, is from April 2006 through to October 2012. The research has run over six and half years as I suspended research for six months from April 2011 to October 2011 to care for an unwell family member.

Table 6.1 Research Key Events Timeline

Year	Key Event
2006	Preliminary discussion with Professor Carryer, Professor Diers, Dr McCloskey, Dr Wilson and Ms Wood around OPSNs. A potential gap was identified around nursing leadership as one of the factors that influenced effective patient outcomes based on the research from Magnet hospital literature. In addition a preliminary overview of the literature found that there was minimal research linking the organisational context with nursing leadership. The organisational lens was therefore considered as providing a scaffold for this research.
2007-2008	Review of literature, topic identified, key participants identified and provisional registration granted. Laschinger and Wong questionnaire identified as appropriate tool to use for gathering qualitative data with modifications to make it fit the New Zealand health sector context. Letter of introduction (Appendix A) sent to the Director of Nurses informing them of the research.
2009	Ethics approval granted (Appendix B) & Phase 1 data – organisational and nursing structure charts sourced. Information letter sent to all DoNs. Follow up was conducted over a period of three months on a monthly basis where required, to try and ensure a good response

	<p>rate. Approval sought and granted from Professor Laschinger in Canada for the use of the qualitative questions for this research (Appendix C).</p>
2009	<p>Phase 2 data sourced – Information sheet 2 (Appendix D); Consent form (Appendix E) and survey questionnaire (Appendix F) sent to all DoNs both as hard copies and through email. Postage paid reply envelopes also supplied. Consent forms were also included with both mail copies and emails.</p> <p>Follow up elicited one phone survey using the questionnaire. One Assistant Director of Nursing responded on behalf of the Director of Nursing as the organisation was undergoing changes at senior leadership level during this time.</p>
2010	<p>Phase 3 data sourced – Initial discussions with Chair of the DHBNZ assisted me with modifications to the original survey. Chair of DHBNZ¹² kindly offered to send survey out on his behalf. Survey questionnaire (Appendix G) sent out by email with an attached consent form. Two Chief Operating Officers responded on behalf of their CEOs. All respondents returned a signed consent form. In addition a journal article was written encapsulating the Phase One data findings and sent off for peer review and published as Hughes, K. & Carryer, J.B. (2011). Nursing structures in New Zealand public hospitals: current configurations. <i>Policy, Politics and Nursing Practice</i> 12(1), 36-45</p>
2011	<p>Phase one data report journal article (Appendix I) was published in January 2011. Phase two & three survey information was analysed and preliminary findings</p>

¹² At the time of the research District Health Boards were represented collectively by DHBNZ and chaired by Murray Geogel, CEO for MidCentral Health.

	(Appendix H) distributed to all participants asking for any changes or where clarification may have been required. A copy of the peer reviewed journal article for the participants was included with the preliminary findings. One very supportive CEO response was received. During this period there was further analysis of the data.
2012	Research findings analysed and summarised. Writing and rewriting of draft dissertation.
2013	Thesis draft finalised and submitted February.

6.2 THE PREPARATORY STAGE

ETHICS APPROVAL

Formal ethics approval is required for any health research in New Zealand before research can be conducted. Currently there are two bodies for ethics approval dependent upon the type of research being undertaken, the New Zealand national body, Health & Disability Ethics Committee (HDEC) and the associated university ethics committee, in this research, Massey University Health Ethics Committee (MUHEC). The ethics approval process has recently undergone change due to the greater focus on clinical research trials. When I applied for ethics approval research involving participants who were health service staff usually required ethical approval from the HDEC. However, on discussion with HDEC the research in this case was deemed low risk due to the low clinical risk to patients and organisational risk to the DHBs and I was advised to seek ethics approval from the University Health Ethics Committee, MUHEC. On completion of the ethics process MUHEC approval was granted for the research (approval letter appended). The ethics approval was granted for three years from the date of approval (March, 2009), and in all information letters to participants, ethics approval has been signalled. The next section covers the case study participants and the ethics requirements regarding the participants.

CASE STUDY PARTICIPANTS

The case study participants for this research consisted of two groups from each of the twenty (20) District Health Boards' most senior managers, Chief Executive Officers and Directors of Nursing working in New Zealand public hospitals. These positions were chosen for research due to the seniority of their role within the District Health Board. Electing to study these two senior leadership roles also provides a fit for the use of case study as a methodology as the positions and roles are defined.

Sandelowski (2011) argues that case study is 'a spatially and temporally defined entity' and subsequently the case is constructed by the researcher (p.154). To ensure the case study was defined both spatially in location and through time, specific criteria were constructed which included:

- That CEO or COO participants were employed by District Health Boards managing publicly funded hospitals,
- Nursing Management (DoNs) were operating at the most senior decision making position within the public hospital, and
- Only CEO or COO managers and DoNs from public hospitals were invited to participate.

The rationale for using the above criteria for participant selection was based on my understanding that the two participant groups operate in a homogenous environment which can provide similar experiences and views based on their similar roles and responsibilities within the organisation (Lunenberg & Irby, 2008). Patton (1999) states that 'rigor in case selection involves explicitly and thoughtfully picking cases that are congruent with the study purpose and that will yield data on major study questions' (p. 1197). The above selection criteria were therefore used to ensure that the two participant groups represented the most senior decision-making groups, involved in management of the public hospitals. Anonymity and confidentiality of participant responses were agreed with the researcher as part of the research ethics approval. All participants involved in responding to the survey questionnaires were also sent a

consent form which was signed and dated and returned to the researcher. All participants involved in the research signed and returned the form.

As the impetus for this research had originated from the McCloskey and Diers (2005) findings around potential adverse nurse sensitive patient outcomes, the research was limited to Directors of Nursing accountable within the public hospital system. The data from the McCloskey and Diers research was mined from public hospital inpatient data and therefore primary care and private hospital data were excluded. It was appropriate therefore, that the research be undertaken utilising the DoNs and CEOs who held accountability for public hospital performance only.

RECRUITMENT PROCESSES

As indicated in the preceding section the recruitment of the participants was through purposive sampling as the selection criteria were targeted to meet the requirements of the research. A letter of invitation to participate in the research, detailing the research information (Information letter 1 appended) was both emailed and posted to all Directors of Nursing and Chief Executive Officers at the District Health Boards. Participation was voluntary and confidentiality of participants was assured. All information posted to prospective participants was sent on Massey University letterhead. Ethics approval for the research was acknowledged in the letters and emails sent to the participants for phases two and three.

In the first phase of the research organisational structure charts and nursing structure charts were requested. It was acknowledged that organisational structure charts could be obtained from DHB websites as in the majority of cases these were available as public documents. However, nursing structure charts were not publicly available on DHB websites and could only be obtained from the District Health Board through the Director of Nursing.

The first phase provided an introduction to the research for participants and established a communication link between participants and the

researcher. In the information sheet sent to participants my positioning and qualifications to undertake the research were outlined. This was necessary to establish a relationship of credibility with the participants. On all the information sheets the participants were told they could contact the researcher if they had any queries or concerns. The response rates for the data are discussed in the following section.

In the second phase the survey was emailed and posted through to the Director of Nurses with a postage paid self-addressed reply envelope attached. There were approximately 60% email responses and 40% postal responses, which indicated a preference for email. Where DoNs had emailed their responses, they also signed and scanned their consent forms back with the survey response form. Participants who returned their response forms by mail also returned their consent forms attached to the survey in the mail. At all times it was noted that participation was voluntary, with all survey responses kept confidential to the researcher and the research supervisor.

The third phase of the survey was conducted slightly differently with an interview with the Chair of DHBNZ to ascertain the best way to ensure the best response rate participants at this senior management level. The Chair reviewed the survey form and made some suggestions around formatting changes to make the survey easier for CEOs to complete, and offered to act as sponsor to send out the survey through the DHBNZ network of CEOs, in the hope that it would positively influence the response rate. The Phase three survey was emailed out with a brief information letter to all DHB CEOs by the Chair's personal assistant and all responses were sent back to the researcher. All respondents also sent a signed scanned or signed posted consent forms directly back to the researcher. All consent forms have been kept in a locked filing cabinet as required by the ethical approval process.

RESPONSE RATES

Response rates varied within the data collection period and a follow up period of three months occurred. The following tables 6.2 & 6.3 signify the response rates from the three different phases:

Table 6.2 Response Rates for Data Collection

Data Collection Phase	Response Rate (n) Total = 20	Response Rate (%)
Phase One Organisation Charts	19	90%
Phase One Nursing Charts	13	61%
Phase Two Nursing Questionnaire	17	85%
Phase Three CEO/COO Questionnaire	10/19*	53%

*The CEO for CDHB is also the CEO for WCDHB

Table 6.3 Combined DHB Response Rates for Data Collection

Combined DHB Data Collection	Response Rate (n) Total = 20	Response Rate (%)
Phase One Combined Charts	13	61%
Phase Two & Three Combined Questionnaires	8	40%

Further discussion on the response rates is found in chapter seven in the data findings chapter.

6.3 DATA GATHERING METHODS

Data were collected from a number of sources including primary sources, semi structured questionnaires and one telephone interview based on the semi-structured questionnaire. All Director of Nursing participants were provided with a separate form on which they could indicate that they were happy to be contacted by the researcher for further data collection. All participants who responded also provided permission to be contacted further as required.

General data for the background were collected from historical secondary sources, government documents and district health board primary documents. This was necessary to provide a setting for the research. In line with understanding whether the analysis of the data is verifiable or 'fitting' primary source data and secondary source data enable a 'sense' of context to be made of the data. Establishing this contextual environment facilitates the ability to learn from the actual responses in the data, and to be able to view ideas emerging from the data that may converge or disconnect with possible explanations around sense-making (Richards, 2005). The convergence or disconnect of the data provides the typical or atypical explanations that can be analysed within the framework of each DHB case study.

Phase one entailed primary source collection of DHBs organisational structure charts and the nursing structure charts. The first phase of data collection was the construction of an information letter to the participants outlining the purpose of the research and requesting a copy of the most current organisational structure chart or nursing organisation chart. A pre-paid self-addressed envelope was included in the request along with the researchers email to provide participants with options for responding. The requests were mailed to all CEOs and DoNs. A thank you email was sent to the participants acknowledging their response.

The phase one data also elicited a further investigation to make sense of the nursing structure charts. Due to the varied titles outlined on the nursing structure charts, it was difficult to gain a clear understanding of the overall structure. A three month web search in 2008 was undertaken of all advertised DHB hospital senior nursing positions from charge nurse upwards. This was to compare the titles with the roles and accountabilities of the nursing positions to gain a sense of whether the different roles were typical or atypical to the research. The results of the web search are discussed in chapter seven.

In phase two (2009), a semi-structured, open-ended questionnaire was sent to the DoNs across the twenty District Health Boards. Semi-structured questionnaires provide a mix of both structured and unstructured questions that enable the participant to freely answer the questions without feeling constrained. This questionnaire was created using the questions from the Laschinger and Wong study to Canadian nurse leaders and modified to capture demographic as well as thematic data (Laschinger & Wong, 2007). The rationale for using this set of questions was twofold, the Laschinger and Wong (2007) profiling of the Canadian Nursing Leadership study was quite extensive and the qualitative questions used provided a useful base from which to work. Second, the Laschinger and Wong (2007) study also incorporated the Magnet hospital principles as part of their assessment of the Canadian Nursing Leadership profiling exercise, and as Magnet was being used in this dissertation as an international benchmark practice to review how New Zealand nursing leadership structures aligned, using the Canadian qualitative questions appeared appropriate and logical.

Part A of the questionnaire consisted of series of structured responses to provide demographic data while Part B held a series of open-ended questions. This questionnaire was accompanied by a letter outlining the purpose of the research and providing the option of emailing the survey or by sending a hard copy of the questionnaire. This was undertaken over a period of six months with the first round being sent in April 2009 and follow up reminders being sent May and July. One of the questionnaire responses requested a telephone interview and after discussion with the participant this was undertaken using the questionnaire in October 2009. A return date of four weeks was given for returning the questionnaire and pre-paid self-addressed envelopes and the researchers email address was provided to participants to provide options for responding.

Part A of the questionnaire included eight structured demographic questions covering: age, time in current role, time in nursing management role, total time in nursing role, highest qualification, to whom they directly

reported, areas of responsibility and whether they considered the structure of their organisation to be flat, hierarchical or a mixed structure. Part B covered seven semi-structured open-ended questions around the following themes: (1) influencing nursing at a senior decision making level; (2) ability to represent the nursing voice in the organisation; (3) mechanisms used to keep at the forefront of nursing issues; (4) resources required in nursing; (5) communication within nursing and the organisation; (6) any impacts from restructuring on the DoN position that may have occurred or was currently occurring; and (7) the three top priorities for nursing in the organisation.

The questionnaires were physically structured into two parts, with Part A and B on separate pages, and a final page providing an opportunity to be contacted further. As Part A provided structured questions, these were able to be highlighted or circled as to the most correct response for the participant's situation. Part A enabled demographical data to be captured which could later be utilised as a contrast against the Canadian data and also the earlier New Zealand dataset established by North et al (2002). Formatting the survey questionnaire was important with lines provided under the questions in Part B to assist participants in avoiding answering questions with a few words or phrases (Lunenberg & Irby, 2008).

The third phase involved sending out a second modified semi-structured, open-ended questionnaire to CEO's with a follow up interview where the participant indicated they were available. After the initial discussion with the DHBNZ Chair it was agreed the best approach to capture the CEO sample was to send the questionnaire out as a survey with a follow up email and hard copy sent four weeks following the first email. The month proposed for this was February/March 2010.

The questionnaire was attached to the email with an introductory paragraph detailing the purpose of the research and was sent out on behalf of the DHBNZ Chair to all CEOs of the DHB's in March 2010. A follow up

email and hard copy was sent eight weeks later to increase the response return rate. The Laschinger and Wong (2007) questionnaire to the Chief Executives in the Canadian study was also used to ensure consistency in the research approach. This questionnaire was also modified to include a structured demographic component in addition to the semi-structured open-ended questions. The two respondents in the follow up round were recorded as Chief Operating Officer (COOs) responses and included in the dataset. The COO has the role and responsibility for managing the public hospital or provider arm and in four of the DHBs the DoN reported to the COO not the CEO. The COO reports directly to the CEO and is a member of the Executive Management Team and is the most senior management position in the provider arm. However, not all provider arms have COOs.

The third phase questionnaire had eight structured demographic questions that could be highlighted or circled. Part B of the questionnaire contained eight semi-structured questions that covered the following: (1) briefly explaining what their role as CEO/COO encompasses; (2) Explaining the type of relationship that role has with nursing leadership in the DHB or hospital; (3) examining whether their perspective on the DoN role and position has changed and if so how; (4) what they saw as the key priorities of the DoN in their organisation; (5) How did they evaluate the effectiveness of the DoN role; (6) Do they think the current DoN role is effective, and if not what would make it more effective; (7) What did they see as the key priorities for nursing in their organisation and particularly for the hospital and; (8) what information or evidence did they use when reviewing the DoN role.

Unlike the DoN questionnaire, Part B of the CEO/COO questionnaire was designed with boxes under each question for responses. Regarding this change to the format, I was guided by what the DHBNZ Chair thought would be a more accessible format for other CEOs. The rationale given by the Chair was that the box would be more readily received and completed than when viewed as a series of lines. A review of the returned questionnaires

from both phase two and three did not seem to indicate that either formatting style had proved to be a barrier or enhancer to response to any questions. It is to be noted that the completed questionnaires received from the DoNs provided fuller and more complete responses to those of the CEO responses. However, there is insufficient evidence to conclude that formatting attributed to this contrast. Following the email release sent on behalf of the DHBNZ Chair, all hard copies of the questionnaire were sent with either pre-paid self-addressed envelopes or the researchers email address for return responses. All questionnaires in both phase two and three were posted and emailed a participant consent form and all respondents supplied either a hard copy signed consent form or a signed scanned form.

Outlined in the methodology chapter this research is based on using a single complex case study incorporating multiple individual cases. Each DHB became a unique case study with both participants coded to their DHB institution. Primary and secondary sources such as individual DHB annual reports and website information provided additional contextual layers to each DHB case study. The structure chart data and the survey questionnaire responses provided the raw data to each case study building up a picture of each DHB case that provided both typical and atypical scenarios. In addition to this the quintains of the two participant groups forms a cross case analysis adding another layer to the research. This leads me onto the next section of this chapter the coding and analysis of the data, and how patterns may emerge that assist with the analysis.

6.4 DATA ANALYSIS METHODS

CLASSIFICATION OF DATA

Classifying qualitative data for content analysis can assist with the search for patterns and themes within the case or across the cases (Patton, 1990). Although a relatively old reference, the method that Patton offers for use in classifying data is still appropriate and current for the content being used in

this dissertation. Cross-case pattern analysis is used to interpret the data across the different sites to enable the information to be classified into a broad range of themes. Adapting Patton’s (1990) *Case Study layers of Possible Analysis* (p. 385) three layers of case study interpretation have occurred in this research. As noted in the preceding section each DHB makes up a unique case study defined by its location. However within this case study there are the two participant groups that also create two sets of cases defined by their unique groupings, that of being either a CEO or DoN. Finally both of these constructed layers are set within the framework of the New Zealand health sector, but the very political nature of the environment influences the decision making processes that impact on the DHBs and subsequently the CEOs and DoNs. This is briefly illustrated in Table 6.4.

Table 6.4. Case Study Interpretation Layers of Nursing Leadership

Layer	Case Study Interpretation
Base	20 DoN and CEO reflections
Middle	20 District Health Board historical and cultural values
Overarching	Government and overarching national health policy influences

Data for all layers of the cases were drawn from the questionnaire responses and individual DHB primary source documents, annual reports, nursing annual reports where available, website information including newsletters and background information on the Board and the DHB. At the program level cross-case pattern analysis has been used in addition to wider Ministry of Health and health sector documentation and historical data. This collection of information formed the base of raw case data, which was then coded. The three layers have been essential to gain an overall understanding of the cases as both sets of participants did not always respond from the same DHB. Data regarding participation response rates are discussed in chapter six.

CODING DATA

Data from all three phases of the research have been analysed for similarities and differences and connections. This supports constructing the case through the use of typical and atypical responses and assists with providing authenticity of the case study. Data from phase one have been collated onto an excel spreadsheet to track responses and look at similarities and differences in the data. Similarities and differences in the charts have been highlighted through a series of codes. This coding was revisited after the coding of phase 2 and 3 data to look for any emergent or connected themes. Data coding for phase one was also cross referenced against current primary sources such as the DHB annual reports, website information and DHB newsletters that were available and reflected on decisions around nursing positions at a senior leadership level. Coding groupings (Richards, 2005; Hardy & Bryman, 2004) are used to divide the data for all three phases: (1) descriptive, (2) topic, and (3) analytical. As noted by Bennett (2007), aggregating the data into clusters can assist with supporting the themes. Stake (1995) has described aggregating data as the “development of issues” (p.123).

The utilisation of a case record (Stake, 2006) for each DHB has provided a methodical way to organise the data. This has included systematically coding data, placing the information at a level beyond the raw data. All the survey responses have been collated into an excel spreadsheet and divided into two parts. Part A demographic responses have been reformatted and are presented as a series of statistics and graphs that can be used to look at typical or atypical patterns within the data. Part B responses for both phase two and phase three have also been transcribed onto a spreadsheet. The responses have been analysed for similarities and differences in both a textual and contextual manner and have been coded based on any developing issues. Further analysis has resulted in the use of the theoretical scaffolding to evolve an understanding of the data and to further refine any emerging ideas (Stake, 2006; Creswell, 2007).

The twenty organisational case records were then converted into case studies through an analysis of the data and are presented in the data findings chapter. The data findings chapter provides the responses of the three datasets. As discussed in chapter three, strong holism was used in presenting the data and following this in chapter eight, the data analysis chapter used weak holism to capture cross comparison to inform the analysis. Cross case analysis (Stake, 1995; Stake, 2006) has been used to assist with data verification using both sets of questionnaires. Issues identified from cross case analysis have been distinguished through a separate colour code. As noted earlier verification of the data (Stake, 1995; Sandelowski, 1986; Creswell, 2007; McGloin, 2008) has also been supported by the convergence of using existing literature on nursing leadership theory, organisational culture theory and gender theory, primary source documents, and the participant questionnaires. Through methodical cross case analysis using a variety of data forms, typical and atypical responses were identified and verified creating a creditable and auditable research trail. The following section explains the methods that were used to analyse the data and the scaffolding that was created through inductive thinking.

METHODS OF ANALYSIS

The framework for analysis in this thesis is an exploratory framework that has utilised inductive thinking. Patton (1990) describes inductive analysis as “the patterns, themes and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis” (p.390). Although the Laschinger and Wong (2007) qualitative questionnaire have been used to provide a general framework for the survey questions, the analysis of the data has been induced from the participant responses. Concepts that have been used in drawing out patterns and themes are drawn from indigenous, sensitising, researcher-constructed typologies, comparative pattern analysis and logical analysis (Patton, 1990). As the different patterns and themes emerged out of both the secondary and primary research data, two primary themes have

emerged from the broader analytical constructions of the data and these have been formulated around constructs of legitimacy and authority. These primary themes play a critical role in underpinning how the participants make sense of the organisational structures that influence decision making process impacting on nursing leadership and are discussed in later chapters in this thesis. To understand how the two primary themes have emerged as dominant in the research it is necessary to return to the premise of sense making that was discussed in chapter three on the theoretical assumptions.

Making sense of individual identity within the organisation and organisational identity is pertinent as a concept for health professionals and the health sector, as like other institutional organisations they have their own culture and language (Weick, 2001). This culture and language is local to the DHB participants and within the overarching health sector is found in the clinical and management sub-culture and sub-language. The phase one data collection of the organisational structure charts and the nursing structure charts provide a good example of an indigenous concept, as they are local or indigenous to that DHB. The organisational and nursing structure charts provide a unique piece of information that is particular to that DHB. However, when viewing the DHB case studies as a collective group it is equally interesting to see how different components of the charts provide a typical or atypical view of the formal processes of that DHB and how similar or dissimilar the organisations appear.

As noted earlier by Pedlar, Burgoyne and Boydell (2010) the changing environment is influencing how leadership is viewed by both the people working in the organisations and external to the organisation. The constantly changing environment within the New Zealand health sector has continued to provide both leadership structural and style changes (Gauld, 2001; 2009). Decision-making processes are always set into an organisational structural context of why the decision is being made or what thought about the need for a change. Conversely a lack of change may also

be the prompt for decisions. This research in its aim to find out how the structures influence decision-making processes impacting on nursing leadership has included organisational identity as a local concept based on the different vision and mission statements the different DHBs use to individualise their organisations from other DHBs.

I have also applied the sensitising concept of patient outcomes to examine the structures impacting on nursing leadership (Patton, 1990). The use of a sensitising concept helps with identifying uniqueness to the cases in the case study. Patient outcomes are the predominant function for which the DHB structures exist. How the care for patients in hospital is provided may differ due to the number of different variables impacting on patient care e.g. costs, size of the organisation, demographics. However, the critical, singular unchanging element is that the hospital is structured to provide the best possible outcomes for the patient. The organisations (DHBs) and the participants of the case study (DoNs and the CEOs) are linked through this sensitising concept of 'patient outcomes'. Funding for the organisation is based on how patient outcomes are determined and costed and therefore impacts on how the organisation is subsequently structured (Fetter, 1991). The use of the patient outcome concept also aligns with international benchmarking practice on providing effective patient outcomes as illustrated by the Magnet hospital characteristics.

The use of a sensitising concept comes from the inclusion of my understanding or sense of the area I am studying. As indicated earlier I have both a clinical and management background and have worked in the health sector, this has given me a set of reference points I can look to for directions (Patton, 1990). My current role teaching in health services management reaffirms those reference points. The health sector setting still primarily comprises government organisations that are managed in a historically bureaucratic manner from the Minister of Health, Ministry of Health through to the District Health Boards and the public hospitals that are registered as their 'provider arms'. Bureaucratic structures and the

provision of patient care present an uneasy mix of tensions between 'efficient' care and 'effective or best practice' care resulting in quality patient outcomes. The dominant political discourse in health becomes a reference point that veers towards a number of directions impacting on the hospital environment, and in particular the nursing environment within the hospital setting. This was evidenced in the introduction outlining the change to the leadership and management structures in the public hospitals in the 1990s with the introduction of the Gibbs report recommendations (Gibbs, 1988; Upton, 1990). The loss of nursing leadership as a result of the changes during this period impacted on the ability of hospitals to provide safe patient care. The evidence provided in the literature on the Magnet hospital programme, see for example, (Aiken et al, 2001; Laschinger et al, 2007; Armstrong, Laschinger & Wong, 2009) indicate that having effective and empowered nursing leadership in hospitals is critical to achieving quality patient safety and care.

Patient outcomes as a sensitising concept has also provided a point of reference for exploring researcher-constructed typologies that have been derived from issues emerging from the data. Areas of accountability, authority, role legitimacy, financial management and budget holding have transpired from the data as common types of issues. Comparative pattern analysis has also provided evidence that the above typologies are common to not only the case study DHB sites but across the DHBs as a national study. The use of these categories also connects with comparative pattern analysis because the health sector has common variables that can be compared. These variables are driven by Ministerial strategies at a national level e.g., increasing clinical leadership across the DHB has a consequential influence on clinical governance. Additionally, historical traditions associated with 'the hospital' as an institution have also provided relevant information when assessing comparative patterns within DHBs and the structures influencing decision-making processes that have been undertaken at a senior management level. This is further explored through

historical literature and the impacts of the gendered workplace on current nursing culture in the analysis in the discussion chapter.

The logical analysis of the cases is undertaken through the use of two sets of evaluator-generated constructions that are inter-connected (Patton, 2009). Evaluator-generated constructions are evaluation tools used to assess and analyse the responses from the survey questionnaires. The first construction is taken directly from the questions in the final report on *A Profile of the Structure and Impact of Nursing Management* by Laschinger and Wong which appear in Appendix B & Appendix C of their 2007 report (Laschinger & Wong, 2007). Responses to this questionnaire are drawn around six specified areas: (1) succession in nursing leadership, (2) ability by DoNs to influence the Senior Management Team, (3) organisational structure on the quality of the work environment, (4) the span of control under nursing leadership, (5) good working relationships and (6) being adequately resourced to perform the work.

The second construction used to evaluate the questionnaire responses is based on the founding principles established in the American Nurses Association Magnet Recognition program. Over time the model that has been used to assess the “forces of magnetism” in hospital credentialing has been refined, and the current model encompasses the following five model components: Transformational leadership; Structural empowerment; Exemplary professional practice; New knowledge, innovation, & improvements; Empirical quality results

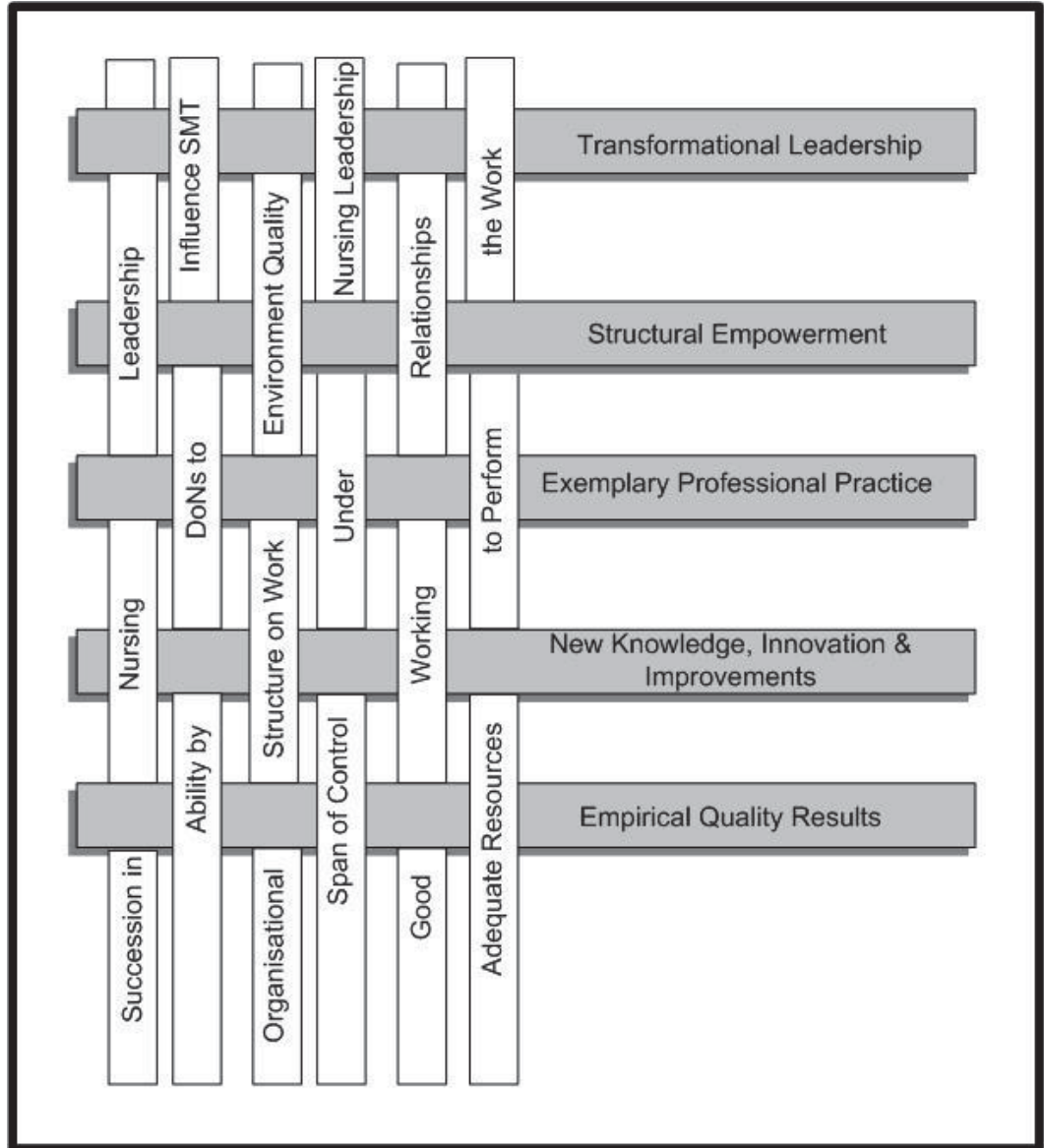
<http://www.nursecredentialing.org/Magnet/ProgramOverview/NewMagnetModel.aspx>.

Both the Laschinger and Wong (2007) adapted questions and the Magnet hospital components provide the framework from which to draw interconnected evaluations of nursing leadership. To ensure I have captured the evaluation criteria I have constructed an interconnected model to review the responses from the survey questionnaires. Diagram

6.1 purposefully weaves the two components together to highlight the interconnectivity.

Reviewing the six Laschinger and Wong strands it can be seen that all of these six strands are required to achieve the five magnet outcomes. Being able to plan for, promote, train and retain good successive nursing leaders that can influence the Senior Management Team (SMT) is critical to provide a good organisational work environment. Within the boundaries of providing a working environment that fosters excellent patient care spans of control have to be carefully monitored for nurse burn out, staff retention, and appropriate skill mix. In addition to this, communication is vital to collaborative working relationships and being able to ensure the appropriate resources are attained. Having these six strands in place provides the transformational leadership that is required for an empowered nursing workforce that will deliver exemplary professional nursing practice. Empowerment is evident where there is the ability to influence SMT and subsequently provide a good working environment. The communication skills of a transformational leader are critical in empowering nursing which results in a professional nursing practice that is responsive to change and new knowledge and ultimately delivers quality empirical results that evidence excellent patient outcomes. It is by utilising the interconnected constructs detailed in Diagram 6.1 that the data findings were analysed and will be discussed in the data analysis chapter. Following on from diagram 6.4 it is timely to consider the audit trail of the research method.

Diagram 6.1. Inter-connected Magnet Hospital Components (Horizontal axis) and Laschinger & Wong Evaluative Constructions (Vertical axis)



6.5 AUDIT TRAIL

The audit trail provides the reader with a sense of trust in the process and enhances the credibility of the research. Holliday (2007) argues that trustworthiness is found through the ‘need to tell the reader of the research the rationale for the choice of social setting, choice of research activities, choice of themes and focuses, the dedication to and thoroughness of the

fieldwork and overall a need to articulate a judicious balance between opportunism and principle' (p. 9). Sandelowski (1986) discusses and expands on the four elements of the 'truth-value' model proposed by Lincoln and Guba (1985). In this model four elements are considered necessary to provide credibility in qualitative research; truth-value, applicability, consistency and neutrality.

TRUSTWORTHINESS

Sandelowski (1986) argues that the truth-value of qualitative research lies in its credibility and this is achieved when the study 'presents such faithful descriptions or interpretations of human experience that the people having that experience would immediately recognise it from the descriptions or interpretations as their own' (p. 30) There are two ways for checking whether 'truth value' is apparent and these come from peer review where the researcher has the phenomenon reviewed by peers, and secondly, validating the findings through participant review. These two methods enable the researcher to check that the findings are grounded in 'truth' and not imagined (McGloin, 2008).

However, in a later article Sandelowski (1993) notes the difficulties with 'member validation' as both the researcher and the participants 'are concerned with staking certain claims, with maintaining certain personas and frequently have divergent interests and goals' (p. 4). There becomes a certain tension when using member validation as the members seek to see themselves in 'their own reality' whilst the account of the researcher has to encompass multiple realities that still manage to portray the participants view. In this dissertation several approaches have been used to establish the truth value or credibility. Phase one data were published in a peer reviewed journal which is appended at the back of this dissertation. A preliminary summary of the data went to all participants seeking feedback on phase two and three findings. A positive response was received from one DHB CEO indicating they were interested in receiving the final report.

As noted in the discussion by Sandelowski (1986) there have been several methods used to assess the trustworthiness of the data.

Trustworthiness was used to verify the data through a process of reviewing counter patterns and convergences in the responses of the participants through the survey questions (Lincoln & Guba, 1985; Sandelowski, 1986; Sandelowski, 1993). As part of the initial verification both the DoN's and CEO's survey responses were reviewed against each other for similarities and differences in their responses. Congruence of the questionnaire data against the main supporting themes from the existing literature that supports current nursing leadership theory was also utilised where typical and atypical elements were identified. In addition DHB annual reports, website newsletters and Ministry of Health documents were reviewed to validate or support where applicable, the responses made by the participants for each of the DHB's.

A response sheet summarising the data was sent back to the participants following a preliminary summary of the survey questionnaire data for comment to ensure the researcher had captured the responses accurately (Appendix F). The response rate from sending out the preliminary summary was poor with only one out of ten CEO respondents replying and no responses from the DoNs. On a positive note the response from the CEO indicated that the research was very well received and they were looking forward to the final report. Anecdotally at Health Roundtable conferences I attended in the last two years I have met up with a number of the DoNs at these events and the response to the research has always been favourable. My impression as a researcher has been that the DHB DoNs are interested in the research but their current operational workload precludes them from being involved in anything other than the day to day running of their clinical domains, and more specifically anything that is going to impact directly on the current nursing workforce and patient load.

Another way in which to establish credibility is in researcher positioning so that participants and peers understand the background and positioning of the researcher. In this dissertation I have established my positioning as a researcher in the introduction to lay the ground work from where my knowledge base and interest in the research has arisen. My nursing and broader health policy background provides me with an insider's view that assists with interpreting the data. However this insider view is tempered with the methodological approach of organisational sense making, and the use of case study method to ensure that the research is robust and critical. I have also indicated in the information sheet and any discussions that I have had with the participants my background and positioning as this has helped establish my credibility as a researcher in the health field.

APPLICABILITY

The second concept, applicability or some use the term replication, is the level of generalisability of the findings to other findings of a similar inquiry. This use of applicability has created quite a lot of debate around generalisation in case study (Stake, 1995; Yin 1981; Yin, 1999). McGloin (2008) states in the beginning of her article 'the purpose of the study is not to generalise data to a broader research sample, but to generate theories' (p. 45) and Yin (1999) poses that case studies are not 'theory driven' but are 'driven to theory' (p. 1212). However, due to the exploratory qualitative nature of this research it is the views of Stake and Sandelowski that are the most applicable. As Stake (1995) notes qualitative research is about 'understanding the complex interrelationships among all that exists' (p. 37).

Stake differentiates between 'petite' generalisations and 'grand' generalisations and notes that as the research progresses what appears at first as a generalisation may need to be refined (1995, p. 7). In this research an example of a generalisation is that all DoNs work at the DHB. As a broad generalisation this is primarily correct, however, there are distinctions to be made which become evident in the research. The first

distinction is in setting up the case study and applying the bounded characteristic, DoNs can also be employed by the DHBs in Primary Health responsible for the primary healthcare setting, in addition there are DoNs also employed in private hospital settings. For the purpose of this research the DoNs being asked to participate within this research are those employed by the DHB and accountable for public hospital nursing. The use of the survey for responses can also provide some grand generalisations as respondents reply to a question that can be linked into a central government policy directive, an example being around nursing workforce as a key nursing priority for the majority of the respondents. It is the use of other primary data such as annual reports and web or newspaper reporting coverage that can be used to provide convergence on the topic of nursing workforce within the individual context of the case. Interpreting the responses of both the CEOs and the DoNs also provides the modification to the generalisation, which as Stake (1995) notes provides the variability of the case.

Sandelowski (1986) also posits that 'generalizability is something of an illusion since every research situation is ultimately about a particular researcher in interaction with a particular subject in a particular context' (p. 31) at a particular time and in a later article debates whether replication of a study can be truly achieved due to the changing configuration of elements that occur within qualitative enquiry (Sandelowski, 2011). Applicability is about the 'fittingness' of the research findings, where the researcher needs to provide both 'typical and atypical elements' that fit into contexts not only within the study situation but also outside the study. Finally the findings 'fit' if the audience of the research find them meaningful (Sandelowski, 1986, p. 32). In this dissertation the wide use of primary sources such as historical accounts and DHB and government reports supported by secondary texts provides verification of the research data through a convergence of the information. Both typical and atypical elements of the survey responses are substantiated through other government documents and supported by not only the methodological

analysis but also through historical contexts found within both primary and secondary texts. This use of typical and atypical elements is particularly noted when reviewing the participant responses, as in a number of cases there was an atypical response from the other responses around certain questions. The responses are discussed in detail in chapter seven, the data findings chapter. Following on from how the case study methodology can be applied to provide both trustworthiness and applicability when using and interpreting the research data is the need to lay down an audit trail so that the findings of the research are viewed as auditable.

CONSISTENCY

The consistency of a study is about reliability and providing a clear and logical trajectory of how the study began, what it covered and where it finished. The rationale for the study in the introduction and the literature review in this dissertation provide the starting point for the research. The findings from the McCloskey and Diers (2005) study and the Carryer et al (2011) research are the catalyst for this research. The theoretical framework of sense making and 'perspectivism' provide the interpretive scaffolding being used within the parameters of case study. The use of this interpretive approach and case study methodology covers in a consistent fashion the way in which the data has been explored and examined and is the progression from chapters five through to eight. Utilising the international benchmarking indicators from the magnet process and the conclusions from the qualitative component of the Laschinger and Wong study provides a way in which to examine the data supported by narrative evidence from primary and secondary texts. Chapter nine provides the discussion chapter and indicates potential answers to the three research questions and where the research finishes and what should happen from that point onwards. The dissertation is structured to provide a logical and consistent progression through the research process.

NEUTRALITY

The fourth element, neutrality, is ensuring that the findings are a result of the study and the participant responses and not due to other biases and perspectives outside of the study (McGloin, 2008). This is also seen as 'confirmability' of the data and its findings and is about emphasising the 'meaningfulness of the findings by reducing the distance between the researcher and the subject' (Sandelowski, 1986, p. 34). An example of a lack of neutrality in this research would be to include perceptions from other professional groups that were not outlined as pertinent in this study.

Interviewing physiotherapists or social workers on how they made sense of organisational structures around nursing leadership would not be appropriate in the context of this particular research. Their worldviews would bring a bias into the research that was evident of how they have made sense of the organisational structures influencing decision making process impacting on nursing leadership but not of how the two participant groups, the DoNs and the CEOs have made sense. The inclusion of these groups would create a sense of detachment rather than engagement with the research material and would only be relevant if the research question was focussed on interpreting how others have made sense of the decision making process impacting on nursing leadership. This would follow a different interpretive research path and therefore is not useful to this research.

The rationale for focusing on nursing leadership and sense making and not including other health practitioners in this research is that nursing is the sole provider of 24 hour care, 365 days a year and has the ability to have one of the greatest impacts on patient care. Using the benchmark of Magnet, nursing leadership is critical in empowering nursing to achieve excellent patient care so it is on nursing leadership that the research is focussed. Exploring the structural influences on decision-making processes between the CEOs and the DoNs of the District Health Boards provides a way of looking at senior management processes that impact on the delivery of health care and consequently the safety and care of patients

within the public hospital system. As noted in the introduction the focus on the role of nursing leadership has been justified with the increasing adverse events that have been recorded in the public hospital system (McCloskey & Diers, 2005; Carryer et al, 2011). Through reflecting on the origins of the research and the research questions using the process of reflective practice neutrality of the research is maintained. Being aware of your own consciousness while observing, interpreting and analysing the data is using reflective practice (Stake, 1995) which I have utilised throughout the research.

6.6 SUMMARY

This chapter outlines the technique and processes used to conduct the data gathering and analysis processes in a manner congruent with the methodology. It builds on both the theoretical assumptions in chapters three and four and the methodology in chapter five. As indicated in the introduction the chapter indicates not only the natural progression of the thesis, but also the evolution of the research and offers an auditable trail of how the research was conducted. In providing the method by which research is being undertaken, the method chapter offers the guidelines and validation that is required to ensure the research is robust.

'Perspectivism' and sense making provide the theoretical assumption that underpins this thesis and the use of case study methodology supports this approach through providing a rich, contextual and layered understanding of the research data. An interpretive and exploratory approach has provided the foundation using a wide variety of data to assist with this process.

The twenty New Zealand District Health Boards are the cases and their CEOs/COOs and the DoNs provide the data for the cases that form the basis for this research. The discussion in this chapter around ethics processes, selection of case study participants, recruitment processes, response rates,

instrumentation and data collection and data coding and analysis provide a clear trajectory of how the research was conducted. This pathway has been systematically and methodically pieced together to form a coherent narrative. Purposefully selected case study participants, survey questionnaire responses and interview responses, secondary and primary sources of data are explored and analysed through a framework of thematic analysis and evaluative constructions using Magnet components and the Canadian leadership study questionnaires. The different layers of data that add depth to each case study assist with ensuring the data is trustworthy, applicable, consistent and neutral. Following on from this chapter, the data findings from the three data collection phases will be examined.

CHAPTER SEVEN-FINDINGS

7.0 INTRODUCTION

Chapter Seven provides the findings of the three different research phases. Following a discussion on the data findings, the next chapter will qualitatively analyse the data. The chapters have been structured in this manner because of the mix of numeric data in phase one and qualitative data in phase two and three and the difficulty in analysing this mix of data to support an inductive qualitative approach. The first phase covers the preliminary analysis of the District Health Board (DHB) organisational structure charts and nursing organisational structure charts. In the second and third phases I report on the responses of the semi-structured questionnaire sent to the Director of Nursing (DoN) and the Chief Executive Officer (CEO) at the New Zealand District Health Boards.

The original target was to engage forty two case study participants to be organised into twenty-one distinct DHB case studies. During the course of the research restructuring of several District Health Boards occurred including some amalgamations. Otago and Southland DHB have been amalgamated as Southern DHB with a single CEO and DoN managing both areas, and West Coast DHB has now come under the CEO management of Canterbury DHB. A number of changes have also occurred amongst the DoNs in the different regions. As in the case of the amalgamation of Otago and Southland DHBs the DoN position was reduced from two to one, however, an executive DoN positions were established with Director of Nursing positions created to support the southern districts. The head count for the DoN sample thus became 20. Restructuring or reorganisation that led to a change in the DoN positions in the following DHBs, Hawkes Bay, South Canterbury, Waikato, Whanganui, Nelson/Marlborough and West Coast. The District Health Boards have been named here as this information is available in the public domain. These changes resulted in a

potential target of 20 DHB case studies with 19 CEO and 20 DoN participants.

The chapter begins with the Phase one findings on organizational and nursing structure charts and progresses onto Phase two, the findings from the nursing questionnaire surveys. Following on from phase two, the findings for the phase three CEO questionnaire survey results are presented.

7.1 PHASE ONE DATA FINDINGS

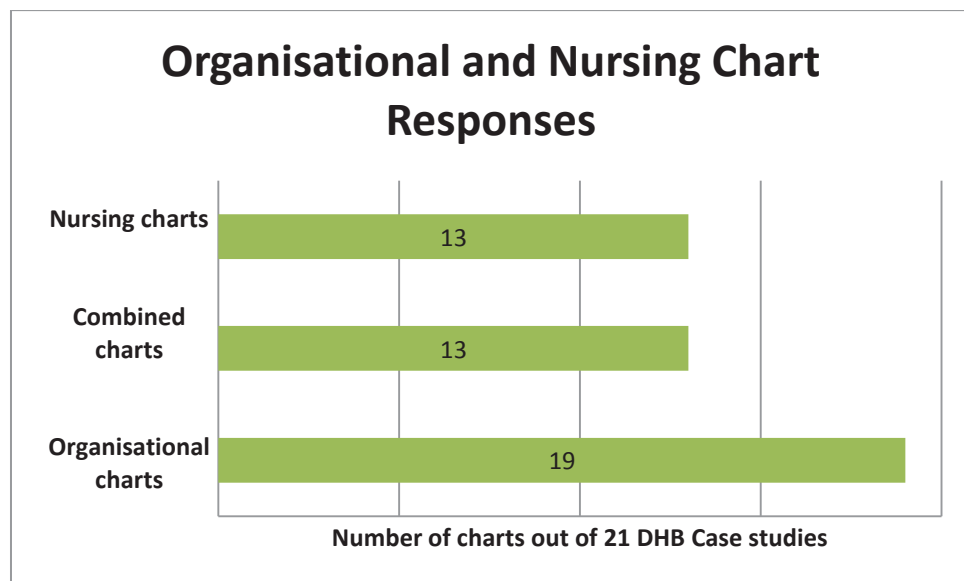
As noted in the methods chapter a letter of introduction and an information sheet were sent to the DoNs during the course of 2007 and 2008 asking for both the DHB and nursing organisational structure charts. The organisational chart was requested to establish lines of reporting and in particular at what level the DoN reported and to whom. The organisational structure charts also helped me identify what types of organisational structures the DHBs could be classified as, and whether they were different or similar.

The nursing organisation charts were requested to also review similarities and differences of the nursing structure between the DHBs. The preliminary analysis of the nursing structure charts provided such a myriad of nursing positions on the charts that further investigation was required. To clarify the differently titled nursing positions found on the nursing structure charts, a review of all advertised senior nursing positions over a three month period was undertaken during 2008. This exercise was essential to establishing some common attributes of the differently titled nursing positions to make sense of the levels of accountability and reporting. The results from this review are reported on in section 7.1.3.

7.1.1 RESPONSES

The response rate following two reminders was 72% and with further follow up phone calls the phase one data collection was brought up to 19 of 21 (90%) DHB organisational charts and 13 of 21 (61%) Nursing structure charts. Both sets of charts were obtained from 13 DHBs (61%). Graph 7.1 shows the breakdown of obtainable chart data.

Graph 7.1 Organisation and Nursing Chart Responses



The response rate was good although it is noted there were fewer nursing structure charts sent through than organisational structure charts, and one follow up email elicited the response *'that the organisation was currently reviewing nursing and there was no formal nursing structure chart available'*. This observation is not meant to generate either a negative or positive value judgement, as structure charts are a mechanism for identifying the formal structures in place within the organisation and can be useful when people working in the organisation or communicating from outside the organisation need to identify who the best person is they wish to contact based on the titled positions in the organisation. Not having a formally identified structure chart is not necessarily symbolic of being disorganised, nor does it suggest a lack of formal structure within the organisation. The reasons for using or not using organisational charts will be discussed further in the analysis in chapter eight.

7.1.2 FINDINGS

New Zealand DHBs are governed by two major acts, the New Zealand Public Health & Disability Act (2000) and the Crown Entities Act (2004). The New Zealand Public Health & Disability Act (2000) sets out the legislated framework for providing both personal and public health services and how the services are funded (NZPHDA, 2000, Sec. 3). The Crown Entities Act provides the framework and governance for all New Zealand Crown Entities including DHBs (CEA, 2004, Sec 3). However, CEOs are mandated to manage the DHB as the DHB Board is enabled through the Crown Entities Act (2004) Section 73 (1) (b) to delegate authority to an appointed CEO, and it is through this legislative mechanism that the CEO sits as the head of the organisational structure chart for the DHBs. With this in mind it is not surprising that the majority of both organisational and nursing charts available for review indicated a hierarchical structure within the organisation headed by the CEO.

The five key points that emerge from the phase one data indicated the following:

- Not all of the DoNs have a direct reporting relationship with the CEO.
- Few or no clear relationships were seen between nursing structure charts and DHB organisational charts.
- On the organisational structure charts there is no clear depiction of how nursing is financially accounted for the delivery of care and the nursing staffing within the organisation.
- The lines between operational and professional accountability were not clearly identifiable.
- The charts all presented completely different organisational and nursing structures operating in the New Zealand public hospitals.

NOT ALL OF THE DONs HAVE A DIRECT REPORTING RELATIONSHIP WITH THE CEO

During the period of the phase one research it became evident that three of the DoNs were positioned within the provider arm (hospital) and reported

to the hospital General Manager (GM) or the Chief Operating Officer (COO) and one DoN was reporting to both the CEO and the COO. This meant that the DoNs working at this level were one step removed from reporting to the CEO or had a dual reporting line. The sixteen remaining DoNs reported directly to the CEO and were often part of a clinical advisory grouping that encompassed not only nursing activities within the hospital, but nursing activities that covered the entire DHB. I revisited the direct reporting line data between DoNs and CEOs in 2011 due to the substantial changes that had been occurring in the health sector and found that the number of DoNs reporting to the CEO was now 18 out of 20 which indicates that the DoN reporting to the CEO is clearly a typical reporting line.

Utilising Stake's quintain or collection of cases it can be seen that a generalisation found in all the organisational structure charts was that through legislative requirements the DHBs were managed by the CEO and this represents a typical scenario within the DHB. However, although the reporting of the DoN to the CEO as a direct report was typical in sixteen of the DHB cases it was an atypical scenario in four of the cases. Even after revisiting the reporting line between CEO and DoN in 2011, two of the DHB cases that were identified as atypical in the 2008-2009 remained at this status in 2011.

Further to reviewing the charts it was noted that in several of the larger hospitals there were executive DoN positions who reported to the CEO and assistant DoNs or DoNs who reported to the GM/COO with regard to the management of hospital services. It is therefore evident that there are two levels of Director of Nursing positions amongst the DHBs, dependent on the size of the organisation. It was also noted that whilst the DoNs that reported to the CEO were in most cases part of the senior leadership team and senior executive team, in two of the case studies they were not part of the senior executive team, which differed from the senior leadership team. Understanding the different levels of reporting is important in determining

the authority that the position of the DoN holds, and this will be further discussed in the analysis chapters.

FEW OR NO CLEAR RELATIONSHIPS WERE SEEN BETWEEN NURSING STRUCTURE CHARTS AND DHB ORGANISATIONAL CHARTS

A review of the DHB organisational structure charts showed evidence of divisional reporting lines and the division of labour. The public hospital was also identified as the provider arm of the District Health Board. Whereas nursing structure charts also had their own set of nursing reporting lines and division these were not easily mapped onto the organisational divisions. What was apparent was a sense of disconnection, not only between the organisational charts and the nursing structure charts, but also the variations between the nursing charts themselves. Within the thirteen organisational case studies where both the organisation and nursing structure charts were available, there was very little information to say how they were related to each other. Information drawn upon to look for relational similarities were position titles and areas of work. Seven of the thirteen charts indicated that they had similar clinical areas in which nurses were deployed for work in similarly constructed clinical areas highlighted in the DHB provider arm section. The relationship between the nursing division and the overall organisation may differ in the informal setting.

The formal organisational charts in their current visual format did not show any clear evidence of where the nursing workforce was located as a profession. This provides an ambiguity when looking at formal structure charts as the clinical hospital setting covers all professional groupings without clearly defining where those groups are located and reflects an assumed knowledge of hospital divisions of labour and work. Given that the nursing workforce accounts for more than half of the entire health workforce working in the hospital setting in DHBs it is surprising that such a large professional group is invisible within the organisational structure. The lack of connectivity that was within the same organisation, between

the organisational structure and the nursing structure charts would also appear to indicate that nursing as a group is functioning in a silo within the organisation and invisible to the rest of the organisation structurally. This was the picture presented in 61% of the cases.

ORGANISATIONAL STRUCTURE CHARTS HAVE NO CLEAR DEPICTION OF HOW NURSING IS FINANCIALLY ACCOUNTED FOR WITHIN THE ORGANISATION

On both the organisational and nursing structure charts it was very difficult to determine whether nursing had any financial or budget accountability, responsibility and authority. In the majority of organisational charts clear linkages with nursing as a division were not depicted and within the nursing charts there were only three linkages to the financial services of the organisation. Overall nursing appeared to be invisible within the formal reporting lines and similarly financial reporting and budgeting was primarily invisible within the nursing structure. One assumption through the organisational charts would be that where the DoN was sitting within the senior or executive leadership environment a relationship was automatically assured with the Chief Financial Officer (CFO) as they were on the same team. However, this was not explicit and again further analysis needs to occur within the informal setting and this is undertaken in the following chapter.

THE LINES BETWEEN OPERATIONAL AND PROFESSIONAL ACCOUNTABILITY WERE NOT CLEARLY IDENTIFIABLE

The benchmarked standard of nurse to nurse reporting found in Magnet hospital processes (Aiken, Clarke & Sloane, 2002; Armstrong, Laschinger & Wong, 2009) highlights the ambiguities that were common in the DHB case studies. Nurse to nurse reporting is one of the characteristics that is identified in magnet accredited hospitals. Nurse to nurse reporting indicates evidence of an empowered work environment that is seen as one of the contributing factors that assists with the retention of nurses and as a result quality patient outcomes. In the majority of cases studies there was very little indication on the organisational structure charts that nurses

reported to nurses. On the nursing structure charts there were two lines of accountability depicted, a professional and operational line of accountability. Whilst it was clear that the professional line of accountability was nurse to nurse reporting, the operational line of accountability did not have similar clarity. Operational managers may have had clinical backgrounds but were often not required to hold a current practicing certificate or to be clinically current in their work field. Often where operational managers are appointed a health professional background is desirable but not essential. In the current political and economic environment with the introduction of generic management as a style of management this depiction of the organisational charts is typical and reminiscent of the health environment resulting from the problematic changes in the 1990s.

The issue raised by the dual reporting of nurses to both a professional nurse manager and an operational manager, is the impact this has on their authority and legitimacy to undertake their work. Eight of the 13 nursing charts clearly depicted dual reporting lines. There is a blurred inference between when professional work is operational work and vice-versa and this also has implications for which position holds the higher authority. Within the nursing structure charts there was an indication that nurse to nurse reporting occurred between registered nurses and the charge or unit charge nurse. However, beyond this level of reporting it is very unclear whether the charge nurse is in a nurse to nurse reporting structure for both operational and professional matters. The dual reporting system does not offer a clear understanding of who is accountable and how this accountability is defined. At what point does operational work become professional work, or professional work become distinct from operational work? The dual reporting of nursing lacks clarity and is ambiguous as it does not enable nurse leaders to have nursing line authority.

The Director of Nursing office focus appeared to be dominated by the following functions: nurse education and professional development

including graduate nurse programs with some of the areas also covering patient flow, bed management and infection control. Where the DoN was situated within the wider DHB often the role was linked into functions such as 'clinical leadership', 'clinical governance' and being part of the 'corporate group' the DoN position was also often under the umbrella of an advisory role. This has implications for authority and raises the question as to whether an advisory role carries a mandate for decision making.

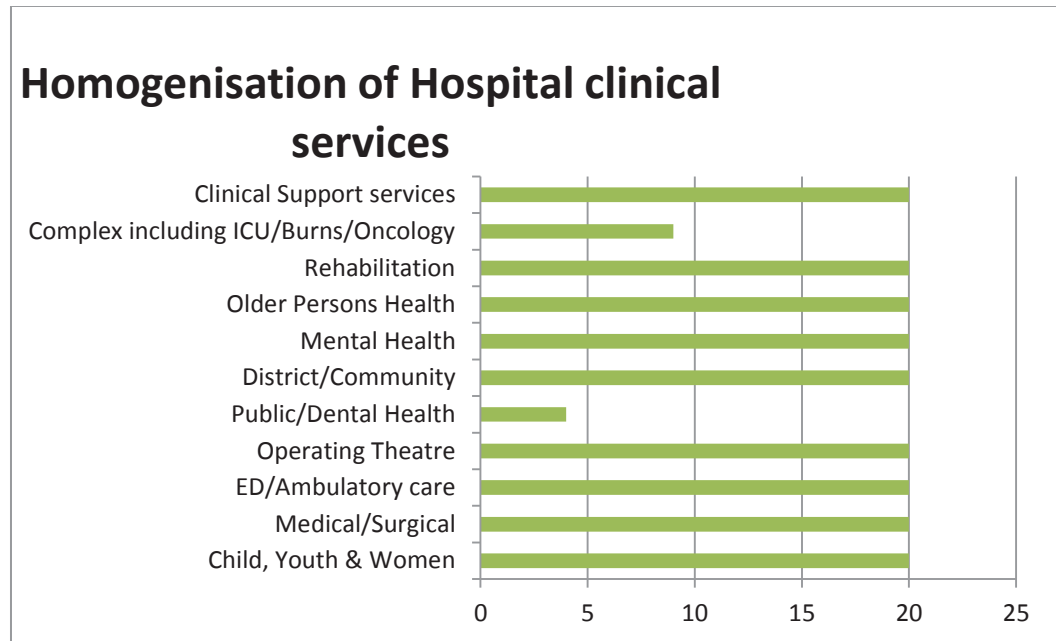
Alongside the ambiguities that occurred in not being able to determine clearly the nurse to nurse reporting there was also the issue of nursing spans of control. In four of the thirteen nursing charts there was a sense of nurse to nurse reporting throughout the nursing structure, but overall there was no clear sense of to whom the nurses reported beyond the charge nurse position. The nursing structure chart also only contained information that was related to nursing reporting and did not include ancillary people, whilst the organisational structure chart did not have the depth of detail to indicate spans of control for any of the hospital clinical divisions. Only one DHB case study had a proposed plan for a nursing structure that included the span of control for which the nurse would be responsible, however this plan was only a proposal and I have been unable to source any follow up information due to a restructuring of this DHB.

THE CHARTS ALL PRESENTED COMPLETELY DIFFERENT ORGANISATIONAL AND NURSING STRUCTURES OPERATING IN THE NEW ZEALAND PUBLIC HOSPITALS.

As indicated in the preceding discussion the organisational structure charts provided some similar characteristics in that the provider arm was evident on the structure charts, and within the provider or hospital arm there was an indication of how the hospital was structured in terms of its division of work. This has been achieved through overlaying the DHB organisational charts to find common terminology that indicates a common or similar work structure. A review of the hospital clinical services provides the most common grouping or cluster of similar terminology. As can be noted the

graph below represents the current twenty DHBs as when this data was being analysed Southland and Otago had amalgamated as Southern DHB. Graph 7.2 presents the homogenisation of the DHB organisational work groupings.

Graph 7.2. Homogenisation of Hospital Clinical Services



As can be noted from the graph the data indicates a high degree of homogenisation within hospital service provision. Where the differences are noted are in the areas of complex acute care such as ICU, Oncology and Burns, and also in the broader public health services. These complex areas of health are dependent upon a matrix of cost and population usage. The high technology and labour requirements associated with these areas tends to be concentrated in the higher urban populations and subsequently the larger public hospitals. Here with all of the DHB case studies the clinical services represent the typical service provision that the individual DHBs offer. What differs with each hospital is the level of service and this is dependent on the location of the hospital and the population supporting the need for that hospital. This data is relevant because it provides an overview of the clinical services provided within the hospital and indicates the broad areas where nurses are deployed and where the DoN has a form

of accountability. This is examined further in the analysis chapter when spans of control are discussed.

The organisational structure charts that were available for 19 DHB were in seventeen cases structured in a typical organisational chart structure with horizontal and vertical lines depicting the different service areas. However in the other two DHBs the organisational charts were constructed in an atypical format not using the regular organisational chart template and offering a circular styled diagram to indicate how they were organised. At this point I will now discuss the additional investigation that was undertaken to clarify titles within the nursing structure charts.

7.1.3 ADDITIONAL PHASE 1 RESEARCH

Due to the profusion of titles that were found on the nursing structure charts the decision was taken to try and clarify or 'make sense' of the different titles to ascertain whether they were completely different positions or just different titles. To do this, all advertised nursing jobs above the level of charge nurse were reviewed for three months during the latter part of 2008. The exclusion criteria for this additional research were that registered nurse positions (RNs) and positions being advertised for nursing staff not working in the public hospital system were not reviewed. To review the advertised positions I looked at (1) to whom they reported (2) their area of accountability and (3) the number and type of staff that were direct reports.

What became immediately apparent was the number of positions that were advertised that had similar accountabilities and responsibilities but different position titles. The various titles found in use in nursing positions appears to be not unusual. Holloway, Baker and Lumby (2009) found in their New Zealand study on specialist nursing, fifty different nursing titles in use. The data findings are depicted in the following table 7.1.

Table 7.1 Similarities in Nursing Position Titles (above RN)

Position Title	Reported To	Responsible For	Direct reports
Charge Manager; Unit Manager; Charge Manager; Duty Nurse Manager and Clinical Manager. NB: all of the above titles appeared interchangeable	Service Manager; Operations Manager; District Manager; Nurse Manager – specified area. NB: all of the above titles appeared interchang eable	Clinical leadership and co-ordination; operational functions; quality and financial performance (budget management only), human resource management and recruitment; risk management; clinical pathway development; workforce development and professional development.	Associate charge nurses; ward co-ordinators/ clerical/administration staff; and registered nurses.

Through undertaking this exercise, sense could be made of the nursing structure charts to determine what the nurse position titles meant and how this impacted on analysing the different nursing chart structures. Once the titles had been analysed it could be seen that despite the different use of the position titles and that positions could be interchanged on the charts, the thirteen nursing case studies still differed in structure. What nursing did in terms of its work was similar across the different DHB case studies, however, how the work was structured was different.

Given the varying sizes of the DHB organisations and the different local needs that may have to be met in service requirements, the different nursing structures are a reflection of these variables. Therefore despite the structures themselves being atypical, the rationale behind their structuring could potentially be considered typical. However this raises questions around the relationship between the wider organisation structuring and nursing and the connections between the two.

7.2 PHASE TWO DATA RESULTS

Phase two covers the nursing questionnaires sent out to the Directors of Nursing at each District Health Board who had accountability for nursing services within the public hospital in that DHB. The survey questionnaires were comprised of two parts, Part A – Demographic questions and Part B – qualitative questions.

The Part A questions assist in establishing a baseline of demographic data. The questions in this section covered: age; time in current role; time in nursing management role; total time in nursing role; to whom they directly reported; the areas of responsibility and the type of structure in which they were working. The two variables of sex and ethnicity were not required as they would have been to be identifiers given the small pool. In relation to the question on potential areas of responsibility, these were listed and respondents circled those applying to them. The areas included nursing line authority, nurse recruitment, financial accountability, nursing budget holding and other whereby they could specify areas that may be specific to their DoN role. In terms of the type of structure DoNs were working in they were offered three choices, hierarchical, matric or flat.

The Part B questions were adopted from the work of Laschinger and Wong (2007) referred to earlier. Some items were modified with permission from the author. There were seven questions in part B which focused on: (1) how they saw themselves influencing nursing at a senior decision making level (2) their ability to represent nursing voice in the organisation (3) what they felt were the mechanisms for keeping at the forefront of nursing issues (4) what resources they required to do their work (5) how they saw communication within nursing and the organisation (6) what had been the impacts of restructuring on the DoN positions and (7) what did they see as the three top priorities for nursing in their DHB.

7.2.1 RESPONSES

A potential 20 participants were invited to contribute to the research and the response rate for this group was seventeen or 85%. Sixteen of the participants were Directors of Nursing with 16 responding by survey questionnaire and one responding by phone interview. The 17th participant was an Associate Director of Nursing as this organisation was undergoing a review process. All 17 participants indicated they were happy to be contacted for clarification either by email or telephone if required with 16 signed consent forms returned and one verbal consent form given preceding the telephone interview.

7.2.2 FINDINGS

The findings have been divided into two sections, the demographic section and the qualitative response section.

DEMOGRAPHIC FINDINGS

QUESTIONS ONE, TWO, THREE & FOUR –

*COULD YOU PLEASE CIRCLE YOUR AGE GROUP,
COULD YOU PLEASE CIRCLE WHICH NUMBER REPRESENTS THE LENGTH OF TIME IN YOUR
CURRENT ROLE,
COULD YOU PLEASE CIRCLE WHICH NUMBER REPRESENTS THE LENGTH OF TIME IN A
NURSING MANAGEMENT ROLE, AND
COULD YOU PLEASE CIRCLE WHICH NUMBER REPRESENTS THE LENGTH OF TIME IN A
NURSING ROLE?*

Questions one, two, three and four covered the age, time in current nursing role, time in management role and years in nursing and were graphed in table format against the Canadian nursing study to provide a comparison. I have used comparison of the demographic data to gain a sense of context of what the New Zealand picture presented. The Canadian nursing leadership profiling study was the only other data of a similar nature that was publicly available so was used to generate a comparison. Table 7.2 provides this comparison of the New Zealand Nurse leaders to the Canadian Nurse Leaders in these areas from the Laschinger and Wong (2007) study.

Table 7.2 New Zealand & Canadian Nursing Leader Comparative Data

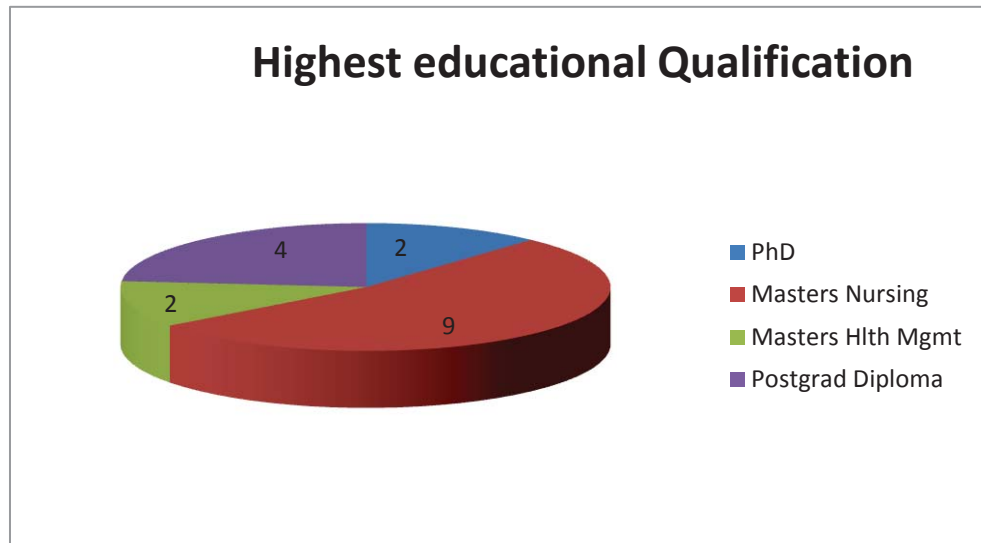
	New Zealand		Canada			
	Senior Nurse Leaders		Senior Nurse Leaders			
	Public Hospitals		Academic Health Centre		Community Hospitals	
	M	SD	M	SD	M	SD
Age	45.5	7.5	50.6	4.0	50.3	5.6
Years in Role	6.4	5.7	3.9	3.4	3.7	3.2
Years in Management	10.1	6.0	21.1	6.6	20.5	6.9
Years in Nursing	16+	N/A	29.3	4.2	28.9	5.5

As can be noted New Zealand DoNs are younger than their Canadian counterparts, and although they stayed in the DoN role longer by comparison they were in a management role for less time than Canadian senior leaders.

QUESTION FIVE -
COULD YOU PLEASE CIRCLE THE GROUP THAT REPRESENTS THE HIGHEST NURSING QUALIFICATION ACHIEVED?

Question five related to educational qualifications and the level of qualification DoNs had attained. Reviewing the educational qualifications of DoNs all seventeen reported undertaking some form of postgraduate study with two completing a Masters in Health Management and nine completing a Masters in Nursing. Graph 7.3 represents the breakdown of postgraduate study undertaken by DoNs.

Graph 7.3 Postgraduate Study Breakdown of DoNs



As can be noted one DoN has completed a PhD, however during the course of the research there was another DoN who had completed study to PhD level but is no longer a Director of Nursing.

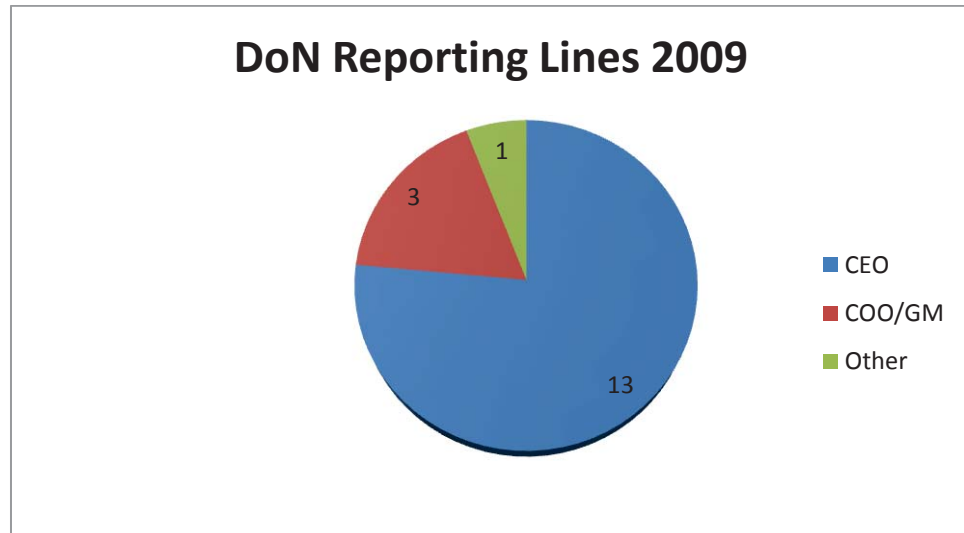
QUESTION SIX -

COULD YOU PLEASE INDICATE WHETHER YOU REPORT DIRECTLY TO THE CEO/COO OR WHETHER YOU REPORT TO THE GROUP MANAGER (PROVIDER ARM)?

As noted in the organisational structure charts in the Phase one data three DoNs did not report directly to the CEO and were reporting to either a GM or COO. In this data one DoN also reported to both the CEO and the COO. The findings of phase one have been substantiated by the phase two survey questionnaire where thirteen out of the seventeen phase two participants reported directly to the CEO, three reported to the COO/GM and one reported as Other. The DoN participant reporting 'other' is represented in the structural chart as dual reporting to the CEO and COO. The findings in phase two would seem to provide credibility to the interpretation of the phase one data through verification of the results. The reporting structures are represented in Graph 7.4. A review of the three DoN positions reporting to the COO also indicated that the level of their educational qualifications did not impact on the reporting levels in comparison to the DoNs who reported directly to the CEO. DoNs in all groups had a mix of either Masters

degrees or Postgraduate Diplomas with neither groups represented at any particular level of qualification.

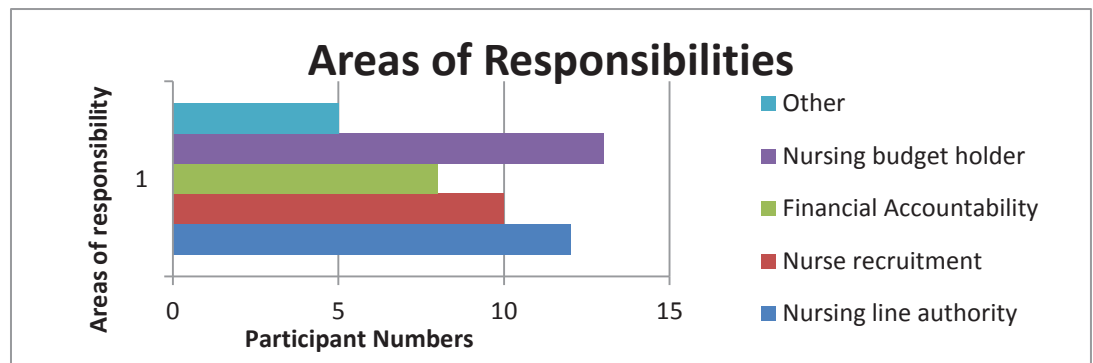
Graph 7.4 DoN Direct Reporting Lines 2009



QUESTION SEVEN –
COULD YOU PLEASE INDICATE BY CIRCLING THE RELEVANT AREAS FOR WHICH YOU HAVE RESPONSIBILITY?

Areas of responsibility were covered in question seven, and DoN self-reporting showed that budget holding (13/17) and nursing line authority (12/17) were the most commonly reported areas amongst the seventeen DoNs. Three of the DoNs stated they had strategic oversight for all of the nursing areas which included nursing line authority and financial accountability. Nurse recruitment was reported by ten participants, financial accountability was reported by eight with some participants also reporting other areas including quality of practice, workforce development and professional development. The responses are represented in graph 7.5.

Graph 7.5 DoN Self-Reported Areas of Responsibilities



Of note was the differentiation between budget holding and financial accountability which will be examined in chapter nine when an analysis of these areas is undertaken. Comments on budget holding appeared to refer to holding a budget for the Nursing Unit which included budget holding for NetP¹³ and professional development. This budget comes from the clinical training agency¹⁴ funding stream from the Ministry of Health, and is ring-fenced within the DHB hospital budget.

Nursing line authority also requires further examination as the nursing survey response to this question provides both verification of the phase one data and an ambiguity associated with line authority that was raised in the phase one discussion around dual reporting lines. An examination of the nursing structure charts provided an indication of dual reporting with professional line reporting being nurse to nurse and through to the DoN. This requires further examination and is discussed in the data analysis chapter.

QUESTION EIGHT -

COULD YOU PLEASE INDICATE THE TYPE OF STRUCTURE THAT YOUR ROLE FUNCTIONS IN?

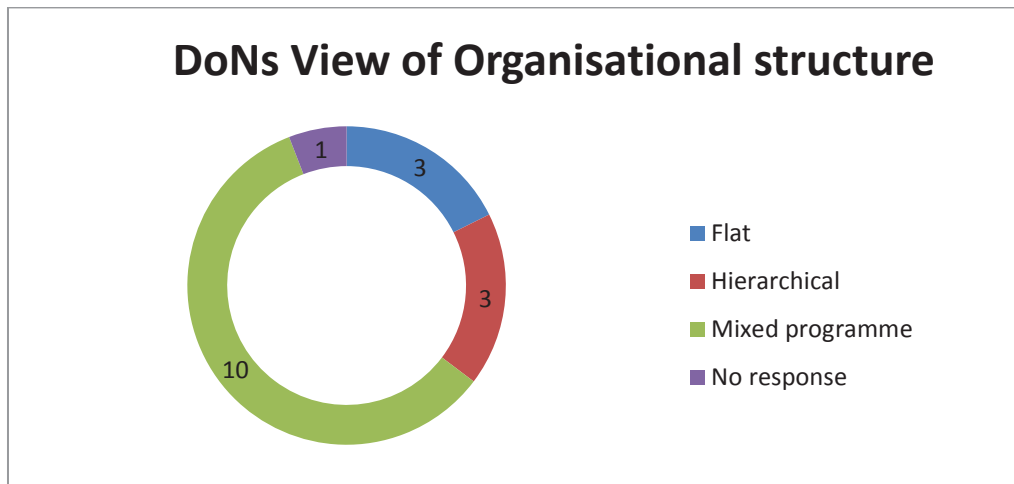
The final demographic question, asked the DoNs to consider the type of organisational structure in which their role functioned, and they were

¹³ NetP – Nurse entry to Practice programme is a nationally funded programme offered by DHBs to support first year graduate nurses entering the workforce.

¹⁴ Clinical Training Agency (CTA) has now been replaced by the Clinical Training Agency Board.

asked to indicate whether the structure was flat, hierarchical mixed or other. The following responses occurred: three participants reported their organisation as having a flat structure, three reported that they were working in a hierarchical structure, ten reported that they were working in a mixed programme structure and one participant did not respond. The mixed programme structure was usually viewed as the organisational structure being hierarchical with the nursing structure flat. One participant circled the mixed structure and made the comment “*traditional hierarchy in overall structure*”. Graph 7.6 provides a visual representation of the response to question eight.

Graph 7.6 DoN Views of Organisational Structure



The responses to how the organisation was structured, as perceived by the DoNs becomes important when examined alongside the formal organisational structure charts from Phase one and the responses from the CEOs in Phase three data and will be discussed further in the analysis chapter seven.

QUALITATIVE QUESTIONS

As indicated previously in the chapter, the qualitative component of the survey questionnaire comprised seven questions, questions nine to fifteen.

QUESTION NINE –

HOW DOES THE STRUCTURING OF YOUR ROLE INFLUENCE YOUR ABILITY TO REPRESENT AND INFLUENCE THE INTERESTS OF NURSING AT SENIOR DECISION MAKING LEVELS AND THE ORGANISATION AS A WHOLE?

Question nine asked participants to report on the structuring of their role and how this influenced their ability to represent and influence the interests of nursing both at the senior decision making levels and at the organisational level. There were six commonly reported responses from the DoNs that covered: (1) being part of the senior or executive management team; (2) being a member of the clinical governance group; (3) the positioning of the DoN to the CEO; (4) having strong clinical leadership; (5) having accountability for professional nursing practice and standards and (6) having a strong quality agenda. Examples of some of the responses that support this commonality are:

"I have a voice at senior management team level, I work with Associate Directors of Nursing to influence practice and the role and place of nursing" (DoN15)

"The DoN role is well positioned in the organisational structure to represent and influence decision making. I work in partnership with the CEO and am accountable for nursing practice, effectiveness, standards and discipline" (DoN1)

"I sit at the top table – and am influential at governance level, I have increased accountability for clinical decisions involving nursing" (DoN2)

"The role is one of influence and leadership rather than management and line authority"(DoN3)

From these responses we gain a sense of the importance the DoNs place on the ability to report directly to the CEO and of being a participant in the senior/executive management group to influence the interests of nursing, of having 'a voice' at the decision-making level. However, what is becoming apparent is the misunderstanding around leadership and line authority as evidenced in the last participant response. There appears to be a sense of disengagement between leadership and nursing which will be discussed in the data analysis chapter.

QUESTION TEN –
GIVEN THE SCOPE OF YOUR ROLE, HOW DO YOU ADDRESS/FULFIL THE VOICE FOR NURSING?

Question ten focuses on how the DoNs perceived their role to be representing nursing or fulfilling the voice for nursing within the

organisation. The six most commonly reported mechanisms were: (1) being able to attend and contribute to nursing issues at forum meetings; (2) attending and participating in the senior/executive management meetings; (3) being involved in monthly service meetings and/or service reviews; (4) being actively involved in the Hospital Advisory Committee (HAC), Community & Public Health Advisory Committee (CPHAC) and the Disability Support Advisory Committee (DSAC) meetings¹⁵; (5) attending and participating in clinical board meetings and (6) publishing or contributing to organisational reports such as the Annual District Plan, Annual Report and Strategic Plan. Examples of comments from participants included

“I am directly involved in setting the vision and standards and nursing agenda. I provide feedback and represent nursing issues to senior management and the Board” (DoN1)

“I am a direct report to the hospital advisory committee and keep updated with what is going on in the organisation” (DoN2)

“The structure allows shared communication and representation at Board level on HAC, CPHAC & DSAC” (DoN3)

“I am involved in leadership forums e.g. executive leadership team and nursing forums” (DoN13)

One participant’s comments reflected the need for two-way communication within nursing. This was not a typical response as most responses focused on being visible at senior meetings.

“This can be difficult at times, therefore it is important to ensure that nurses keep me informed and/or report to me on a regular basis” (DoN8)

The second atypical response related to the role in ‘nursing representation’.

“The DoN role is a leadership role for the organisation not a ‘representative’ of the profession per se” (DoN13)

¹⁵ HAC, CPHAC & DSAC committees are established under Sections 34, 35 and 36 of the New Zealand Public Health & Disability Act 2000 and advise on ‘matters relating to hospitals’, ‘health improvement measures’ and ‘disability issues’.

This sense of what the nursing leadership role might mean in terms of the organisation and requires further examination, and will be discussed in the data analysis chapter.

QUESTION ELEVEN –

WHAT MECHANISMS OR STRATEGIES DO YOU USE TO KEEP ABREAST OF NURSING ISSUES IN YOUR ORGANISATION?

Question eleven asked participants to discuss the mechanisms they used to keep well-informed of nursing issues in the organisation. The four most commonly reported responses to this question were: (1) high visibility through walk rounds, open door policy and nursing leadership rounds; (2) Attendance at Executive Management Team/Senior Management Team meetings was viewed as important; (3) Having clear, concise reporting lines, a consistent structure and good nursing governance and (4) other strategies included the use of staff surveys, participating in submission processes and being involved in nursing development and postgraduate education. A sample of comments that reflected these points were:

“I rely on the nursing leadership infrastructure, direct reports as well as involvement in a number of nursing/service forums” (DoN1)

“One on one working with nurse leaders.... Walk about leadership rounds” (DoN15)

“I meet with nurse leaders of services individually and as a group chair.....staff engagement surveys” (DoN5)

“I or one of my team are members of all clinical committees within the organisation” (DoN17)

“Meet with the line manager of a team of nurse consultants and educators the ‘eyes and ears’ whose roles are across the continuum... walk arounds and open door policy” (DoN13)

It can be seen that DoNs used a variety of mechanisms to keep in touch with nursing issues in the organisation that included visible and invisible mechanisms.

QUESTION TWELVE –

WHAT RESOURCES DO YOU HAVE TO FULFIL THE PROFESSIONAL NURSING PRACTICE ASPECT OF YOUR ROLE?

Given that nursing usually comprises more than half of the professional staff that work across the DHB public hospitals, question twelve considered what resources enabled the DoNs to work in their role, with the question focussing specifically on the ability for DoNs to undertake the professional nursing practice aspect of their role. The responses provided five areas from which the DoNs used as either a resource or support: (1) Nursing development units, Professional Development Recognition Plans (PDRPs)¹⁶, CTA funding and Nurse entry training Programme(NetP); (2) Support from nurse leaders which included nurse educators, nurse practitioners, Clinical Nurse Specialists (CNS) and charge nurses; (3) educational partnerships and relationships fostered through Nurse Executives New Zealand (NENZ); (4) relationships with the SMT, CEO and clinical directors (CDs) were considered supportive and (5) through professional practice forums and presentation at hospital orientations. The examples for this question were mainly focussed around PDRPs, NetP and CTA funding with a number of comments reporting:

'I have established a practice development group which includes nurse educators, CTA co-ordinator, NetP co-ordinator....expected to lead professional practice' (DoN5)

'the role is strategic – I engage in professional nursing practice through forums with lead and key nurses' (DoN4)

'I have a team of nurse educators.....responsible for all nursing/midwifery policies and procedures, professional fund oversight and administration, CTA funding oversight and administration' (DoN14)

'I manage a nursing development unit that covers nurse consultancy, nursing programmes- PDRP, NetP and CTA postgraduate nursing' (DoN9)

The predominant resourcing on which DoNs commented was related to nursing professional development and nursing education. The comments appeared to indicate that they felt they had support from their nurse

¹⁶ Performance development recognition plans (PDRPs) are required by the Nursing Council of New Zealand to ensure competency to practice and are used by DHBs as an assessment tool to move up to the next level within the RN scope of practice.

educators, clinical nurse specialists and nurse practitioners and in some cases the clinical directors, and senior management team.

QUESTION THIRTEEN -

HOW WOULD YOU DESCRIBE THE DEGREE AND NATURE OF CONTACT/COMMUNICATION YOU HAVE WITH OTHER LEVELS OF PATIENT CARE MANAGEMENT IN ORDER TO SEEK OR SHARE INFORMATION ON ISSUES THAT YOU MAY NEED TO ADDRESS?

The overwhelming response to the question on communication was one of positivity. All participants reported good communication channels within their organisation citing that the degree of communication ranged from regular through to good in both formal and informal links. Comments on the nature of communication in the organisation were cited as being positive, collaborative or participatory and this was exemplified through good collegial relationships and close working relationships with clinical director (CD) and the chief medical officer (CMO). Overall the responses in this question were very similar and provided a sense of typicality when viewing communication amongst the medical and nursing professional groups.

There were two participants who also cited areas in the organisation where communication proved to be challenging. These areas were in targeted areas around resident medical officer (RMO) shortages, inflexible workforce solutions, working with other allied health professionals, and with non-clinical managers who failed to consult. In the case of the managers who failed to consult it was felt that there were knowledge and language barriers that impeded the working relationship. As can be seen from the following examples, the DoNs sense making of communication overall within their organisation was perceived as satisfactory and meeting their needs.

“Degree of contact/communication moderate to high regular nature of contact/communication positive and collaborative” (DoN8)

“very good communication” (DoN3)

“For our size organisation the interface is reasonable with pretty good communication – some positions/individuals this requires more than others” (DoN14)

“degree and nature of contact/communication around levels of patient care management or other issues that may need addressing is one of seniority and participation” (DoN7)

“Contact/communication is at a high level and reported through a number of forums that are in place in the organisation” (DoN17)

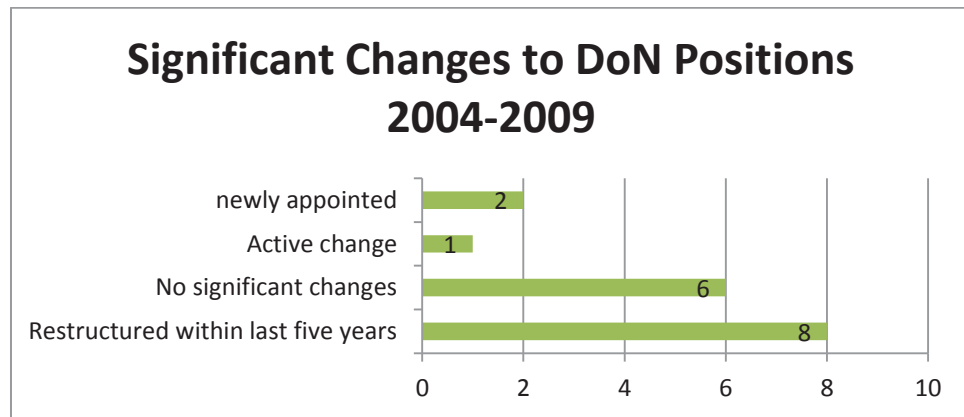
Communication is one of the informal ways in which organisations can be made sense of by their people. The data from phase two on communication and the DoNs sense of what is happening within their organisation provides a way in which to understand how the participants are making sense of the decision making processes that impact upon them and will be further discussed in chapter eight.

QUESTION FOURTEEN –

THINK ABOUT THE LAST TIME YOUR ROLE WAS RESTRUCTURED OR CHANGED IN A SIGNIFICANT WAY, WHAT WAS THE IMPACT ON YOU AND HOW DID YOU CARRY OUT YOUR ROLE OR YOUR ABILITY TO PROVIDE LEADERSHIP? (FOR EXAMPLE WHEN DID IT OCCUR, WHAT PROMPTED IT AND WHAT WAS THE CHANGE?)

This question is significant given that the health sector in New Zealand underwent significant restructuring during the 1990s and continues to be subject to constant change. Eight of the seventeen participants reported that their roles had been restructured within the last five years (2004-2009), whilst six reported no significant changes with their roles in the last five years (2004-2009). One of the seventeen participants reported that they had experienced some degree of change within the last five years (2004-2009) and two were recently appointed to the role. Graph 7.7 highlights the numbers of DoNs who have experienced changes over the period 2004-2009.

Graph 7.7 Significant DoN Position Changes 2004-2009



The participant who had experienced some degree of change also stated that they were actively seeking change and made the following comment:

"I prompted it in a proactive manner to relocate the DoN role from a provider division role reporting to the COO to a role which reported to the CEO"(DoN13)

Regarding the impact the changes had on the role all reported that they had experienced increased spans of control, that they now had increased responsibility and accountability with some participants reporting an increase in the clinical focus in their role due to the increasing focus on clinical governance.

Where there had been restructuring or significant change a number of participants had the following comments to make:

"My role was restructured it was very stressful and protracted" (DoN16)

"Recent talk about disestablishment of the DoN role....., not only personally disappointing but also disappointing for nurses in the hospital" (DoN6)

"I was left 'hanging' for months and it was the worst year. I felt very ineffective and demoralised" (DoN8)

The above comments are very telling in how restructuring or significant change on any position impacts on individuals and can be best summed up by one of the participant's comments:

"generally it disables direction and intent of the speed of change, causes much angst and stress, whereby process is questioned" (DoN2)

QUESTION FIFTEEN –

WHAT ARE THREE CURRENT TOP PRIORITIES FOR NURSING OR PATIENT CARE IN YOUR ORGANISATION?

The final question in the survey questionnaire covered the three current top priorities for nursing or patient care. The three most common responses were patient safety and safe staffing, nursing workforce and professional development of nursing and thirdly, getting back to basics in nursing care and having safe professional practice. This was reflected in the following comments:

“Safe staffing amidst management restructuring, workforce and professional development, safe professional practice” (DoN15)

“top priorities – workforce issues ensure that there are safe staffing levels demand and supply correspond, ensure smart competent staff that are motivated to ensure no harm (patient safety) comes to patients and families” (DoN2)

“Three current top priorities are encompassed under safe staffing, healthy workplace umbrella. Trying to improve ability to match acuity/workload and staffing capacity planning” (DoN5)

“Three current top priorities for nursing or patient care in organisation are getting back to basics in nursing care, patient safety and workforce development” (DoN9)

7.3 PHASE THREE DATA RESULTS

The Phase three data are from the survey questionnaire responses that were sent to the Chief Executive Officers. The survey questionnaire was similar to the Director of Nursing questionnaire and was also divided into two parts with a demographic section and a qualitative question section. The questionnaire also comprised the Laschinger and Wong (2007) CEO qualitative questions that were asked in the Canadian Nursing leader profile study, also modified to fit the New Zealand context. Part A, the demographic section was made up of six questions covering age group, length of time in your current role, length of time in a management role, occupational background, area of expertise and highest qualification achieved and the type of organisational structure in which they work.

Part B, the qualitative section was made up of eight qualitative questions that covered: explaining their role, explaining the type of relationship the CEO role has with the nurse leadership structure in the DHB, their perspective of the DoN role, the key priorities of the DoN, evaluating the effectiveness of the DoN role, whether the nursing structure and current DoN role is effective, the key priorities for nursing and the mechanisms for reviewing the DoN role.

7.3.1 RESPONSES

As indicated in the methods chapter the CEO survey questionnaire was sent out by the DHBNZ chair who indicated he would act as a sponsor in his role as chair for the phase three dissemination of surveys to other CEOs in this research project. There were a total of ten responses from nineteen CEOs. In two of the case studies the participants who responded were the Chief Operating Officers (COOs). In the case of this participant group the preferred response method was a scanned email copy. Signed consent from the CEOs and COOs were also sent through scanned email.

7.3.2 FINDINGS

The findings have been divided into two sections the demographic section and the qualitative question section.

DEMOGRAPHIC FINDINGS

QUESTIONS ONE, TWO, THREE -

COULD YOU PLEASE CIRCLE YOUR AGE GROUP,

COULD YOU PLEASE CIRCLE WHICH NUMBER REPRESENTS THE LENGTH OF TIME IN YOUR CURRENT ROLE,

COULD YOU PLEASE CIRCLE WHICH NUMBER REPRESENTS THE LENGTH OF TIME YOU HAVE SPENT IN A MANAGEMENT ROLE?

The demographics indicate that 70% of the CEO/COOs were in the age group 51-55, and 30% were equally placed in the 41-45, 46-50 and 56-60 year age groups. The time spent in their current role was mixed with 30% of CEOs spending 6-10 years in their current role, 20% were equally apportioned between less than one year, three to five years and eleven to fifteen years.

While they may not have been in their current role for a long period of time 50% had extensive management experience reporting over twenty-one plus years working in a management role. This was followed by 30% reporting they had worked in a management role for sixteen to twenty years and 20% reporting having worked in a management role for less than 15 years.

QUESTIONS FOUR, FIVE & SIX –

COULD YOU PLEASE CIRCLE WHICH OF THE FOLLOWING REPRESENTS YOUR OCCUPATIONAL BACKGROUND,

COULD YOU PLEASE CIRCLE AND INDICATE THE AREA OF EXPERTISE OUT OF THE FOLLOWING LIST WHICH REPRESENTS THE HIGHEST QUALIFICATION ACHIEVED,

COULD YOU PLEASE INDICATE THE TYPES OF ORGANISATIONAL STRUCTURE THAT YOUR ROLE FUNCTIONS IN?

The predominant occupation reported by the CEOs was a management background with 50% reporting in this area, of these one CEO also highlighted both management and nursing as their occupational background. Thirty per cent reported that they had come from a nursing occupational background with 10% reporting a medical occupational background.

This result appears to be typical for the CEOs working in health as a Google search of the CEOs who did not respond to the questionnaire shows that out of the other ten CEOs, seven have backgrounds in finance, accounting and economics and three individuals having an occupational background in nursing. The dominant occupation for a CEO working in the DHB sector during the period of this research would therefore have been that of a business background. This finding is to be expected given the political and economic influences at the time. Table 7.3 portrays the CEO demographic results.

Table 7.3 CEO Demographic Results

Questions	Responses
Age	70% reported being in the 51-55 age group, 30% were equally placed in 41-45, 46-50 and 56-60 age groups
Years in Current Role	Mixed groups with 30% spending 6-10 years in their current role, 20% equally apportioned between less than 1 year, 3-5 years and 11-15 years
Years in Management Role	50% reported having worked in a management role 21+ years with 30 % reporting working in a management role for 16-20 years, 20% reported less than 15 years
Background	50% reported having non-clinical backgrounds 40% reporting having a nursing background and 10% a medical background
Highest educational Qualification attained	60% reported having attained Masters and 40% reported having attained Bachelors degree
Type of structure	40% reported the type of structure as mixed, 50% reported Hierarchical and 10% reported a flat structure

Having reviewed the CEO demographics the following comparison was undertaken with the DoN data to understand how the two case study quintains, the CEOs and the DoNs compared. Tables 7.4 & 7.5 show the CEO-DoN comparisons.

Table 7.4 CEO-DoN Age, Years in Role & Occupation comparison

Comparative Demographics	DoNs		CEOs	
	M	SD	M	SD
Age	45.5	7.5	53.3	8
Years in Role	6.4	5.7	6.1	5.9
Years in Management	10.1	6	18	7

As can be noted above the average age of the CEO was eight years older than the average age of the DoN and that the two average ages of both groups are representative of the aging health workforce. Both quintains

experienced the same average length of time in the role, however, the CEOs reported a much greater time spent in an overall management role than the DoNs.

Although sex has not been requested as part of the statistical dataset as the participant pool is small and identifiable, a google web search of the DHBs shows that the dominant sex of CEOs working in the DHB sector is male and the dominant sex of DoNs working in the DHB hospital provider arm is female. Gender is an important factor as nursing is a predominantly female profession and the impacts of being a female leader within a predominantly male led organisation are discussed further in chapter eight. The next table shows the comparison of the highest educational qualifications between the two quintains.

Table 7.5 Highest Educational qualification attained

	Highest Degree level			
	BA	Postgrad	Masters	PhD
CEOs	40%	0	60%	0.00%
DoNs	0	25%	68.75%	6.25%

The graph shows that the DoNs have attained higher qualifications than the CEOs as an overall group. One of the reasons this may be the case may arise from having a more specific clinical career pathway as opposed to a generic management pathway. The length of time spent in the management role of CEOs is greater than that of the DoNs and this factor compared to higher qualifications may play more of a role in determining seniority for organisational management positions. As discussed in chapter four, the context of the gendered workplace as it impacts on the structures influencing DoN leadership will be further examined in the discussion chapter. The last question in Part A of the survey questionnaire - the demographic section focuses on the organisational structure.

The comparison of the responses to this question provided a sense of whether the DoNs and the CEOs may hold the same view of the organisation. In the majority of the responses this appeared to be the case where often both parties saw the organisational structure as mixed with both hierarchical and flat apparent within different levels. There were three case studies where the CEO and the Don differed in their view, with two DoN's viewing their organisational structure as mixed and the CEO viewing the structure as hierarchical. In the case of the third DoN participant they reported that the organisation was mixed with the CEO reporting a flat structure. From these responses it can be seen that the likelihood of the organisational structure as being a mixed structure with both hierarchical and flat level apparent as typical of a DHB structure.

QUALITATIVE FINDINGS

The qualitative component of the CEO questionnaire comprised eight questions. The responses to questions numbered seven to fourteen will now be discussed. It should be noted that in some of the questions the term Director of Nursing (or equivalent) is used, this is because some of the DoN titles are also the Director of Nursing & Midwifery, Executive Director of Nursing & Executive Director of Nursing & Midwifery.

QUESTION SEVEN –

COULD YOU BRIEFLY EXPLAIN WHAT YOUR ROLE ENCOMPASSES AS CEO/COO?

Overall this quintain reported the following descriptors of their role as being '*strategic*' or '*setting strategic direction*', '*providing leadership*' and '*working inter-sectorally*'. Other areas that were encompassed in the CEO explanations covered developing and supporting the vision for the region, financial management of the DHB, providing the right environment to achieve results and being a figurehead and spokesperson for the DHB. Comments from the CEOs were as follows:

“Leader & Champion, Figurehead & Spokesperson, Financial & Clinical outcomes, Strategic planning, system development and liaison with others”
(CEO4)

“Aligning the resources available with the Board’s direction” (CE08)

“Planning, organising, leading, controlling, figurehead, giving information, making decisions” (CE03)

“Discharging the strategic intent of the Board” (CE07)

The responses from the CEOs are typical from what is expected for individuals who have been delegated by the Board to lead an organisation, and from a position of seniority within the organisation.

QUESTION EIGHT –

COULD YOU EXPLAIN YOUR ROLE AND THE TYPE OF RELATIONSHIP THAT ROLE HAS WITH THE NURSE LEADERSHIP STRUCTURE IN THE DHB/HOSPITAL?

Six of the CEOs reported that the DoN was a direct report and provided a link to nursing through the organisation. Three reported that the DoN was accountable to the COO with two participants highlighting that the line of reporting to the COO was similar for both the DoN and the Chief Medical Advisor (CMO). Three CEOs pointed out that the DoN was a member of the executive team. Comments from the CEOs that explained the type of relationship best represented as:

“I have a very constructive relationship” (CE07)

“Reports to the CEO in a professional advisory role” (CE03)

“I rely on the DoN for nursing and midwifery professional advice and for leading the implementation of the vision, values and strategic goals of the DHB” (CE06)

“provides me with advice/direction on not only nursing issues but also clinical effectiveness for the organisation and quality improvement activities” (CE05)

Overall the explanation of the role supports the data from both phase one and phase two with direct reporting to the CEO being the most commonly reported. The most common response around the type of relationship was strongly linked to advice or advising on nursing issues with two comments including the importance of nursing in clinical governance. The sense of working in an advisory capacity will be further discussed in the analysis chapter as being an advisor does not provide the DoN with the required authority.

QUESTION NINE –

HAS YOUR PERSPECTIVE ON THE DIRECTOR OF NURSING (OR EQUIVALENT) ROLE AND POSITION CHANGED OVER YOUR PERIOD OF TENURE, AND IF SO, HOW?

In question nine the CEOs indicated that in their view the DoN is the leader for nursing issues and an important player on the executive/senior management team. Six of the ten CEOs stated that their perspective had not changed and the dominant response was that the role still remained critical to both organisational clinical leadership and nursing leadership. One CEO stated that their perspective of the role had been ‘reinforced’ and another CEO acknowledged that the role had changed to ‘a degree – but largely around responsibilities that had been agreed with the DoN’. Some of the comments that reflect these findings are:

“the role is of strategic importance” (CEO1)

“DoN is (a) key member of senior leadership team recent restructuring moved role from advisory position to leadership position” (CEO9)

“DoN position always regarded as critical to the leadership of the DHB – role was reinstated to a full FTE when I became CEO” (CEO5)

“DoN role has been established for over 10 years, hence has had a presence and influence for some time (as was the intention)” (CEO8)

“I remain committed to the role and function and see it as integral to achieving ‘In Good Hands/Clinical Leadership’ and to building a positive/healthy organisational culture. The role also helps lead the ‘Lean Thinking and productive Engagement’ directions” (CEO6)

QUESTION TEN –

WHAT DO YOU SEE AS THE KEY PRIORITIES OF THE DIRECTOR OF NURSING (OR EQUIVALENT) IN YOUR ORGANISATION?

Having indicated how they viewed the DoN role in their organisation the CEOs were asked what they saw as the key priorities of the DoN. The most dominant response reported by all ten CEOs was professional leadership and professional responsibility of nursing staff. Following this the next most commonly reported responses were around nursing workforce development and monitoring professional nursing standards. Other responses included quality and safety and assisting with meeting DHB strategic goals and targets. Two of the responses provided very succinct examples of the key priorities:

“Leadership and management of the nursing resource so as to ensure safe service within available resources” (CEO10)

“Right nurses (right number, skill mix and motivation) at the right place and time, and identifying the right future workforce” (CEO3)

Overall the CEO responses focussed on the DoN being responsible for the nursing component of the organisation and ensuring that professional nursing standards were met and monitored to keep patients safe. One CEO expressed his belief that the DoN should be *‘visible in demonstrating values’* and *‘lead by example’* (CEO9). Three CEOs included the word patients in what they saw as part of the DoNs key priorities: *‘Integrating services for patients’* (CEO3), *‘advocacy for nursing and patient issues’* (CEO5) and *‘patient centred systems’* (CEO4).

QUESTION ELEVEN –

HOW DO YOU EVALUATE THE EFFECTIVENESS OF THE DIRECTOR OF NURSING OR EQUIVALENT ROLE?

Evaluating the effectiveness of the DoN role produced diverse responses with six of the ten CEOs stating that they used formal performance review mechanisms including annual performance review against an agreed set of objectives, 360 degree feedback tools, and meeting organisational key performance indicators (KPIs). Other mechanisms that were used were whether hospital accreditation and Quality Healthcare New Zealand (QHNZ) certification had been achieved, and achieving results in any ongoing projects such as *‘releasing time to care’*. Four of the CEOs provided comments that indicated that effectiveness was measured more informally. The following two comments that reflect this more informal evaluation are from DHBs where the DoNs report to the COO not the CEO:

“mostly informally or subjectively, although there could be a number of objectives/quantitative measures that could be used” (CEO8)

“whether she delivers on her objectives”(CEO7)

The other two comments are from DHBs where the DoN is a direct report to the CEO:

“very effective, essential contributor to an efficient, effective DHB” (CEO2)

"I evaluate the person in the role, and their ability to work in a matrix management structure" (CEO1)

The comments from the CEOs where the DoN is not the direct report tend to suggest atypical responses from the rest of the CEO group where the focus is more a reflection on efficiency. These responses may represent an indication of making sense of a position that is not directly reporting to you and so a degree of distance is evident in the response which will be discussed further in chapter eight when looking at the formal structure.

QUESTION TWELVE –

DO YOU THINK THE CURRENT NURSING STRUCTURE AND DIRECTOR OF NURSING ROLE IS EFFECTIVE, IF SO HOW IS IT EFFECTIVE, AND IF NOT, WHAT WOULD MAKE IT MORE EFFECTIVE?

All of the ten CEOs reported that they thought the role was effective but some indicated varying degrees of effectiveness. One CEO reported that the role was *'about 80% effective'* and indicated that there was a greater balance between *'clinical and financial accountability needed'* (CEO10). Restructuring was also a visible factor in the responses in this question where one CEO reported that the role had been effective since restructuring as it was *'no longer an advisory role'* (CEO9), whereas another CEO indicated that *'there will be some changes in a restructure to ensure that accountability and responsibility is aligned'* (CEO7) with a third CEO signalling *'structural review is nearing completion'* (CEO3).

The focus by the CEOs on clinical and financial accountability is critical as this is one of the areas that the DoNs are expected to have accountability and responsibility and yet from the data in the DoN findings this appears to be not the case. The implications of these two opposing findings will be discussed further in the next chapter.

Two other CEOs indicated that the Nursing structure and DoN role was effective making the following comments:

"Recently reviewed it and decided not to change it" (CEO5)

"Yes, I am satisfied with the current arrangement and believe any change would be detrimental to progress (i.e. restructures cause loss of productivity, momentum and retention problems)" (CEO6)

As a researcher making sense of the responses, I would see the CEOs comments as responding to the second part of this question, focusing on whether they have viewed the current DoN role as effective, and that largely their views were that it was an effective role. In relation to the first part of the question regarding the current nursing structure as being effective, the previous responses from the CEOs would indicate that as they see the DoN role as the leader and figurehead responsible for the nursing structure, and therefore the role of the DoN and the nursing structure are an implied single entity.

QUESTION THIRTEEN -

WHAT DO YOU SEE AS THE KEY PRIORITIES FOR NURSING IN YOUR ORGANISATION AND PARTICULARLY FOR THE PROVIDER ARM?

As mentioned in the previous response to question twelve, there appears to be explicit thinking that the DoN role and the nursing structure operate as a single entity and this was reinforced with one of the CEO responses for this question who referred his responses for the key priorities for nursing as being the same key priorities for the DoN in question ten. Overall the most common responses from the CEOs covered three areas as key priorities for nursing, the first was workforce development, the second was quality care/quality improvement and the third was focussing on the patient /consumer.

Within the responses on workforce development the comments covered issues such as: *'identifying and developing future workforce – competencies, mix roles'* and reflected a concern around the *'aging workforce'* and the ability to *'extend scopes of practice'* (CE03). Improving quality was reflected as having *'a continuous quality improvement focus'* (CE010), *'process reform'* (CE03), *'achieving quality standards'* (CE07), *'safe and quality service to patients/consumer'* (CE06) and *'reducing critical incidents and utilisation of root cause analysis to improve quality of care'* (CE05). This was closely followed by comments on *'keeping the patient in the centre of decisions and all that nurses do'* (CE06), *'attitudinal – customer first'* (CE04), and *'patient safety initiatives'* (CE03).

Patient safety, workforce development and quality was part of a common language that was reflected in both the DoNs and CEOs comments that showed a congruence in what the priorities were. How these priorities translate into practice differs within the two quintains with the DoN quintain focussed on 'safety' reflected in '*patient safety*', '*safe professional practice*', '*safe staffing*'. The CEOs whilst acknowledging safety as important include the parameters of '*responsible use of resources*', '*best possible clinical service within available funding*' and '*taking accountability and responsibility for the service they provide and resource they use*'.

QUESTION FOURTEEN -

WHAT INFORMATION OR EVIDENCE AND MECHANISMS DO YOU CONSIDER OR USE WHEN DESIGNING OR REVIEWING THE DIRECTOR OF NURSING OR EQUIVALENT ROLE?

As with question eleven on evaluating effectiveness of the DoN role, this question also provided a mixture of formal and informal mechanisms that CEOs would consider when designing or reviewing the DoN role. Six of the CEOs reported they would use some formal indicators to design or review the DoN role such as 360 degree feedback mechanisms, KPI indicators, internal business scorecards, delivery against organisational objectives and delivery against quality and process improvements. Other mechanisms that were considered were different feedback mechanisms such as '*feedback from peers and nurses*' (CEO9), '*peer feedback from clinical partnerships*' (CEO5), '*conversations with stakeholders, nurse in particular*' (CEO9) and '*considering feedback from processes such as accreditation audits and surveys*' (CEO6).

Three of the CEOs indicated they would undertake research and benchmark against other DHBs as well as look at international literature. One CEO indicated that as part of reviewing the DoN role they would look at other DoN job descriptions and discuss the role with the DHB board and the executive leadership team (ELT). Two of the CEOs indicated they would discuss the role with either the Ministry of Health or the chief nurse at the ministry. One CEO expressed a very organic approach to reviewing the role, commenting:

“Start by basing it on an advisory role and if the ability and interest of the individual and needs of the DHB are such that the person can grow into a broader more operational role involving more direction of the nurse workforce than simply advising. I wouldn’t want just an advisor” (CEO7)

This comment indicates that the role is considered fluid and provides some evidence of complex adaptive thinking, however there is also a sense of confusion as to what this fluidity might mean which is discussed in the next chapter.

7.4 RESEARCH RESULTS SUMMARY

In summary, the Phase one findings offered some typical and atypical findings amongst the different DHB cases studied. Overall there was a sense of homogeneity in how the work was organised within the different DHB settings but very little sense of connectivity with how nursing was incorporated into these structures. How these findings connect or compare with the data found in phase two and three will provide another layer of sense-making into how decisions around nursing leadership are made.

The phase two nursing survey questionnaire provided insight into both the formal and informal organisational structures. Through the demographic data it can be seen that the responses in phase two support the data in phase one on direct reporting of DoNs, which adds verification to the data. It is noted that it is typical for the majority of DoNs to be in a position to report to the CEO, whilst in three cases this was an atypical response.

The responses on budget holding and financial accountability raise questions of autonomy and empowerment. Budget holding is not often associated with as much autonomy as financial accountability. In the case of holding a budget, this is already pre-determined based on a combination of historical and current economic factors. Where an individual has financial accountability there is often more autonomy associated with managing finances as resources can be shifted around in response to changes. This understanding is based on my own experiences as a business advisor

working in one of the DHBs and having worked at the Ministry of Health in a policy analyst role. To add to the complexity of this area, the survey questionnaire responses from the CEOs indicated in some cases that they wanted more financial accountability aligned with clinical responsibility and yet the DoNs were not provided with this accountability and responsibility. There also appears to be some confusion in making sense of this area by both quintains that will be further discussed in the next chapter.

The stress associated with restructuring or any significant changes that have occurred is also important, as half of the DoNs had experienced restructuring and with two recently appointed DoNs, this indicates changes have occurred in 10 of the DHB case study sites. The responses from the phase three data also support the inclusion of restructuring as an influencing factor as evident in the CEO responses to the effectiveness of the DoN role in question twelve. This will be examined further in the analysis chapter when discussing how the informal structures contribute to understanding the organisation.

Many of the findings appear to support the responses of both sets of quintains, although as noted in section 7.3. phase three data findings, in question thirteen on key nursing priorities what is being reported by the DoNs and the CEOs has different interpretations. It is to the concept of sense-making we return to analyse the data findings. Chapter eight follows on with further analysis of the overall findings from the three data phases.

CHAPTER EIGHT - DATA ANALYSIS

8.0 INTRODUCTION

In the previous chapter I presented the results from the three different phases of data collection. I now turn to the qualitative analysis of those findings. The main findings from the three phases of data collection were:

1. The organisation and nursing structure charts were different across the District Health Boards (DHBs).
2. Few or no clear relationships were seen between nursing structure charts and District Health Board organisational charts.
3. Not all of the Director of Nurses (DoNs) had a direct reporting relationship with the Chief Executive Officers (CEOs).
4. The DoN is not always functioning at the executive decision-making level
5. There is ambiguity around the financial responsibility and subsequent accountability that DoNs hold as part of their role.
6. The dual accountability that is held by the DoN and apparent in the majority of DHBs has created blurred lines between professional and operational accountability.

8.1 THE ORGANISATIONAL AND NURSING STRUCTURE CHARTS WERE DIFFERENT ACROSS THE DISTRICT HEALTH BOARDS.

In the phase one dataset the organisation structure charts and the nursing structure charts were reviewed and analysed for differences and similarities. Anderson-Wallace (2005) states that ‘the term “organisational structure” has been widely used over a long period to denote a wide range of institutional processes that are said to help define organisations’ (p. 169). He notes that in general utilising the term has always been linked with focusing on ‘functional hierarchies and roles along with notions of authority, accountability and responsibility’ (p. 169). The reason for looking at the structure charts in this research was therefore a way of

establishing the configurations within each of the DHBs. As discussed in chapter seven organisational structure charts are used to provide an organisation with a means of identifying who reports to whom in the chain of decision-making. Nursing structure charts provide a similar function.

8.1.1 PURPOSE OF STRUCTURE CHARTS

The charts therefore perform a purpose, which enables identification of roles and positions by both the people working within the organisation and people outside of the organisation. The charts themselves have evolved from the establishment of bureaucratic structures and reflect the 'need for predictability, order and precision' within the organisation (Bennis, 1966, p. 249). Structural charts are useful as a way of organising the people and the divisions of work within the structure. Looking at the charts allowed me as an outsider to understand what the reporting structures of the different DHBs as an outsider looked like, and thereby gain an understanding of how the organisation was formally organised.

Although the majority of DHBs use a standard pyramidal arrangement to visually depict the structure within their organisations, two of the DHBs have moved away from visually representing their organisations in this manner with these charts configured in circular styled drawings. The change in some of the DHB structures can be seen as representative of a shift from the traditional bureaucratic make-up evolving to a more organic and complex adaptive approach. The shifting structures and the impact this has on the future of DoN positioning will be discussed in chapter nine. Having established that structure charts have a purpose to assist with visually depicting the order of an organisation I now move onto examine why the charts might be structured so differently.

8.1.2 ANALYSIS OF STRUCTURE CHARTS

As noted in the last chapter there were nineteen differently structured organisations charts and thirteen differently structured nursing charts. These charts differed in the way the hospital divided their work, and in the roles and positions that were responsible and accountable for those work

divisions. The differences were seen in the phase one dataset, visually through an examination of the written charts.

Visually reviewing the charts I was looking for common position titles and reporting lines within both organisational and nursing chart structures. The findings in the organisational charts provided a mixture of common titles in some areas and not in others, but also quite different reporting lines. The nursing charts also had a complex mixture of positions and reporting lines which led to additional data being sourced to understand the plethora of nursing position titles within the different DHB organisations. The complexities of the titles were illustrated in the data findings chapter Table 7.1 where similarities were found between different nursing titles through their reporting links and responsibilities assigned to the different positions.

Overall the charts were visually different however common functions were evident on further examination. Analysis of the qualitative questionnaire data reveals no apparent rationale that underpins why both the organisational structures and nursing structures are so different. As discussed in chapter four the contextual influences of isomorphism (Di Maggio & Powell, 1983) enable a theoretical understanding as to why the structural charts are different and yet provide evidence of homogenous work divisions and services. The historical influences discussed in chapter four also assist with making sense of the differences and similarities found in the structure charts. The move to new public managerialism (Brown, 2008) increased the requirement for competition between the District Health Boards and subsequently created a need for difference or diversity amongst structures when competing for funds (Boxhall & Purcell, 2011). However, historically the division of work has always been medically driven based on diagnosis and treatment of diseases and the funding of DRGs (Fetter, 1991) and this continues to influence the division of work and services provided within the public hospital. Therefore the structures outwardly appear different, yet the services provided within the public

hospital are similar. I will now move onto the second finding as both these findings relate to the visual assessment of the structure charts.

8.2 FEW OR NO CLEAR RELATIONSHIPS WERE SEEN BETWEEN NURSING STRUCTURE CHARTS AND DISTRICT HEALTH BOARD ORGANISATIONAL CHARTS.

The second finding from examining both the organisational and nursing charts was that across the thirteen DHB case studies where both charts were available, there was very limited information on the charts that indicated they belonged to the same organisation. There appeared to be a sense of disconnection between organisational structure and nursing structure charts. In seven of the case studies the impression I received from mapping the charts was a vague general recognition of similar clinical areas, but not the ability to directly map a nursing chart onto an organisational chart where clear divisions of work could be identified.

Although structural chart differences are noted across and within the DHBs, it is important to understand as noted above, that there is a core group of dominant health services that are being provided within the public hospital setting that influence the organisational structure. This was evidenced from an examination of the different organisational charts and the most commonly grouped services as indicated in Graph 7.2 in the previous data findings chapter. Therefore a paradoxical and complex mix of different positions and reporting structures exists within and across the DHB hospital case studies where a predominantly similar group of services are provided. Whilst the data from the questionnaire does not explain why this occurs, the historical data and organisational theory data offer insights into how the effects of the restructuring in the 1990s have influenced the organisational structuring within the District Health Boards. The competitive advantage required by organisations to compete for funding has created a need for the organisation to seek diversity as discussed in 8.1. It is this perceived need to 're-create' how a service looks that provides us

with a potential explanation as to why work divisions supplying similar services look different.

8.2.1 OBSERVABLE CONTRADICTIONS OF NURSING IDENTITY

As indicated in the previous chapter this lack of visual connection between the two groups of structure charts appeared to indicate that nursing as a group was siloed within the wider organisation. An examination of the qualitative data responses indicated that a number of apparent contradictions exist in the DHB. In some cases, responses in the data indicated that nursing was not siloed within the organisation, and this was evident when looking at the predominant focus for what needed to be achieved by the organisation of both the CEO and the DoN. Similar responses from both groups indicated that they were speaking the same rhetoric and looking to achieve the same outcomes for the organisation and this can be seen in both questionnaires around the question on the three top priorities,

“Safe staffing.... Safe professional practice.....ensuring patient safety’, ‘match acuity/workload and staffing capacity planning” (DoNs)

“Safe and quality service to patients/consumers’, ‘identifying and developing future workforce – competencies, mix roles’, ‘achieving quality standards” (CEOs)

In both these sets of statements, providing safe patient care and having the nursing capacity to do so underpin the rhetoric. However it is also in the following comment, that there is a contradiction of the perception of nursing not being siloed within the organisation that exists,

*“keeping the patient in the centre of decisions and **all that nurses do”***
(CEO6)

This comment encapsulates the paradox of a nursing identity. This sense of a non-specific identity of nursing within the organisation, in the comment ‘*all that nurses do*’ implies there is an unknown quantity in the term ‘all’ and a sense of vagueness about what it is nurses do. Yet the same words can also be seen to be a confining identity, in the word ‘do’ as the ‘doing’ is

specific only to nursing. This seeming confusion about the nursing identity is also supported by the sense that the CEOs did not know what the role of the DoN actually encompassed and this was evident from the comments by CEOs when asked to discuss what they saw as the DoN's priorities for their organisation. The CEOs saw advocacy for patients and nurses as a priority of the DoN however, they also wanted the DoN to '*ensure a safe service within available resources*'. The expectation by the CEO that the DoN will act as an advocate for both nurses and patients but also be mindful of the competing financial constraints places the DoN in a position that has inherent professional tensions. This will be further discussed within the context of financial accountability and budget holding.

As noted in the introduction and the literature review chapters there was a shift in the late 1980s from a triumvirate management of the hospitals to a generic management based on the introduction of new public managerialism. This shift forms a complete organisational culture change and I now suggest that this change has led to the third finding on DoN reporting structures as discussed in the following section.

8.3 NOT ALL OF THE DIRECTOR OF NURSES (DONS) HAD A DIRECT REPORTING RELATIONSHIP WITH THE CHIEF EXECUTIVE OFFICERS (CEOS).

All three phases of the data collected covered the reporting position of the DoN role in the organisation. In the phase one data, the organisational structure charts revealed that seventeen of the DoNs reported directly to the CEO and three of the DoNs were reporting to the Chief Operating Officer (COO). In phase two the DoNs were asked about how they saw themselves in relation to reporting to the CEO & senior management team, and 13 of the 17 DoN participants responded that they reported directly to the CEO. One DoN reported to both the CEO and the COO and the other three DoNs reported to the COO. The responses from the CEOs also supported the findings with seven of the ten CEO participants reporting that the DoN was a direct report, and three indicating that the DoN reported through the

COO. The research data therefore indicates that 85% of the DoNs are direct reports to the CEO and thus have a relative level of power associated with their position, whilst 15% of the DoNs are atypical of this quintain as they report at a lower level through the COO.

8.3.1 THE IMPORTANCE OF DIRECTOR OF NURSING STRUCTURAL POSITIONING

Previously it was indicated that the structural positioning of the DoN role was important in determining the authority of that position and I will now discuss why this is the case. When trying to make sense of how the organisation works, it is the hierarchy and chain of command that denotes who has power, and therefore the level of reporting determines the level of authority or power of the DoN. It is also important to note that structural positioning is not just about the formal reporting mechanism, but also about the informal processes that support the role. Peach (2007) notes that the structures set expectations as to what the relationships within the organisation will be and the positioning in the structure establishes the status of the position. Scott, Sochalski & Aiken (1999) report that one of the key attributes that nursing leaders require to be effective leaders is that they 'uphold a position of power and status within the hospital organisation' (p. 10). The significance of the reporting position is echoed in the data research in one of the DoN comments

"Reporting to the CEO makes a difference as otherwise the opinion of the DoN is not always sought after by senior colleagues...." (DoN8)

There is a sense here that if the DoN was not to report to the CEO they would not be viewed as in a position of authority and subsequently be excluded from the senior decision-making conversations. This is also supported by Peach (2007) in her opinion study of New Zealand senior nurse experiences, as she comments that 'they [senior nurses] feel their concerns about the delivery of patient care are not understood at the highest level of the organisation unless nursing has a voice at a high level' (p. 2).

8.3.2 HOW DOES DON AUTHORITY MANIFEST ITSELF

This view of 'having a voice' is also seen in the following comments from the DoNs as they reiterate the sense of authority they attribute to the position,

*"I have a voice at senior management level ... to **influence** practice and the role and place of nursing" (DoN17)*

*"I sit at the top table.... I have increased **accountability** for clinical decisions involving nursing" (DoN2)*

*"The DoN role is well positioned in the organisational structure to represent and **influence** decision making..... I am **accountable** for nursing practice, effectiveness, standards and discipline" (DoN1)*

There is the impression that the DoN authority is tied in with being able to influence and have accountability for nursing. They perceive as a direct report of the CEO they have influence that is legitimated through their structural positioning in the hierarchy. There is also a sense of an active role being portrayed in these comments as the words 'to influence' and 'being accountable' provide the reader with a sense that the person is doing something, and that something is overseeing nursing within the hospital. The sense of being able to influence is strongly supported in the literature as part of a leadership role. It is in the ability to challenge and then mobilise resources through influence that outcomes are achieved (Pedlar, Burgoyne & Boydell, 2010). Armstrong, Laschinger and Wong (2009) also report that 'having the power to get things done rather than coercion of employees' indicates that the individual is not only effective but also influential. Kanter (1979) discusses effective power, and this is achieved through having influence and being able to influence in the work environment. This is seen in the organisational structures of formal and informal power. Formal power provides the DoN with both the visibility and the discretion to undertake the work that is seen as central to the organisation's goals. In this context the DoN is in a position where they can be influential, for example, they have influence by virtue of their legitimated authority and status. In the informal power structure there is the need to have strong networks and communication with superiors and

peers and it is through this informal power structure that the DoN is able to influence others (Armstrong, Laschinger and Wong, 2009).

In the Magnet hospital program nurse leaders are empowered as a result of working in a significantly improved work environment. Hospitals that are Magnet credentialed have consistently been shown to provide 'better nurse work environments and better nurse and patient outcomes' (Kelly, McHugh & Aiken, 2011, p. 429; Scott, Solchalski & Aiken, 1999). This improved work environment includes as one of the key aspects 'nurse participation in hospital affairs'

(<http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx>). The context for understanding the influence the DoN requires to perform their work is outlined in the methods chapter, diagram 6.1 where the results from the Canadian nurse leader profiling study and the magnet hospital program components were interwoven to provide a framework for analysing the data. Here the 'ability by DoNs to influence the senior management team (SMT)' interweaves with the magnet hospital component of 'structural empowerment' and the ability to participate in hospital affairs. The interface of these two components enables DoNs to be empowered and effective in their roles. The DoN comments in this research data therefore suggest they perceive themselves as having an active role, they have a voice, and are structurally positioned and able to influence decisions impacting on nursing within the organisation.

Discussion on what the nursing leadership role might mean in terms of the organisation and particularly those senior to the role is also important to understand in the context of being able to influence. However, I suggest a contradictory view is apparent in the comments from the CEOs and there is the sense of a more passive role where advice versus authority is being played out,

*"Reports to the CEO in a professional **advisory** role"* (CE03)

*"I rely on the DoN for nursing and midwifery professional **advice**..."* (CE06)

*"provides me with **advice/direction** ..."* (CE05)

In these comments the focus is not on influence but on the advisory capacity where being able to advise does not have the same level of authority as being able to influence. This sense of being in an advisory position was also reported in the Peach (2007) survey where it was reported that 'It is seen as an advisory role by the CEO and other members of the senior team, and therefore at times lacks "teeth" especially relating to operational matters. There is no issue when it relates to professional issues for nursing; I am expected to provide the right answers' (p. 9). The different comments around working with authority or working as an advisor raise questions around structural empowerment.

Returning to the principles embodied in the Magnet hospital program, it is having a strong organisational structure with effective and innovative processes that is viewed as a central tenet to achieving structural empowerment. This structural empowerment is further reinforced when there is evidence of 'strong nursing representation in the organisational committee structure' and that 'executive-level nursing leaders serve at the executive level of the organisation'. Other requirements to achieve structural empowerment require the nurse leader to report directly to the CEO and that there is a 'functioning and productive system of shared decision-making'

(<http://www.nursecredentialing.org/Magnet/ProgramOverview/ForcesofMagnetism.aspx>). Subsequently my analysis of the research data indicates that the role of advising is passive and thereby not functioning at the level required within a shared-decision-making forum. The sense of disempowerment is attributed to the advisory type of role that the DoN is placed in, where the DoN is not able to practice autonomously as a nursing leader because they are not accorded authority in the decision-making forum. This lack of authority is evidenced in the following comment as we see changes starting to occur within the DHBs around the DoN positioning,

"DoN is [a] key member of senior leadership team recent restructuring moved role from an advisory position to [a] leadership position" (CE09)

The move to reposition the DoN into a leadership position acknowledges that the DoN role needs to be more than just an advisor.

However, the changes to reposition the DoN at a more active participatory level are still slow in evolving and this is evident where the DoN position is not always included within the executive leadership team (ELT). The majority of cases where the DoN is involved is at the senior leadership team (SLT) level and this has implications for financial decision making, where decisions are made at the executive level and not the senior leadership level. Therefore it is argued that there are two very different participant perceptions of authority accorded to the role of DoN and this becomes more evident when the atypical case studies are discussed.

8.3.4 ATYPICAL CASE SCENARIOS

In the case studies where the DoNs report through to the COO, the level of reporting of the DoN reinforces a far more passive role linked to a management rather than a leadership role of nursing within the hospital setting. Comments that illustrate this sense of being located in a more management than leadership role are,

“In theory the COO has overall responsibility....” (CE04)

“The nurse leader is accountable to the COO” (CE07)

“able to make decisions within delegated authority level” (DoN5)

There is a strong sense of the passive voice in these statements and a subsequent lack of authority apparent in these positions. This lack of authority for DoNs positioned at this level within their DHB organisation can only lead to disempowerment. As noted earlier in the discussion Kanter (1997) identifies power as one of the contributing factors to the structural positioning of individuals within their work environment. The evidence from the research data indicates that DoN and CEO perceptions of what constitutes authority differ and this sense of a passive positioning is even more evident in the DoN who is not a direct report of the CEO. The consequence of this passive positioning of the DoN role impacts on the

functioning of the DoN at the executive decision-making level and this will be discussed next.

8.4 THE DON IS NOT ALWAYS FUNCTIONING AT THE EXECUTIVE DECISION-MAKING LEVEL

In the chapter seven findings it was noted on the structural charts the majority of DoNs responsible for the wider DHB nursing were often visually located under the umbrella of an advisory column and linked into such functions as 'clinical leadership' and 'clinical governance'. The question in the data results chapter was therefore raised as to whether located in this advisory capacity the DoN was structurally positioned to have the mandate for decision-making. As discussed in the previous section the incongruence between the different perceptions of authority would suggest that there is a passive positioning of the DoN role in the organisation. The lack of influence attributed to the DoN's structural positioning and the consistent reporting by CEOs of DoNs acting in an advisory capacity impacts on being able to influence, and therefore a diminished mandate for decision making at an executive level occurs.

To better understand whether there is a diminished mandate examining the consequences of the decision making process and who is held accountable for the outcome is also important. Reviewing whether being held accountable equates to a shared decision making process or that of a passive participant, is of value to look at the functioning of the DoN at the executive decision making level. One way of finding out about accountability is to look at the expectations that the CEO has of the DoN role. The comments from the CEO when asked what they saw as the nursing priorities for the organisation, provide us with insight into their expectations,

"improving quality, patient safety and productivity" (CEO7)

"safe and quality service to patients/consumers....taking accountability and responsibility for the service they provide and resources they use... improving productivity" (CEO6)

“best possible clinical service within available funding, continuous quality improvement focus” (CEO10)

“improving efficiency of nursing care” (CEO5)

“responsible use of resources” (CEO4)

All of these comments are connected by a sense that the DoN as the leader of nursing, is responsible and accountable for ensuring that nursing not only provides a safe, quality service within the set resources but that they are also looking for increased productivity and efficiency in the provision of nursing care. These expectations are not unrealistic in the current fiscally constrained environment. Returning to the inter-connected framework in diagram 6.1 the components that interweave and are required to support the expectation of the CEO are ‘adequate resources to perform the work’ and ‘transformational leadership’ which are also then tied into a second magnet hospital component ‘empirical quality results’.

In the forces of magnetism, transformational leadership focuses on the quality of nursing leadership. Descriptors of this style of leadership are often conveyed as ‘knowledgeable, strong, risk-taking nurse leaders who follow a well-articulated, strategic and visionary philosophy in the day-to-day operations of the nursing services’ and this quality leadership is reflected in the patient outcomes

(<http://www.nursecredentialing.org/Magnet/ProgramOverview/ForcesofMagnetism.aspx>). However the data indicate that the majority of DoNs are not given the opportunity to be transformational leaders as they are constrained by the conflicting mix of expectations of providing ‘*professional advice*’ and ‘*taking accountability and responsibility for resources....*’ rather than ‘having responsibility of the budget for managing resources’.

There is a repetitive focus by CEOs on the word ‘improving’ where DoNs are expected to be responsible for ‘improving quality’, improving productivity’, ‘improving efficiency of nursing care’, and ‘improvement of patient safety and process reform’. With the requirement to improve comes the need to manage risks and DoNs are in the unenviable position of having to manage and be responsible for risks that they do not have an

overall mandate to manage. This lack of having an overall mandate is the result of the positional structuring of the DoN role which has impacted on the ability the DoN has to make decisions, and again this is tied up with the comments on 'providing professional advice', 'being a professional advocate' where the DoN positioning is located in this passive and advisory role. In this structural positioning the DoN is disempowered and unable to take overall responsibility for the quality of patient care, although there is an expectation that they do so, which further reinforces a sense of failure and disempowerment.

Armstrong, Laschinger & Wong, (2009) also highlight the linkages between an empowered work environment and the quality of patient care. They argue that an improved climate of patient safety is more likely in an empowered work environment that enables support for nurse professional practice. However, transformational leadership is only one factor through which the empowered work environment is facilitated.

Laschinger, Sabiston & Kutzscher(1997) use Kanter's theory of structural power in organisations to link work empowerment with the context and content of nursing work. Kanter (1977) asserts that structural power is determined by three avenues: opportunity, power and the social composition of peer clusters. The first of these avenues of structural power is opportunity, and this is derived from being able to progress within your work and within the organisation. An example of a DoN who would be considered high in opportunity would be where the DoN had the ability to 'create power and action-oriented informal groups', 'consider themselves members of the larger organisation rather than the local unit' and 'when dissatisfied, engage in active change-oriented forms of protest; collective action, formal meetings, suggestions for change'. Conversely the DoN who was considered low in opportunity would be considered to 'be critical of high power people, of management, or at least, fail to identify with them', 'be more attached to the local unit than to the larger organisation, and, hence, be more parochial' and 'orient peer groups towards protection and reassurance, with strong loyalty demands; and hence, discourage members

of the group from seeking mobility' (p. 247). In the data there is evidence of high opportunity with the following comment,

"The DoN role is a leadership role for the organisation not 'a representative' of the profession per se" (high opportunity)(DoN13)

"I prompted it in a proactive manner to relocate the DoN role from a provider division role reporting to the COO to an executive DoN role reporting to the CEO" (high opportunity)(Don13)

It is evident from these comments that the DoNs consider themselves as a member of the larger organisation rather than the local unit. Being able to engage in active change and suggestions for change, suggests that in this case the DoN is in a position of high opportunity.

In the case of the atypical DoN reporting cases, low opportunity is evident as the comments of the CEOs always acknowledge the DoN role as a subset of reporting through to the COO.

"The nurse leader is accountable to the COO" (CE07)

"In theory the COO has overall responsibility with DoN & CMO reporting" (CE04)

The implication from these comments is one of a failure to identify with the more subordinate position.

Using the second determinant of organisational power, Kanter (1997) signifies that this determinant enables individuals to mobilise resources. In this scenario the DoN's capacity to act is based on both the structural positioning and the informal networks that have been formed. Kanter (1997) further progresses this argument to include other factors such as 'the discretion embedded in the job, the visibility of the function, the relevance of the function to the current organisational problems, approval of high status people and the favourable alliance with peers' (p. 247). Again the research data from the viewpoint of the DoNs and how they kept to the forefront of nursing (Q. 10) indicated that there was a sense of high organisational power through 'high visibility', 'fostering higher group

morale' and a 'favourable alliance with peers' (p. 248) as evident in the following comments,

"Requires a high degree of visibility and attention to relationships" (DoN1)

"visible at front line to CEO level" (DoN2)

"Close working relationship with chief medical officer (CMO)" (DoN14)

"I give voice to the nursing perspective at the management table" (DoN10)

However, although the comments indicate the DoNs have networked to improve alliances with people who have a high level of authority, there is little indication from the majority of DoN comments that they themselves have the authority to make decisions to mobilise resources through these networks and alliances, rather they 'advocate' and 'advise'.

Communication is also a critical tool for making sense of the environment and the question on communication provided a way of understanding how the DoNs made sense of the decision making processes in their organisation which is also linked to having high organisational power. However whilst the DoNs reported overall that there was an impression of good communication existing within the organisation through the following comments,

"Degree of contact/communication moderate to high regular nature of contact/communication positive and collaborative" (DoN8)

"degree and nature of contact/communication around levels of patient care management or other issues that may need addressing is one of seniority and participation" (DoN7)

There is an inherent contradiction found when asked about role restructuring. Rather than words being used to describe communication processes within the organisation as being 'positive and collaborative' and 'participatory' the following comments reflect a completely opposite view. Restructuring of the DoN role is viewed as a response to 'the relevance of the function to the current organisational problems' it is argued that in these situations low organisational power is evident as noted by the following comments,

“my role was restructured from..... to and remained much the same it was very stressful and protracted. I just kept going the best I could and did not talk about it much” (DoN16)

“generally it disables direction and intent of the speed of change, cause much angst and stress [and the] process is questioned” (DoN2)

“I was left hanging for ... months and it was the worst year. I felt very ineffective and demoralised...” (DoN8)

What the majority of DoNs note as being positive communication channels and a collaborative way of working is inconsistent with the above comments on how their roles have been impacted on in times of restructuring. The above comments reflect a contradiction of what is being said and what is actually occurring. On one hand the CEOs have indicated that they find the DoN role valuable to the organisation as noted in previous comments, yet the comments from the DoNs indicate a loss of value to the position and the role, and a strong sense of disempowerment.

The third determinant that assists with enabling structural power is what Kanter (1997) refers to as the proportion or social composition of people in the organisation. The DoN in this instance can be categorised as being in both a very small proportion and a very high proportion. This is because the DoN position is unique and very visible, and as highlighted above in the earlier discussion in section 8.1 ‘face misperceptions of their identity and role in the organisation and hence, develop a preference for already-established relationships’ (p. 249). Therefore the role is considered as being represented by a very small proportion within the organisation. However, the DoN role is evident in a high proportion within the nursing group in the organisation as they are ‘seen as one of the group, as fitting in’ and ‘be[ing] accurately perceived, hav[ing] a congruent identity and ease in self-presentation’ (Kanter, 1997, p. 249). From Kanter’s theory of structural power it can be ascertained that the DoN in this research requires high opportunity, high organisational power and high proportion to be empowered and yet the data would indicate that these factors are not always apparent in the New Zealand context.

This thinking supports the Laschinger, Sabiston and Kutzscher (1997) study where they randomly sampled 550 nurses from two urban teaching hospitals and a community hospital¹⁷ using the following three surveys, the Conditions for Work Effectiveness Questionnaire (CWEQ), the Job Activities Scale (JAS) and the Organisational Relationships Scale (ORS). The results from this study indicated that the nurses perceived themselves to have a moderate degree of access to empowerment structures overall. The responses from the questionnaires also indicated a consistency with Kanter's theory. In effect the DoN who viewed their job as being relevant, flexible and visible and had well established informal alliances would also perceive that they had access to 'sources of job-related empowerment' (p 349). Laschinger, Sabiston and Kutzscher (1997) argue that it is the combination of the formal power, for example, the structural positioning of the nurse leader and the informal power, the use of strategic alliances and networks combined that enable the nurse leader to mobilise the resources necessary for work effectiveness.

Wong, Laschinger, Vincent and O'Connor (2010) also reviewed the decisional involvement of senior nurse leaders (SNL) in a Canadian nursing study. They reflected on the re-engineering that had occurred in health and the increasing scope of accountability senior nurse leaders have as a result of these changes. In their study they developed a model to examine the timing of involvement, the breadth of content expertise, the number of decision activities and the perception of influence in organisational decisions. Both CEOs and SNLs were participants in the study which covered 66 healthcare organisations in 10 Canadian provinces. What the study reports is that SNLs participate in decision making at the executive level and thereby contribute to organisational processes that impact on nurses and patients. However, one of the areas of interest for this research is where the highest influence in decision making occurred for SNLs. The study showed that the 'highest level of influence was reported for decisions

¹⁷ Overall a 61% return rate was recorded from the three hospitals.

regarding professional practice and the lowest influence was reported for operational decisions' (p. 128). Furthermore the CEOs reported that the highest level of expertise and influence over decisions for SNLs was accorded to decisions made around professional practice whilst the lowest range of expertise was accorded to organisational planning activities (Wong et al, 2010). This leads to the question of whether this situation occurred in the New Zealand case study. Based on the CEOs comments it can be seen that the majority saw the DoN as contributing advice on professional nursing issues rather than operational activities,

“essential for clinical leadership and professional standards” (CEO2)

“more involved in leading and directing nurses as a whole” (CEO3)

The international literature supports the evidence from this New Zealand research that the majority of DoNs in this case study primarily execute the highest level of decision making over nursing professional practice with comments from the CEO confirming this perception. What cannot be ascertained from the data is whether the DoN is involved in more general, higher level operational decision making. However, the contradictions of the role as illustrated by the comments from the CEOs and the DoNs in the research data indicate that the majority of DoNs in the DHB public hospital setting do not have the structural power necessary to mobilise the resources that are required to effect their work. This is because the comments support the position as one of an advisory position. The inability to mobilise resources is discussed in the following sections on financial accountability and dual reporting processes.

8.5 THERE IS AMBIGUITY AROUND THE FINANCIAL RESPONSIBILITY AND SUBSEQUENT ACCOUNTABILITY THAT DON'S HOLD AS PART OF THEIR ROLE.

The ability to mobilise resources is viewed as a critical component of having structural empowerment and as discussed above, and illustrated in diagram 6.1 is one of the key components that enables the DoN to function

effectively in their work. However, the visual research data from the structural charts indicates as previously noted that the DoN although being part of the senior leadership team (SLT) is not always a member of the executive leadership team (ELT). Further to this there are no clear connections of the functional reporting lines, on the organisational charts linking the DoN to the chief financial officer (CFO).

CEO responses however, indicate that there is an expectation that the DoN will be accountable for resources,

“leadership and management of the nursing resource so as to ensure safe service within available resources” (CEO10)

“right nurse(right number, skill mix and motivation) at the right place and time, and identifying the right future workforce” (CEO3)

“Taking accountability and responsibility for the service they provide and the service they use” (CEO6)

Further comments from the CEOs around the effectiveness of the DoN role also reiterate the expectation that the DoN has accountability for the nursing budget. One CEO commenting,

“the role was 80% effective and a greater balance between clinical and financial accountability was needed” (CEO10)

It is important to note one of the DoN's stating that,

“[I] represent nursing issues via general/service managers including funding and planning – although this is the area I feel less effective” (DoN1)

This comment is not surprising when considered in the light of a recent study undertaken by Gamblin (2012) where 13 clinical nurse managers discussed leadership roles and the lack of training for leadership available to nurses. Although there was the expectation that nurses would be able to become leaders in a short space of time as indicated *‘[my] Masters in management research project was prompted by observing that clinically trained nurses were expected to suddenly become managers simply courtesy of a title change’*(p. 8). Gamblin (2012) goes further to add that there is a *‘somewhat fragile and precarious environment in which senior nursing positions operate in New Zealand’* (p. 9). The expectations being placed on

the DoN role to be a leader and be accountable are being undermined by the role not having the resources to undertake the work. There is a difference between holding a budget for a specified service, for example, nursing professional development, and being responsible for the nursing budget overall. This mismatch between budget holding and having financial responsibility for the nursing budget becomes evident in the following case where the CEO makes the comment that as part of their role as the senior executive of the DHB,

"[I am} providing/ensuring the right environment exists to achieve results"
(CEO8)

And yet the DoN for that case in her responses on priorities for nursing states that there is,

"financial unsustainability of nursing infrastructure and IT" (DoN7)

The disconnection in this case, where one individual views their role as providing resources and the other party lacks the resources to do the work are obvious. The disparity between lacking the resources to undertake the work and the expectation that the work will be completed is further emphasised when reviewing the responses relating to the DoN and budget holding.

In question seven the DoN was asked to identify relevant areas for which they had responsibility, where two areas highlighted were financial responsibility and budget holding. Nursing budget holding was reported by 76% of the DoN participants and as noted in the data findings chapter, the descriptors around holding the budget was primarily for the DoN unit and covered professional development and training. Financial accountability was reported by 47% of the DoNs, where participants gave the impression that having authority of the budget was strategic and not operational. The logic underpinning a strategic oversight of the nursing budget fails to take into account the requirement for autonomy in nursing. As Laschinger, Finegan and Wilk (2011) point out it is nurse managers who 'shape the context of nurses' work by influencing the quality of support and resources

available on the work unit' (p. 124). Arnold et al (2006) review American chief nurse executives (CNE) for their views on structural positioning and their integrated strategy around financial performance. In this review the CNEs reported being held accountable for 'supporting health system financial performance through nursing budget management strategies' and this is achieved through a number of mechanisms with a focus on 'improving financial management performance among nurse leaders' (p. 13). They also report that improving relationships with the CFO and finance departments is critical and consider that 'fiscal management of nursing resources are an import foundation to their roles'. Furthermore, the CNEs felt that without 'a strong financial performance the perception of nursing in their organisation is vulnerable' (p. 14).

The ability to have adequate resources as indicated in the Canadian nurse leader profiling study (2007) and the Magnet hospital program of gaining empirical quality results can only occur when nursing has authority for the overall nursing budget. The lack of operational oversight of the budget means that DoNs do not have a direct influence or authority on operational matters and this lack of financial authority impacts on their ability to provide resources for nursing staff. This sense of having a strategic oversight of the budget has also been linked to the lack of line authority DoNs have for nursing in their hospitals.

8.6 THE DUAL ACCOUNTABILITY THAT IS HELD BY THE DON FOR NURSING, AND APPARENT IN THE MAJORITY OF DHBS, HAS CREATED BLURRED LINES BETWEEN PROFESSIONAL AND OPERATIONAL ACCOUNTABILITY.

The rationale for removing the nursing operational budget is found in the 1990s health restructuring that occurred across western countries. Liu et al (2009) report that the previous functional and discipline based health services had been reorganised to service line structures and interdisciplinary care teams and this has predominantly affected nursing structures within hospitals through the decentralisation of nursing. The political and economic thinking supporting the restructuring in the 1990s,

advocated that greater efficiencies and cost savings could be achieved through the decentralisation of traditional services and reorganising these services into 'product' or service lines. This idea of the product or service line has been compounded by the use of diagnosis related groupings (DRGs) and its impact on financial accounting (Fetter, 1991). As noted in Arnold et al (2006) developing realistic nursing budgets can be quite difficult because of budgetary and financial accounting rules and systems (p. 14). In New Zealand hospital budgets are primarily pre-determined, based on a mix of case-weights and per capita population costs that are set by the National Health Board. Hospital budgets have evolved historically over time and changes to the budgets are usually incremental unless the organisation is restructuring. Even within the restructuring the overall hospital budget will not change outside of the annual apportioned consumer price index (CPI) but the internal allocations will alter.¹⁸ There is a continued drive for efficiencies currently being sought by the Minister of Health, and to keep hospital costs down there is an impact on how the internal hospital budgets are allocated and in particular to nursing resources. Hospital budgets are coded to a complex group of service lines and are based on a mix of historical allocation and money received for new initiatives. Costs and responsibility for nursing FTE are spread between services and the service manager. The splitting of the nursing FTE budget responsibility between services reinforces the lack of authority the DoN has over the overall nursing budget and the blurred lines of accountability in the hospital system.

Liu et al (2009) studied line authority for nurse staffing. In the sample surveyed only 19% reported having nursing line authority where the structure incorporated service lines in the hospital organisation. Hospitals utilising a traditional discipline organisational structure had nurse executives reporting 100% as having nursing line authority. Where there was a mixture of service lines and discipline lines 88% reported having

¹⁸ This knowledge is based on my experience as a DHB Business Advisor for six years.

nursing line authority (p. 343). The findings of the study showed that where nursing executives had nursing line authority the nursing care costs in the acute care setting were lower and the implications were that reducing the authority of the nurse executive for nursing line authority may have adverse effects on nursing costs (p. 349). Mathews, Laschinger & Johnstone (2006) studied empowerment in line and staff¹⁹ organisational structures and stated that ‘staff nurses who had a Chief Nurse Executive (CNE) in a line structure felt significantly more empowered in their access to resources than nurses with a CNE in a staff structure’ (p. 526). Wong et al (2010) found that Senior Nurse Leaders (SNLs) who worked in service line organisations and lacked a discipline-based nursing service reported a ‘decreased direct supervision of nurses and challenges in achieving consistency in quality of nursing care’ (p. 123). It can be seen through the international literature that having nursing line authority is the preferred structure to achieving quality nursing and patient outcomes and this is also supported by the magnet hospital program in its recognition that exemplary professional practice is best achieved through role modelling by transformational nurse leaders.

8.6.1 NEW ZEALAND DHB NURSING LINE AUTHORITY

Reviewing the New Zealand research data only two of the DHBs reported nursing line authority with eight of the 13 responses indicating a dual line reporting, in three DHBs reporting lines were unclear. Dual line reporting occurs when nurses report professionally through the nursing line but operationally through to a service manager. This type of dual line reporting where the DoN is seen as the main advocate for the professional responsibilities of nursing was also supported by the following CEO comments,

“professional lines report to professional leaders of nursing and DoN”
(CEO4)

¹⁹ Staff organisational structures are equivalent to service line structures

*“The DoN has DHB role responsibilities and accountability for Nursing and Midwifery **professional leadership**” (CEO6)*

This model is consistent with the restructuring and the political economic thinking that supported generic management structures, however it is not consistent with best practice internationally and there is no empirical data to support whether it has been a cost effective model in New Zealand.

In light of the international data it can be seen that through having dual accountability structures, there is the potential for a negative impact on DoN structural positioning at the executive level in New Zealand DHBs. The lack of nursing line authority hinders their ability to participate and influence operational issues impacting on nursing within their DHB. This was exemplified in the research data in the following DoN comments,

“Found dealing with service managers with no clinical backgrounds as difficult to deal with through either not being consulted where decisions were being made that potentially affected clinical outcomes, or being overruled due to fiscal concerns” (DoN6)

“Managers inflexibility in workforce increased demand for more staff, resource utilisation” (DoN1)

These comments highlight similar difficulties to those expressed by the Canadian senior nurse leaders working in service line organisations (Wong et al, 2010). There are two schools of thought regarding nursing line authority and consequently having the budget for nursing. The first school of thought argues that the change to nurse leader roles increases their opportunities in organisational leadership positions. This thinking is premised on having greater authority over interdisciplinary and broader based programmes and appears to be modelled on the ‘new managerialism’ style of management. The second school of thought argues that the changes in the nursing line structures ‘diminishes authority and communication links between senior nurse leaders and other nursing personnel and deprived nurses of disciplinary leadership representation at the policy making level’ (Wong et al, 2010, p. 123). Reviewing the New Zealand data in this research, it is argued that the authority of the DoN has been diminished where there is minimal nurse to nurse reporting in the

organisational structure. This has been evidenced by the inconsistencies between the DoN and CEO responses on questions around structural reporting, financial accountability and expectations of the DoN role.

8.7 SUMMARY

Structurally the organisation and nursing charts whilst depicting the formal hierarchical chain of command and visual positioning of the roles were all quite different in format and the possible reasons for this will be discussed in chapter nine. The lack of connectivity between the two charts indicated a sense of nursing being siloed within the organisation and this was supported by the comments in the data which focussed on the accountability of the professional lines of nursing. The lack of nurse to nurse reporting supports a sense that the DoN does not have structural empowerment because the authority is compromised by the lack of direct nursing involvement in the operation lines of reporting. The current health sector is funded based on operational performance and the financial structures and service line organisation hinders the DoNs ability to undertake the work they are expected to perform.

I have used the inter-connected Magnet hospital components and the Laschinger & Wong evaluative constructions depicted in Diagram 6.1 in chapter six to examine the components necessary to enable the DoN to perform their work, and understand how these components can impact on the structural empowerment of the DoN role. The components of being able to influence the senior executive, the organisational structure on work environment quality and acquire adequate resources to perform the work are closely aligned with having transformational leadership, structural empowerment, and exemplary professional practice to gain empirical quality results. It is argued that the absence of any of these components influences the decision making capacity of the DoN at the executive level within the context of the New Zealand public hospital environment.

The connection between decisional involvement at the executive level by the DoN and quality patient outcomes is well reported in the international literature on the magnet hospital programme. As noted in the introduction studies by McCloskey and Diers (2005) and Carryer et al (2011) indicate that potentially nurse sensitive patient outcomes have not improved in New Zealand public hospitals in the last 15 years and the trends indicate that these patient outcomes continue to be adversely impacted. By utilising the data in this dissertation and analysing it through the inter-connected Magnet hospital components and Laschinger and Wong evaluative constructions it can be qualitatively determined whether the positioning of nurse leaders in the current organisational structures has the potential to impact on patient outcomes in New Zealand public hospitals. The analysis of the research data shows that the dual accountability processes of service line reporting do not provide the DoN with the authority required to be empowered at the executive level over operational nursing and this is evidenced by a lack of structural positioning and operational financial accountability of nursing. In chapter nine I will discuss how the structural positioning of the DoN has come about through an examination of historical factors, gender influences and organisational theory. I will also look at where this research might offer further opportunities to benefit nursing leadership.

CHAPTER NINE - DISCUSSION

9.0 INTRODUCTION

In this final chapter I will briefly review the findings and then explore the different contextual influences that can further shape the analysis. I will then discuss and offer some recommendations on how to improve the way forward for nursing leadership in the New Zealand public hospital setting.

In chapter four the different facets of organisational structure, history and gender were discussed as ways in which sense can be made of the contextual factors that contribute to the analysis of the data. The drive for efficiency and the subsequent rational economic policies imposed on the health sector have impacted on nursing leadership detrimentally as highlighted by Finlayson and Gower (2002) and Gauld (2001). The context of organisational structures and isomorphism provide a way to structurally examine and understand how these economic rational policies have played a role in diminishing nursing leadership authority.

It would not be reasonable to consider a predominantly female occupation without attending to looking at the history and potential of how gender is operating. As discussed in chapter four an examination of both primary and secondary source history texts indicates a covert persistence of gendered thinking and this has played a role in influencing how nursing leadership and authority has been perceived. All of these factors in addition to an analysis of the data have contributed to making sense of how the organisational structures have influenced nursing leadership in the New Zealand public hospital setting.

9.1 A REVIEW OF THE FINDINGS

In the analysis it was argued that the structural positioning of the DoNs in the New Zealand public hospitals whilst incorporating professional line authority lacked operational authority that enabled decision making at the executive leadership level. The dual accountability of the nursing role that

has been imposed in the majority of the DHBs has resulted in a lack of empowerment that is further compounded by a disconnection with the operational nursing budget with the consequence that the DoN does not always have the resources required to perform the work. Consequently, the combination of a lack of responsibility at the operational line reporting level and the overall nursing budget highlights a serious barrier to achieving an alignment with the Magnet hospital program.

The data also reinforced the contradictions found in what was being stated and what was occurring. Whilst there appeared to be a perception by the DoNs that they had a voice at the executive decision making level, the use of the words by the CEOs of advisor, advisory capacity, providing professional advice, advice on nursing issues indicates that the 'voice' the DoN has is regarded predominantly as an 'advisory voice'. Another area in which there appeared to be very different perceptions were in the comments on nursing leadership restructuring. These comments clearly indicated a loss of value placed on nursing leadership positions and roles which was juxtaposed against the comments by both the CEOs and the DoNs that the role was valued and highly influential. The reason for the changing views on what is valued and what is not at any given point in time can be explained further when we look at the concept of nurses as an economic unit of labour.

9.2 NURSES AS AN ECONOMIC UNIT OF LABOUR

North and Hughes (2012) argue that nursing is conceptualised as 'a labour unit and a cost to the organisation' (p. 192). As noted in chapter one in the introduction, the reasoning behind this thinking is not too difficult to understand as economic pressures continue to be applied to healthcare services in New Zealand. However, it is this perception of nursing as a labour cost that influences how nursing is regarded within the context of the organisation.

Healthcare organisations today are moving from the professional bureaucracy of Mintzberg's depictions to becoming complex adaptive

systems. Along with performing as a complex adaptive organisation is the requirement for nursing leadership to ensure that nursing is empowered and able to adapt to the changing organisational environment. North and Hughes (2012) raise the issue that nursing 'intellectual capital and skills' are underestimated in this changing organisational context, as the view of nursing as a labour unit of cost is tied up with the 'past and present approaches reflecting the machine metaphor of organisations' (p. 194). There is a tension between nursing being perceived as a cost and an asset that is also linked with the tensions District Health Boards have in the current environment, in trying to be adaptive organisations that are still enmeshed in a bureaucratic hierarchical structure evident in how the New Zealand government funds these organisations.

In chapter four I discussed Max Weber's notions of authority and legitimacy and how critical to nursing leadership these constructs have been over time through the themes of domesticity and the relative power of the medical profession. It is to these constructs I also turn when looking at nursing being perceived as an economic unit of labour, as this perception as rightly indicated by North and Hughes (2012) also acts as a devaluer of nursing. Having authority, and having this authority legitimised is as Kanter (1993) also acknowledges a sign of influence and power.

Isosaari (2011) talks about the concept of power as not being popular, as it is normally perceived in relation to the health professional and patient care and over time this has been construed negatively. However, in this dissertation it is organisational power that is key to perceptions impacting on nursing leadership and particularly in relation to the decision-making processes that impact on nursing leadership structures. An interesting insight from Isosaari's article is the comment "the actors whose roles are more critical for the organisation gain more power" (p. 385). This comment is based on the perception that hospitals are structured as professional bureaucracies where 'the main performers are doctors, and nurses are classified as support staff' (p. 386). Returning to the notion that nursing is perceived as an economic unit of cost, where nurses intellectual

capital and skills are not readily perceived or acknowledged, lends weight to the idea that nursing and nurse leaders are not viewed as 'critical actors' within the organisation and as a consequence lack the authority and legitimacy associated with having structural power. The comments in the data iterated by the CEOs around the advisory positioning of nursing also support this concept that nursing leaders are not seen as the critical actors. This idea is further explored in the context of the visibility of nursing leaders.

9.3 NURSING LEADERSHIP VISIBILITY

Fedoruk and Pincombe (2000) point out that nursing visibility has to extend beyond the nursing parameters and is too often invisible from the agenda of decision and policy making forums. Partnership and collaboration has to be not only with colleagues but with hospital managers and administrators. Credibility and realism go hand in hand with the promotion of a visible position that is able to influence where required to gain resources to improve the work environment for nursing and its patients. Lomas (2010) focuses on the fact that the DoN needs to broaden their focus so they become visible in the boardroom. The ability to be able to talk beyond nursing and cover 'financial, marketing and commercial issues as well as health and safety issues' are seen as required competencies that make the DoN position not only creditable but also reinforces the visibility of the DoN as an influential and key player of the strategic management or leadership team. Lomas (2010) argues that where DoNs do not have this ability to provide a broader focus and only comment on nursing issues they are often 'downgraded or marginalised' when they do raise clinical issues (<http://www.nursingtimes.net/5013872.article>).

This is reinforced in the research data where in one DHB the CEO actually comments that they would like the DoN to pick up more financial accountability, stating that the role was '*about 80% effective*' and indicated that there was a greater balance required between clinical and financial accountability needed. However, the marginalisation occurs as the

expectation of the DoN to be financially accountable is incongruent with what the DoN is actually able to financially control. Other CEO comments have highlighted the need for the DoN to take up wider accountability as seen by wanting *'responsible use of resources'*, *'best possible clinical service within available funding'* and *'taking accountability and responsibility for the service they provide and the resource they use'*. The lack of clarity around financial accountability is also highlighted by one of the DoNs as they state *'represent nursing issues to senior management and Board. Indirect via clinical/nursing leadership infrastructure, via general/service managers including funding and planning – although this is the area I feel less effective'*. There is a tension underpinning the prescribed visibility the DoN role has, as it is subject to expectations that the DoNs take on a wider accountability that is consistent with a greater visibility but are constrained by an economic environment steeped in traditional budgeting processes and a lack of acknowledged authority that precludes them from doing so.

Sense-making, as Weick (2001) argues is about perceptions and it is critical that senior nursing leadership visibility is perceived to be valuable enough to influence organisational decision making beyond nursing issues. This need for nursing leaders to be well informed is not only supported by Lomas (2010) but also by Laschinger and Wong (2007) who found in their research on nursing leaders in Canadian hospitals that the respondents within the survey *'emphasized that the scope of the chief nursing officer role is seen as broader than nursing'* (p. 31). One of the reasons why a change has to occur between the expectation and the reality of nursing leadership visibility is because the traditional hierarchical hospital structure has undergone *'transformational change'* and there is a more complex adaptive structure working organically to survive in the current environment, subsequently DoNs have to work outside of the traditional nursing domain.

This argument for visibility extends even further as consideration is given to the positioning of the DoN role in relation to the organisational financial concerns. In four of the case studies DoNs were not part of the executive

group that included the Chief Financial Officer (CFO). Through being distanced from the executive financial decision making arena there is a sense of the DoNs being structurally disempowered as their positioning to this group is invisible and inaudible. Pedlar, Burgoyne and Boydell (2010) argue that in times of uncertainty 'the impact of risk and its dangers frequently induces invisibility on the part of those who should be showing leadership' (p. 188). In the case of nursing leadership it would appear that the lack of visibility combined with the distancing of the DoNs from the executive leadership group ensures that they are not influential in this forum. Although by the end of the research it was noted that the numbers of DoNs who did not have direct reporting relationships with the CEO had decreased to two, providing an indication that there were potential changes in DoN visibility.

Inclusion and visibility are two vital factors that ensure nursing leaders are empowered and influential in their DHB. The research data indicated that there were a number of layers to the level of inclusion and visibility that impacted on how the DoN was able to perform their work. The level of inclusion is based not only on where the DoN is positioned but where the influential networks are that support inclusion (Kanter, 1977; Pedlar, Burgoyne and Boydell, 2010). Where a DoN is excluded from the executive leadership team (ELT) the position is more likely to be marginalised and therefore the person restricted in their ability to gain access to the required resources. In addition DoNs who were positioned further down the reporting hierarchy were also more at risk of being disempowered and less influential in gaining access to necessary resources (Kanter, 1997). One of the overriding factors that appeared to determine DoN positioning was the continued emphasis of siloing nursing into '*what nurses do*' and not enabling nursing leaders to contribute more widely to the greater organisation.

It is also argued that contributing to making sense of the analysis the contextual factors such as the dominant operating capitalist economic system in combination with a traditionally disease driven model of health

continues to influence how nursing is positioned in a 'specified place' which constrains nursing leaders. As noted in chapter four the economic rationalism that has resulted from the governmental push for efficiency across health sectors globally has continued to enforce a hierarchically structured health system in New Zealand. The dominant hierarchical bureaucratic structures are compounded by the traditional funding pathways that governments use to fund healthcare. It is this formal funding process in combination with the continued dominance of the disease driven model in healthcare that constrains nurse leaders to being formally positioned leaders with limited authority. The continued lack of understanding by senior management of what is nursing and how as a profession it is evolving, in a medically driven and output oriented health service continues to be a challenge to all DoNs working in New Zealand public hospital systems and one that hinders achieving magnet hospital benchmarked best practice.

9.4 WHAT THIS MEANS FOR NURSING AND PATIENT OUTCOMES

The restructuring of all health roles that occurred in the 1990s also impacted on financial accountability as in the continued quest for difference, nurse manager roles were replaced by roles that did not require a nursing qualification. The generic manager did not report to the DoN on financial matters and this process thereby removed the DoN further from financial decision-making. Kanter (1997) ascribes this process as placing individuals into a position of powerlessness as they are not given the resources and authority to make final decisions and execute action. This situation is not new to New Zealand nursing leaders as noted in the *Report of the Ministerial Taskforce on Nursing* (1998) where it was reported that 'senior nursing positions in hospitals are largely advisory and have little control over nursing resources. Nurses hold the nursing-services budget in only five (out of 21) public-sector hospitals' (p. 67). The telling factor about this comment is that in all the structuring differences that have occurred in the DHBs and the subsequent restructuring to find efficiencies, over a

period of ten years DoNs are still struggling to gain authority over the operational nursing budget for which they are being held accountable for nursing fulltime equivalents (FTE).

I would argue that one of the underpinning reasons for this lack of structural empowerment is due to the lack of organisational cultural change that has occurred at a senior management level, even when changing organisational culture is what is being sought. There are two types of change levels, the first is at a level often referred to as 'skin deep' and the second 'cultural transformation' (Morgan & Sturdy, 2000). What appears to be the case in the DHBs is the level of 'cultural transformation' occurring with the configuration of the resources within the hospital and the 'skin deep' level occurring at the top end of the hierarchy. One of the supporting reasons for arguing this differentiation is based on the capitalist mode of production. Within the organisation, management is driven to create efficiencies based on the difference between the resource costs (labour, technology and consumables) to provide the services and the payment for the services. The lower the resource costs to provide the services in relation to the payment for the services the greater the return to management. Therefore to drive the costs of resources down is paramount to gaining efficiencies. However the DHBs are faced with a tension in this equation as they also have to meet legislative requirements and quality imperatives that do not always provide DHB management with the efficiencies that need to be gained. So whilst the DHBs use 'cultural transformation' to restructure the resources of their organisation to attempt to gain efficiencies, they are unable to change the drivers that underpin this cultural transformation as they are operating in a capitalist mode, so there will always be an element of 'skin deep' change. This notion of a 'skin deep' change process being in action is also reinforced through the traditional dominance of central government and the coercive isomorphism that continues to occur as a result of economic drivers of capitalism.

To continue this line of thinking using the capitalist mode of production, we can look at the issues that underpin the dual accountability of the hospital nursing structures. I return to the comment by Di Maggio and Powell (1983) where power and authority resides in the ability to control 'the production of the producer'. With the implementation of dual accountability there is a sense that the DoN does not have the control or authority over the nursing operational line, they therefore do not have the authority to control 'the production of the producer'. It is acknowledged they have control of the quality of the production through professional oversight but not the authority over the production itself.

The impetus for establishing this way of reporting is primarily a function of new public managerialism and further evidence of constraint brought on by the operating capitalist economic process as ways of managing production are captured in a generic mode of transmission. This is due to the replacement of nurse to nurse reporting as being inconsistent with a generic management model. Through the implementation of this type of management the necessary understanding of the work environment and the product (health care) is not apparent, nor required. Using a generic management model, nursing managers can be viewed as easily replaceable resources and their professional nursing knowledge not valued in the management role. As Baumann and Blythe (2003) comment a common strategy for achieving cost reduction was to downsize personnel as they accounted for over half of the operational costs of the hospital. As nursing accounted for a large proportion of the personnel they were the most affected by downsizing and many nursing jobs were lost. However, the volume of work did not disappear and nurses were required to have larger spans of control with fewer resources and in some areas nurses were replaced with other management related roles not necessarily related to the health specialty area.

The increasing spans of control to which DoNs are now exposed, also provide a tension as the expectation of the role grows but the subsequent financial authority does not. This has been evident in the data with the

reporting of the increasing portfolios by the DoNs as organisational quality and safety roles also fall under their umbrella. Comments from the data indicate that these roles have grown quite extensive with the inclusion of the quality and safety component as we see DoNs reporting increased accountability in the safety and quality agendas with comments such as *'adopted the quality and risk portfolio'* and *'the quality unit and professional development unit reporting to me'*. Duffield, Kearin, Johnson and Leonard (2007) comment on the growing expectations of the DoN role and how the expanding span of control contributes to a decreased ability to influence policy and decision-making because they are not able to represent nursing issues directly as they cannot be at the leadership table at all times. Laschinger and Wong (2007) also highlighted the growing pressure nurse executives in Canada were experiencing as they managed increasing spans of control in the current health sector environment. Although DoNs have increasing spans of control as they respond to the diverse environment in which they are managing, they are undertaking this work within an environment that has contributed to reducing their visibility and where their agency continues to be challenged.

The hospital restructuring changes in New Zealand in the 1990s devolved authority from the nursing leadership role (Gibbs, 1988; Upton, 1991). The removal of the operational line of authority from nursing leadership marked a subsequent decrease in nursing visibility at a senior management level and disempowered the DoN. As noted by Laschinger and Wong (2007) having line or operational authority is one of the ways in which senior nurse leaders are represented in the organisation and are empowered through this accountability. The removal of this operational staffing component from the DoNs appears to imply that the position is that of a professional advisory role. However there appear to be incongruity between practice and narrative where the CEOs want a DoN who is not in an advisory role but the operational jurisdiction they require is not available. This confusion is apparent in the following CEO statement that was highlighted in chapter seven,

“I started by basing it [DoN position] on an advisory role and if the ability and interest of the individual, and needs of the DHB are such that the person can grow into a broader more operational role involving more direction of the nurse workforce than simply advising, I wouldn’t want just an advisor” (CE07)

This comment appears to indicate that there is an expectation for organic growth of the role to occur, but this growth is dependent upon a number of factors and the factors may not necessarily align. For example where the ability and interest of the individual may grow, this may not be parallel to the needs of the organisation.

The use of the generic manager has the potential to not only disempower nursing leaders through displacement but also to change the dynamics required to achieve ‘autonomous nursing practice’ and ‘the control over nursing practice’, two of the components of magnet hospital benchmarked best practice. The challenge to differentiate between professional practice and operational nursing is one not easily distinguishable. It is in this challenging area of trying to differentiate and be held accountable for professional nursing practice that DoNs are calling for a return to *‘back to basics’* nursing and *‘safe professional practice’*. It is argued that the call for these nursing priorities as indicated in the research data, are a signal that dual accountability reporting is not meeting the needs of either the nurses nor the organisational requirements of safer patient outcomes.

The reason for restructuring the triumvirate leadership model was based on a view by the Minister of Health, the Hon. Simon Upton, that the system was too ‘centralised’ and ‘fragmented and politicised’ (1991a, p.1). The limitations of the old system were seen to restrict the ability to manage and resulted in frustration at the delays in getting decisions made. Upton comments that ‘Boards suffer from divided loyalties and unclear responsibilities. Managers are frustrated by interference and muddled accountability’. The new system promised clear accountability with

managers 'having to stand up and be counted' and directors who 'will have to take responsibility for their decisions' (1991b, p. 3).

The inference was that the previous structure was too bureaucratised and created obstacles for any changes that needed to be made. This notion that the medical and nursing professions were partly accountable for the number of obstacles in getting decisions made in the health services was echoed in the United States where the hospitals were also being restructured. As Weinberg notes, 'in making decisions about redesigning the nursing structure, hospital administrators considered changes at an administrative level. They hoped that by weakening nursing's influence, they would remove an obstacle to rapid decision-making and change. Dismantling the nursing structure, they believed, would make the hospital a more flexible organization, better prepared to take action to control costs and increase revenues' (2003, p. 95).

There is a sense of coercive isomorphism occurring as nursing structures are being re-organised to provide greater flexibility for the organisation. However mimetic isomorphism is also evident where the changes to nursing structures themselves create homogeneity of the nursing workforce through reinforcing a pattern of dual accountability. This results in a subsequent loss of 'nursing autonomy' and ability to have 'control over nursing practice'. Again I return to the research data to support this sense of loss and empowerment as the priorities for nursing are reported as '*safe professional practice*', '*safe staffing*' and '*patient safety*'. The focus on safety implies that the practices and staffing are unsafe and given the regulation and educational standards nursing has as a profession the perceptions of 'being in an unsafe situation' is a damning indictment on how the organisation is operating.

To further this point around safety and the inference of 'being unsafe' Black (2005) points out the restructuring that occurred in hospitals also impacted on how the division of labour was segregated. The different areas of work such as cleaning, portering, supplies, catering and maintenance

have all been separated from nursing management. This change to how nursing co-ordinated and managed patient care has resulted in a loss of 'horizontal integration, in which nurses manage all these functions at the level of the patient and the ward' (p. 1395). It is the integration of managing all of these functions by nursing that achieves safe, quality patient care. The loss of nurses to senior nursing roles saw the loss of both institutional knowledge and a pivotal function for managing the different services in an integrated manner.

The recurring theme of '*being safe*' and '*providing safe practice*' highlights the fact that there have been concerns by nurses around the inability to maintain safe patient care in the current environment. This sense of a lack of safety is also highlighted by the comments of Professor Alan Merry, Interim chair for the New Zealand Health, Quality & Safety Commission around the consistent trends of adverse events in hospitals that include falls, clinical management and medication errors. He notes in the report *Making our Hospitals Safer*, that 'the occurrence of the same types of event over and over again strongly suggests problems that lie primarily in the systems and processes used in providing health care. The vast majority of the incidents reported here do not have a single cause and are not the fault of one individual' (2010, p. i). It is therefore argued through an analysis of the research data that DoNs have continuing concerns for patient safety in a system that does not support their ability to be truly accountable for nursing practice under their current leadership mandate.

9.5 LIMITATIONS

Limitations of the research methodology have been addressed in 5.2. Other limitations that constrained the research were related to time and cost. Direct interviewing of participants would have provided further depth to the qualitative analysis. In addition on advice from the Chair of DHBNZ, it was not seen as feasible to interview the CEOs with a survey being suggested as the best way to gain CEO participant capture. Similarly there were time constraints in trying to interview the DoNs.

9.6 WHERE TO FROM HERE

It is important to note that during the course of this research, and since the data collection period there has been an overt political shift towards greater clinical involvement of DoNs within the DHBs and public hospitals. The government has put emphasis on the DHBs increasing their clinical governance and a greater focus nationally has been set up on quality and patient safety. The continuing requirement for reporting by DHBs of adverse outcomes for patients overall has led to this increased focus on quality and safety. As noted in the discussion above, patient safety is a high priority for the DoN and evident in all of the hospital narratives. The issues the DoNs faces to create a culture of safety in the current working environment in New Zealand public hospitals are complex given the current structural positioning of the DoN role and the related funding arrangements and expectations of accountability. Doucette (2012) offers some insights into how nursing executives can create a culture of safety. In the first instance it was to identify whether the nurse executive ranked the competency of 'having the knowledge of, and dedication to, patient safety' as one of their top priorities (p. 53). The second was to identify the barriers to safe cost-effective practice and to be involved in removing them. Furthermore Doucette also identifies that one of the key methods for gaining better patient outcomes and producing financial benefits for the organisation is through successfully leading interdisciplinary groups.

The increasing political influence towards greater clinical governance in the DHBs has provided an avenue for decision making in which the DoN's in the current New Zealand DHB environment can position themselves to influence achieving greater outcomes for patients in the public hospitals. Although I would have to agree with Gamblin (2012) that the DoN position is vulnerable and subject to constant political change. The findings in this research support a sense of vulnerability of the role.

The following discussion offers some recommendations to be considered for an improvement of aligning nursing leadership with Magnet hospital principles. Structural changes that could be made over time would be the change of non-clinical manager positions to nursing manager positions. The wider scope in interpreting nursing for registered nurses would enable these nurses to include a managerial and financial component to their clinical knowledge. In the current fiscally constrained environment this knowledge is a necessity. It would also follow that structural changes would be required in nursing education which would need to include a practical health management component that enables nurses to make the connections between achieving patient safety and being cost effective. The study undertaken in the United States by Liu et al (2009) provides an indication that nursing line authority is more cost effective than service line authority in acute care settings.

A pilot study could be developed to implement a nurse line authority project in one of the more innovative larger DHBs. This project could be recommended through the clinical governance structure and would need to be run for two years to establish benefits. Utilising the Magnet hospital principles the pilot could evaluate the costs of running a structurally empowered nurse work environment against improving patient outcomes. The creation of an alignment around the key issues of patient safety, work culture and cost containment utilising the magnet hospital principles will provide a framework on which to develop the pilot. The challenges to this pilot will not only be potential managerial resistance but also establishing how the financial and budgeting process might work to support the project. This idea stems from a need to see system changes that are evolving with not only nursing changes but the changing way in which patients view healthcare. This dissertation provides a starting point for discussion around implementing changes not only to the current nursing leadership structures but also to nursing education. Doucette (2012) states 'the one permanence in the role of the nurse executive is change' (p. 54-55). Constant evolution in response to patient demands, a need for clearer

transparency and cost effectiveness continues to emerge in various stages and the nurse executive will be expected to lead nursing in the organisation through difficult decisions.

RECOMMENDATIONS

1. That all DoN reporting lines report directly to, and be accountable to the CEO.
2. That DoN performance appraisal mechanisms contain a set of Key Performance Indicators(KPIs) that are clearly linked to maintaining safe and effective patient outcomes.
3. That a pilot study be considered in one of the smaller DHBs for the DoN to be responsible and accountable for both professional and operational nursing lines including financial budgets.
4. That as a result of recommendation three clinical management positions that are staffed by nursing personnel be titled nurse managers and report both operationally and professionally through a nursing line.
5. That further to recommendation four management positions with clinical accountabilities be staffed by personnel who have appropriate clinical expertise and hold a current annual practicing certificate (APC).
6. That postgraduate nursing courses not directed towards Nurse practitioner roles include a core managerial, health policy and financial paper.
7. That undergraduate nursing courses contain a practical health management module which includes both policy and fiscal literacy.

9.7 THE THREE RESEARCH QUESTIONS ANSWERED

To conclude this dissertation I return to the three research questions that were outlined in the introduction:

- How are nursing leadership structures configured in the organisational structure of each District Health Board?

- How did these structures come about and, why do they differ across the country?
- How does the pattern of New Zealand structures align with what is known internationally to be best practice?

In response to question one, the findings from the data indicate that the configurations of organisation and nursing leadership structures were visually varied, however there were similarities inherent in the informal processes within the organisation and chapter four and nine highlight how this may have come about. The determinants that underpin these structures are power and authority and these two constructs have evolved from a complex mix of political and economic factors and historical influences that continue today to influence the DoN positioning in the DHB structures. In the final question, an analysis of the research indicates the barriers that impede the alignment of New Zealand nursing leadership structures with the Magnet hospital best practice are: the structural positioning of the DoN in relation to operational accountability, the continued use by the majority of DHBs of only professional line reporting and the consequent lack of operational financial authority for nursing.

In conclusion, this thesis has sought to make sense of the DoN structural positioning within the New Zealand public hospital system. The findings indicate that there is an ambiguity to the structural positioning of the DoNs, which is linked to the perceived expectations of the DoN role by senior management, and the lack of operational financial authority that is accorded to the role. The combination of these two factors undermines the DoN authority within the public hospital, which in turn causes disempowerment of the role. The lack of adaptability in the current institutional structures contributes further to the ambiguity of the structural positioning of DoNs as they attempt to meet the expectations of a complex adaptive system within the constraints of a rigid bureaucratic system.

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APPENDIX A – INFORMATION SHEET

1



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Information Sheet
Title: Profiling Nursing Leadership in the New Zealand Public Hospital system

Introduction
Hi my name is Keri-Ann Hughes and I am 1st year PhD student at Massey University School of Nursing. I am a registered nurse who has a varied background with an interest in organisational management and nursing. I am currently undertaking research in the area of nursing leadership, particularly within the hospital setting. Professor Jenny Carver (Professor of Nursing, Clinical) from Massey University is my primary supervisor and Professor Jill White (Professor of Nursing), University of Technology, Sydney is my second supervisor. I am looking at profiling nursing leadership within the New Zealand public hospital system and this has been prompted by a similar research exercise that has successfully been undertaken in the Canadian health setting.

Research Aim
The aim of the study will be to gain an understanding of the decision-making processes that impact on how nursing leadership is configured within each District Health Board.

The research questions:
How are nursing leadership structures configured in the organisational structure of each District Health Board in New Zealand?
How did these structures come about and, why do they differ across the country?

The first part of the study involves sending an information sheet to all 21 District Health Boards in New Zealand and asking for a copy of their organisational charts and their nursing structure chart and will be a paper based exercise to provide background data for the study. The second part of the study involves the use of a questionnaire with the Nurse Executives New Zealand group, and the third part will be through the use of structured interviews (electronic or face to face) with Chief Executives of District Health Boards and significant nurse leaders.

Part one of the study does not require ethical approval as organisational structures are in the public domain. Many organisational charts are available on the DHB web sites.
Ethical approval will be sought for part 2 and part 3 of the study.

Brief background
A large study of nursing leadership and structures in Canadian hospitals has just concluded. The aim of that study is to assist with the decision making process when nurse leader role configurations and organisational structures are being designed. By determining the best mix of organisational structures, support and strategies, management will be able to achieve retention of nurse leaders and optimal staffing as well as quality patient outcomes (Laschinger/Wong 2003). The final report for this study has just been released.

The use of a similar exercise in New Zealand Hospitals will provide information about nursing leadership that does not currently exist. In light of overseas studies and the results of the New Zealand studies (McClosky & Diers; Davis et al) it is essential that a greater understanding of nursing leadership in New Zealand be attained. The restructuring of health during the 1990s and the consequences of this restructuring have had negative impacts on nursing leadership within the current hospital system.

The study will not identify any individual District Health Boards and all information will be kept confidential and used only for the purposes of the research.

I am happy to provide you with a copy of the full study proposal or answer any questions you may have about the study at any time. You may also contact my supervisor:
Professor Jenny Carver
Department of Nursing
School of Health Sciences
Massey University
Phone: 06 356 6059 ext 7719.

 Te Kaitiaki
to Kaitiaki

APPENDIX B – ETHICAL APPROVAL



Massey University

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(Research Ethics)
Private Bag 11 222
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T: 04 439 8720/87615
F: 04 439 8622
humanethics@massey.ac.nz
researchethics@massey.ac.nz
100@massey.ac.nz
www.massey.ac.nz

25 March 2009

Ms Kerri-Ann Hughes
P O Box 175
RONGOTEA

Dear Kerri-Ann

Re: HEC: Southern A Application – 09/15
Reviewing the configuration of nursing leadership in the New Zealand Public
Hospital system

Thank you for your letter dated 20 March 2009.

On behalf of the Massey University Human Ethics Committee: Southern A, I am pleased to
advise you that the ethics of your application are now approved. Approval is for three years. If
this project has not been completed within three years from the date of this letter, reapproval
must be requested.

If the nature, content, location, procedures or personnel of your approved application change,
please advise the Secretary of the Committee.

Yours sincerely

Professor Julie Boddy, Chair
Massey University Human Ethics Committee: Southern A

cc: Prof Jenny Carryer
School of Health & Social Services
PN351

Prof Warwick Slinn, Acting HoS
School of Health & Social Services
EN351

APPENDIX C – APPROVAL FOR USE OF CANADIAN LEADERSHIP QUESTIONS

Page 1 of 2

Kerri Hughes

From: Heather Laschinger [hkl@uwo.ca]
Sent: Wednesday, 6 May 2009 10:17 a.m.
To: Kerri Hughes
Cc: hkl@uwo.ca
Subject: Re: Permission to use qualitative questions for Doctoral study

hi Kerri...sorry to miss your call today when you called all the way from New Zealand!...was on a conference call so couldnt pick up!!

you certainly can use our tool in your study...it would be interesting to see your results...and learn more about nursing leadership in NZ...sorry for not getting back to you earlier...Heather L

----- Original Message -----
From: Kerri Hughes <Kerri.Hughes@midcentraldhh.govt.nz>
Date: Tuesday, May 5, 2009 5:49 pm
Subject: Permission to use qualitative questions for Doctoral study
To: hkl@uwo.ca

> Hi Professor Laschinger
> I am a doctoral student based in New Zealand and I emailed early last year around your research - Profiling Nursing in Canadian Hospitals, as I am currently undertaking PhD research on leadership in the New Zealand Public Hospital system and I found your research very interesting and insightful. I have also tried to ring today and left a message, this email is following up on that phone call. I have submitted my research for ethical approval through Massey University and been granted ethical approval for my research. This research includes a survey to the Directors of Nursing and Chief Executive Officers at our 21 New Zealand public hospitals. I would like to ask your permission to use the qualitative questions you used in the appendix of your research (with due acknowledgement and also referencing) for my survey to the Directors of Nursing and to the Chief Executives in my research over here. Could you please let me know if you are happy to grant this permission, I have attached an information sheet for you and am happy to respond to any further questions. Alternatively I am happy for you to contact my Massey University Supervisor Professor Jenny Carrier on 00 64 8 356 9099 ext 7719. I look forward to your reply.

>
> regards
>
> Kerri-ann Hughes BA, MPP, MA(Hons), PGDBA, RN

> Business Leader, Public & Dental Health

> Mid Central Health

> PH 06 350 9123 Fax 06 350 9111


>
>

> **Attention:**
> This e-mail message and any attachments contain information that is confidential and may be subject to Legal and Medical privilege.
> If you are not the intended recipient, you must not peruse, use, pass on or copy this message or any attachments.
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6/05/2009

APPENDIX D – INFORMATION SHEET

2



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Reviewing the configuration of nursing leadership in the New Zealand public hospital system

INFORMATION SHEET

Researcher
My name is Kerri-ann Hughes and I am a PhD student at Massey University, School of Health and Social Services. I am a registered nurse who has a varied background with an interest in organizational behaviour and nursing. I am currently undertaking research in the area of nursing leadership, particularly within the hospital setting. Professor Jenny Carryer (Professor of Nursing) from Massey University is my primary supervisor and Professor Jill White (Professor of Nursing), University of Sydney is my second supervisor.

Project Description
This research aims to assess how the leadership structures as they currently are, have come about, and to explore what connections exist between the evidence connecting organizational design to patient safety and the decisions made about nurse leadership deployment.

The study is a three phase study. Phase one is a document review of District Health Board organizational charts and nursing structure charts that has been completed. Phase two of the study is to survey (descriptive survey tool) the Nurse leaders at Director of Nursing or equivalent level as this group of nurses form the most senior group within the District Health Board. Phase three of the study is to interview the Chief Executive Officers or Chief Operating Officers of the District Health Boards, and also the Chief Nurse at the Ministry of Health.

Recruitment & Selection
Selection of participants is purposive with participants being CEOs/COOs and Directors of Nursing (or equivalent) from District Health Boards in New Zealand. Participants will be emailed a questionnaire survey in the case of Directors of Nursing (or equivalent) and invited to participate in email or phone interviews if they indicate this on the survey. CEOs/COOs and the Chief Advisor Nursing at the Ministry of Health will be invited to participate in interviews.

Invitation to participate & Project Procedures
This information sheet is an invitation for you to participate in this research. Accompanying this information sheet will be a consent form, survey questionnaire (Directors of Nursing)/ copy of interview questions(CEO/COOs) and a *stamped-addressed envelope*. There will also be the option for emailing the questionnaire for those who would prefer an electronic copy.

Information Sheet – Reviewing the configuration of nursing leadership in the New Zealand public hospital system |

Te Kōwhiri
o Te Pūkaki

Directors of Nursing

Once all the questionnaires have been returned they will be analysed. Questionnaire participants will be given the opportunity to be interviewed if they indicate they would like to do so. For participants wishing to participate in an interview, a phone interview will be arranged at a time mutually agreed.

CEOs/COOs & Chief Advisor Nursing Ministry of Health

CEOs/COOs and the Chief Advisor Nursing Ministry of Health will be sent the information sheet by post and also by email asking if they would be interested in participating in either an email interview or a phone interview. Following indication that they would like to participate in the research the interview questions will be emailed through with a return date or a phone interview arranged at a time mutually agreed.

All interviews will be transcribed and sent back to participants for review with *stamped-addressed envelopes* or email arranged.

Data Management

Data will only be accessed by the researcher and supervisor and is subject to Massey University Research guidelines. The study will not identify any individual District Health Boards or participants in this research, and all information will be kept confidential and used only for the purposes of the research.

Participant's Rights

Questionnaire participants only

- Completion and return of the questionnaire implies consent. You have the right to decline to answer any particular question.

Interview participants

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study (within two months of data collection);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- ask for the recorder to be turned off at any time during an interview;
- be given access to a summary of the project findings when it is concluded.

Ethics Approval

This project has been reviewed and approved by the Massey University Human Ethics Committee: *Southern A, Application 09/15*. If you have any concerns about the conduct of this research, please contact *Professor Julie Boddy*, Chair, Massey University Human Ethics Committee: *Southern A*, telephone 06 350 5799 x 2541, email humanethics@massey.ac.nz.

Project Contacts

Researcher

Kerri-ann Hughes
School of Health & Social Services
Massey University
Ph 021 654 260
Email: k.a.hughes@massey.ac.nz

Supervisor

Professor Jenny Carryer
School of Health & Social Services
Massey University
Ph 06 356 9099 ext 7719
Email: J.B.Carryer@massey.ac.nz

I am happy to provide you with a copy of the full study proposal or answer any questions you may have about the study at any time.

APPENDIX E – PARTICIPANT CONSENT FORM

 **Massey University**
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***Reviewing the configuration of nursing leadership in
the New Zealand public hospital system.***

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I wish/do not wish to have my tapes returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ Date: _____

Full Name - printed _____

Participant Consent Form



APPENDIX F – NURSING QUESTIONNAIRE



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Nursing Leadership Questionnaire

Researcher: Kerri-ann Hughes (PhD student)
Supervisor: Professor Jenny Carryer, Massey University
2nd Supervisor: Professor Jill White, Sydney University
Institution: Massey University

Questionnaire Information

This questionnaire is in two parts. Part A is for providing a *statistical base to draw a snapshot of the organisation* and Part B is to *enable themes to be drawn out* on understanding around your views on nursing leadership. There are 15 questions in total. Question 16 is optional about further contact.

The *statistical snapshot* is to draw a picture of current nursing leadership and provide a context and base line.

The *thematic questions* have been drawn (with permission) from the Canadian Nursing Leadership study conducted by Professor Heather Laschinger and Dr Carol Wong 2006-2007.

Please feel free to elaborate on either part of the questionnaire as your views are extremely important to this research.

Please return the questionnaire by the marked date in the *stamped-addressed envelope provided*.

Confidentiality

All of the information pertaining to this study is strictly confidential and no names of individuals or organizations will be divulged during the course of the research, or referred to in the research findings. Material collected by the researcher is stored and subject to the university research guidelines. The research proposal and this questionnaire has been subject to the Massey University Ethics process.



Part A – Statistical Organisational Profiling

Q1. Could you please circle your age group:

20-25 26-30 31-35 36-40 41-45 46-50
51-55 56-60 61-65 66+

Q2. Could you please circle which number represents your length of time in your current role:

Less than 1 year 1-2 years 3-5years *
6-10 years 11-15 years 16 years+

Q3. Could you please circle which number represents your length of time in a nursing management role:

Less than 1 year 1-2 years 3-5years
6-10 years 11-15 years 16 years+

Q4. Could you please circle which number represents your length of time in a nursing role:

Less than 1 year 1-2 years 3-5years
6-10 years 11-15 years 16 years+

Q5. Could you please circle the group that represents the highest nursing qualification achieved:

PhD
Masters
PostGraduate Diploma
PostGraduate Certificate
Bachelor
Diploma
Certificate
Other Please specify.....
.....
.....

Q6. Could you please indicate whether you report directly to the CEO/COO or whether you report to the Group Manager(provider arm):

CEO/COO Group Manager Other (Please specify)
.....
.....

Q7. Could you please indicate by circling the relevant areas for which you have responsibility :

Nursing line authority nurse recruitment budget holder

Financial accountability nursing other (please specify)
.....
.....

Q8 Could you please indicate the type of structure that your role functions in:

hierarchical flat mixed program

Part B Qualitative Themes

Q9 How does the structuring of your role influence your ability to represent and influence the interests of nursing at senior decision making levels and the organization as a whole?

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Q10 Given the scope of your role, how do you address/fulfill the voice for nursing?

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Q11 What mechanisms or strategies do you use to keep abreast of nursing issues in your organization?

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Q12 What resources do you have to fulfill the professional nursing practice aspect of your role?

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Q13 How would you describe the degree and nature of contact/communication you have with other levels of patient care management in order to seek or share information on issues that you may need to address?

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Q14 Think about the last time your role was restructured or changed in a significant way, what was the impact on you and how did you carry out your role or your ability to provide leadership?(For example when did it occur, what prompted it and what was the change?)

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Q15 What are three current top priorities for nursing or patient care in your organization?

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Q16 Would you be willing to be contacted for further clarification by either email or telephone?

Yes

No

If you answered yes please supply the following details:

Name:.....

Phone No:.....

Email:.....

Please note this sheet will be removed upon the return of the questionnaire in order to maintain anonymity of responses.

Thank you for your time. 😊

APPENDIX G – CEO/COO QUESTIONNAIRE



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CEO/COO Interview Questions (Length 14 Questions)

Researcher: Kerri-ann Hughes (PhD student)
Supervisor: Professor Jenny Carryer, Massey University
2nd Supervisor: Professor Jill White, Sydney University
Institution: Massey University

Why this research is important:

Managing a DHB is a game of strategy. Knowing who and what your chief reports do is critical to the effectiveness of this strategy. Nursing workforce constitutes approximately 60% of your DHB and particularly provider arm workforce, and knowing and understanding that their leadership and vision supports yours as CEO is critical to success.

Purpose:

This research is the third phase in a study on Nursing leadership in new Zealand hospitals and I want to hear and understand what your view is on Nursing leadership and the Director of Nursing role in your organization. This is a sequential process where DoNs have also responded to a nursing leadership specific questionnaire in Phase 2.

What you will get out of this research:

This research will provide you with a summary of the main points and analysis of the research. It is hoped you can use this analysis to formulate strategies for review at your executive management/senior management leadership meetings.

I am happy to respond to any queries or questions and can be contacted via email or phone:

Email: k.a.hughes@massey.ac.nz
DD: 06 350 9123

Kerri-ann Hughes
Health & Social Sciences
Private Bag 11 222
Massey University
PALMERSTON NORTH

Please email your answers directly onto the questionnaire or alternatively fill in and post or scan to the above address by 5pm Friday 12th March 2010.

Confidentiality

All of the information pertaining to this study is strictly confidential and no names of individuals or organizations will be divulged during the course of the research, or referred to in the research findings. Material collected by the researcher is stored and subject to the university research guidelines. The research proposal and this questionnaire has been subject to the Massey University Ethics process.



Part A – Statistical Organisational Profiling

Q1. Could you please tell me which is your age group:

20-25 26-30 31-35 36-40 41-45 46-50
51-55 56-60 61-65 66+

Q2. Could you please tell me which of the following represents your length of time in your current role:

Less than 1 year 1-2 years 3-5years
6-10 years 11-15 years 16 years+

Q3. Could you please tell me which of the following represents your length of time in a management role:

Less than 1 year 1-2 years 3-5years
6-10 years 11-15 years 16 years+

Q4. Could you please indicate which of the following groups represents your occupational background; you can choose more than one:

Management Administrative Nursing
Medical Allied Health Other (Please specify)

Q5. Could you please indicate which of the following group represents the highest qualification achieved:

Professional registration
PhD
Masters
PostGraduate Diploma
PostGraduate Certificate
Bachelor
Diploma
Certificate
Other Please specify.....
.....
.....

Q6 Could you please indicate the type of structure that your role functions in:

Hierarchical flat mixed program

Part B Qualitative Themes

Q7 Could you briefly explain the nature of your role as CEO/COO & Chief Advisor Nursing (where this is applicable)?

Q8 How do you explain the nature of your role and relationship to the nurse leadership structure in the District Health Boards/Hospital?

Q9 Has your perspective on the Director of Nursing position (or equivalent) role changed over your period of tenure, and if so how?

Q10 What do you see as the key priorities of the Director of Nursing (or equivalent) role in your organization?

Q11 How do you evaluate the effectiveness of the Director of Nursing or equivalent role?

Q12 How do you think the Director of Nursing (or equivalent) role is best structured for effectiveness?

Q13 What do you see as the key priorities for nursing in your organization?

Q14 What information or evidence do you consider in structuring nurse leadership positions?

Thank you for your time, a summary of the questions and your responses will be sent to you for confirmation and clarification.

APPENDIX H – PARTICIPANT SUMMARY FEEDBACK



Massey University
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To: DHB CEOs, COOs & DoNs
From: Kerri-Ann Hughes – Massey PhD Student
Date: 22/11/2012
Re: New Zealand Nursing Leadership Research Summary – Brief Update

Brief Background

A study of nursing leadership and structures in Canadian hospitals was conducted in 2004-2006. The aim of that study was to assist with the decision making processes when nurse leader role configurations and organisational structures were being designed. By determining the best mix of organisational structures, support and strategies, hospital management will be able to achieve retention of nurse leaders and optimal staffing as well as quality patient outcomes. (Laschinger, Wong:2003)

The use of a similar, qualitative exercise in New Zealand public hospitals will provide information about nursing leadership that currently does not exist. In light of overseas studies and the results of the New Zealand studies (McClosky & Diers:2000; Davis et al:2003; Carryer et al:2011) it is essential that a greater understanding of nursing leadership in New Zealand be attained. The restructuring of health during the 1990s and the consequences of this restructuring have had negative impacts on nursing leadership within the current hospital system.

Research Aim

The research aim, as noted in the original information sheet, has been to gain an understanding of the decision-making processes that impact on how nursing leadership is configured within each District Health Board.

Research Questions

The research questions that have followed on from this aim are:

How are nursing leadership structures configured in the organisational structure of each District Health Board?

How did these structures come about and, why do they differ across the country?

How do these nursing leadership structures align with what is known internationally to be best practice?

Data Collection

This is an inductive, qualitative case study. There are three primary phases of data collection. Phase One has involved a review and analysis of District Health Board



organisational and nursing structure charts. Phase Two and Phase Three has been the sending out of a survey questionnaire to DoN's and CEOs and COOs if CEOs were unavailable. The survey questions were based on the qualitative questions used for a similar profiling exercise undertaken by Laschinger & Wong(2007) on Canadian Nursing Leadership.

All 21 DHBs were invited to participate, although this number has been reduced to 20 with the merging of Otago and Southland DHBs to form Southern DHB. There were 15 responses from the 21 DHBs for the Phase One data collection. In Phase Two, 16 DoNs replied to the survey and in Phase Three, 9 CEOs and COOs responded. Both demographic and thematic data was captured from the questionnaires.

The research is a 6 year part-time doctoral study from July 2006 – March 2012. The first phase was undertaken in 2007-2008, Phase two survey questionnaires were sent out in 2009 and Phase three questionnaires were sent out in May 2010. All data from these phases is now collected and analysis is underway.

Findings to Date

The data captured in the Phase One findings illustrated that while the majority of DoNs reported directly to the CEO a number of them reported to the COO and were therefore a level removed within the structure. This has implications for influencing decision making as DoNs who directly reported to the CEO were often part of the Executive Leadership/Management Team as well as the hospital Senior Management/Leadership team, whilst DoNs who reported directly to a COO were only part of the Senior Management/Leadership team for the hospital.

Often structural charts will indicate various operational and professional reporting lines, however there was a wide variety of different charts and reporting lines professionally were not always clear. Dual reporting for nursing brings challenges as the operational managers are not always clinical and communication channels become stretched or break down. Evidence of this was found in some of the DoNs responses in the survey around communication and the difficulties they had around overarching issues on patient care when dealing with a non clinical manager.

The nursing structural charts could not easily be mapped onto the organisational structure charts for the organisation they belonged to, and all of the organisational charts were different. Understanding spans of control was different for all DoNs and what they were expected to undertake. While there is an expected degree of difference due to the varying size of the organisation and composition of the services they provide there were difficulties in analysing relative spans of control. This was also reiterated in the Phase two surveys through the different responses that Dons supplied in the questionnaire.

Financial reporting and budgeting was not clearly linked to Nursing in the organisational structure charts. This lack of clarity around financial accountability and budgeting was reinforced with the Phase two questionnaires to DoNs. All of the DoNs were primarily responsible for budget holding around their own immediate unit and the NetP funding but were indirectly held accountable for the overall nursing budget. The lack of clarity is also further reinforced in the Phase three

questionnaires to CEOs where it was noted by a number of them that they would like the DoN to become more financially accountable.

Summary

The research questions focus on how nursing leadership has been configured in New Zealand public hospitals, how did the structures come about, and why. Additionally, the question is asked do the nursing leadership structures align with international best practice. A review of literature in the area of nursing leadership, Magnet Hospitals, New Zealand health, New Zealand Nursing, organisational design, behaviour and communication indicates that DoN roles have been configured out of a combination of historical, economically and politically driven variables. The data from the three phases supports the variables that have been indicated in the review of the literature. DHB organisational structure charts, overall continue to follow the hierarchical structures found in a bureaucratic management style. Nursing culture and history has also contributed to the way the DoN role has followed on from the matron of early 19th century. The political and economic variables that impacted on the New Zealand health system have played a significant role in the restructuring of health care over the last two decades and the impact this has had on not only nursing as a discipline but nursing leadership. The question of alignment with best practice also poses an interesting analysis as the comparator has been Magnet Accreditation that has been looked at both as an overarching concept and then broken down into broad Magnet component parts.

Where to from Here....

Fine tuning analysis and writing thesis up. The thesis is due 2nd April 2012 and the research is currently on track for submitting for this date.

A publication on Phase One has been accepted by Nursing Policy, Politics & Practice (peer reviewed US journal) I have appended a copy for your information: Hughes, K. & Carryer, J.B. 2011. *Nursing Structures in New Zealand Public Hospitals: Current Configurations*. Policy, Politics & Nursing Practice. Sage Journals. DOI:10.1177/1527154410393978

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Regards
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