Role of the ward sister: tensions, pressures and opportunities


Summary
This article investigates the factors that have shaped the role and work experiences of ward sisters and charge nurses. The article considers how ward sisters make sense of the tensions between their clinical and managerial responsibilities and the contradictions inherent in different aspects of their role. It offers suggestions on how these tensions might be alleviated.

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The position of ward sister includes both clinical and managerial responsibilities. While they are professionally accountable for standards, co-ordination and delivery of care (DH 2001a), ward sisters also have a pivotal role in decisions affecting the implementation of governmental and organisational policy. For example, although policies such as single sex wards may seem straightforward to politicians and the public, the complex realities at ward level require careful negotiation of the competing interests of patients (Dixon-Woods et al 2009). The direct relationship ward sisters have with patients means that they, unlike more senior managers, witness the consequences of competing policy objectives and operational realities and may be blamed when things go wrong.

Against this, as a Royal College of Nursing (RCN) (2009) report titled Breaking down Barriers, Driving up Standards concluded, ward sisters find it difficult to delineate their role given an absence of agreed definitions and of clarity about its aims, purpose and functions. They struggle to control the demands and pressures placed on them in the form of the varying expectations of managers, patients, other health professionals and junior staff. In addition, the formal bureaucratic processes and hierarchies within which they are obliged to work mean that they may lack the authority to implement the key actions that underpin nursing standards (RCN 2009).

Breaking down Barriers (RCN 2009) concluded that these tensions and contradictions were having an adverse effect on the working lives of ward sisters to the extent that some felt that their job had become "almost impossible".

This article examines the factors that have shaped the role and work experiences of ward sisters and charge nurses and invites the reader to consider how these challenges might be alleviated.

THIS ARTICLE ADDRESSES a growing tension in the role of the ward sister. The terms ‘ward sister’ and ‘charge nurse’ can be used interchangeably. The term ward sister is used in this article for purposes of brevity. Practitioners and policy makers have recognised that the ward sister is ‘the backbone of the NHS and the hub of the wider clinical team’ (Department of Health (DH) 1999). As practitioner-managers with 24-hour responsibility for care, ward sisters are at the interface between management and clinical staff; thus they are at the ‘point of care delivery’, where policy aspirations meet operational realities.
sisters. It investigates how government policies over previous decades have multiplied demands on ward sisters. It considers the resulting tensions to which ward sisters have become subject and how practitioners have attempted to make sense of and manage these tensions. Finally, strategies are suggested to help overcome the challenges that these tensions have presented.

**Government policy and public sector change**

The character of the present role of ward sister has been shaped by a succession of government policy initiatives and organisational changes. Labour governments between 1997 and 2010 sought to expand the role of nurses (DH 1997, 1999). NHS trusts have been expected to strengthen the contribution that nursing can make to improving access to services and to quality by encouraging and supporting nurses in their acquisition of new knowledge and skills (DH 1997, 1999). Nurses have taken on routine work from junior doctors, whose working hours were gradually reduced in compliance with the European Working Time Directive (DH 1998).

This expansion of responsibilities has been achieved without any increase in the overall number of nurses and has, therefore, added to nurses’ workloads (Calpin-Davies and Akehurst 1999). At the same time, statements by Labour health secretaries suggested that developing nurses’ motivation was also a government priority, on the assumption that this was key to productivity (Hoggett 1996).

Two further policy initiatives have combined to steer senior nurses towards greater managerial responsibilities. First, in a speech to the RCN conference in 2000, the then secretary of state Alan Milburn asserted that ward sisters were the ‘linchpin’ of hospital services but for too long had been given responsibility without power. This signalled the Labour government’s view that nurses’ traditional subordinate status to both doctors and managers was holding back their contribution to the health service. It presaged a commitment to a scheme through which ward sisters would be able to take control of their ward’s budget for maintenance and repairs (Duffin 2000).

The then chief nursing officer, Sarah Mullally, saw this initiative as an opportunity for ward sisters to ‘reclaim the wards’ (DH 2001b). Others pointed out that it could also be perceived as an attempt to enlist nurses’ commitment to the government’s agenda and enhance their motivation.

A subsequent health secretary, John Reid, articulated an aspiration for a new generation of ‘entrepreneurial’ nurses. Nurses would be expected to place less emphasis on conformity to the bureaucratic culture of rules and hierarchy in the NHS and, instead, be more ‘entreprising’ in the sense of creating and implementing new ideas, being less risk averse and less bound by rules (Reid 2003).

What was not recognised fully in this broad aspiration was that budgetary responsibility, entrepreneurialism, risk taking, personal initiative and creativity might all conflict with the principles of caring and equitable treatment (Bolton 2003).

**A context of change**

This move to instil greater managerial responsibility and entrepreneurship among nurses was part of a wider attempt to change the self-identities of public sector professionals (Casey and Allen 2004). The increase in the use of managerial language and practices is a theme that has been running through government initiatives in the public sector in the UK since the 1980s. More specifically, NHS trusts have been encouraged to imitate the private sector by adopting human resource management practices such as performance appraisals and quality improvement programmes. Managers such as ward sisters have been encouraged to move from routine supervision to ‘leadership’ to get the best from a more flexible, highly skilled and educated workforce (Proctor and Currie 2002). This, in turn, has been founded on broader organisational change in the form of more decentralised decision making, in which ward sisters take on the enhanced role of ‘business unit managers’.

The reality of change did not quite match the intention. As was the case with first-line managers in other types of organisations (Hales 2003, 2005), the essentially supervisory nature of the role of ward sister remained remarkably resilient, even if, in some instances, it was supplemented by broader budgetary and human resource responsibilities.

As practitioner-managers, ward sisters have been professionally accountable for maintaining standards of nursing care and for co-ordinating delivery of care. This has necessitated adopting a largely supervisory role. However, the DH insisted that it was the leadership, in terms of standards of care, provided by ward sisters that was crucial ‘to prevent lapses in… fundamental and essential aspects of care’ (DH 2001a). Organisations were now expected to ensure that ward sisters’ personal and professional responsibility and accountability were matched by organisational structures and arrangements that allowed and
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(Gould et al 2001). A culture of targets More recently, the NHS has

been subject to a system of governance involving the measurement of performance against specific targets, with managers being held accountable for achieving those targets and either rewarded for doing so or at risk of dismissal for failing. Again, the effect has been equivocal because, although this regimen of ‘targets and terror’ has put managers under considerable pressure, it has also given them a more explicit role, in terms of capacity management, in what has always been a clinically dominated organisation (Bevan and Hood 2006).

As first-line managers with both clinical and

managerial responsibilities, ward sisters have also

been subject to the pressure to achieve targets. However, despite the pressure, they may have had much to gain, as they may have been able to use their newly acquired management authority to allocate resources and shape processes around quality of care.

Overall, the combined effect of these
government initiatives and organisational
changes has been not only to offer opportunities
to ward sisters but also to pose threats to their
perceptions and experience of their role. Greater
managerial responsibilities may increase ward
sisters’ capacity to shape their ward
environment but some ward sisters may fear the dilution of their clinical authority and contribution. Evidence suggests that ward sisters feel that the threats outweigh the opportunities and that, as a consequence, they have experienced dissatisfaction, stress and disillusionment with their role (Allen 2001, Doherty 2007, RCN 2009).

Ward sisters’ experience of their
developing role

Since 1991 the ward sisters’ role has been
directed increasingly towards management
duties and away from direct clinical practice. At that time, the Audit Commission (1991) recommended that budget and human resource management should be devolved to ward sisters and that they should spend a greater proportion of their time managing

and developing staff, rather than providing
direct patient care.

Ward sisters have, however, continued to

be counted in the clinical staffing resource

for their respective wards, creating potential
tensions and conflict between their clinical

and managerial functions (Willmott 1998, Bolton 2005). Indeed, the report, High Quality Care For All (DH 2008) eschewed the term ‘manager’ and instead talked of senior clinicians as ‘practitioners’, ‘leaders’ and ‘partners’, insisting that ‘clinician’s first duty will always be their clinical practice’.

In a ‘professional bureaucracy’, such as the

NHS, managerial or administrative functions are considered to be of secondary importance to the complex service provided to patients by clinicians (Mintzberg 1979). In healthcare organisations the authority of professionals tends to outweigh the authority of the manager, and managers have been portrayed as offering a supporting role to clinicians who are engaged in patient care (Ackroyd and Bolton 1999, Currie et al 2009). However, professionals in hybrid roles have found that the demands of managerial duties and responsibilities erode their level of engagement with clinical practice and, consequently, their credibility as practitioners (Llewellyn 2001).

These developments have given rise to concern that practitioners who become ward managers may lose their clinical credibility without gaining status as managers, and that the resulting tensions may make the role less appealing, given ward sisters’ ambivalence about being ‘managers’ (Willmott 1998). As the RCN (2009) study Breaking Down Barriers, has shown, ward sisters have a primary commitment to an occupational, rather than an organisational, identity and therefore are motivated to manage their wards more by a passion for nursing than an aspiration or desire to be ‘a manager’ (Bolton 2005, RCN 2009). This tension has been important in that the effectiveness of practitioner-managers is founded on their ability to be credible in both professional and managerial roles (Ferlie et al 2005).

Clinicians in managerial roles have attempted to resolve this tension by selecting and manipulating the administrative aspects of their role so that they align more closely with their professional interests. In short, administration has been subordinated to clinical concerns (Llewellyn 2001, Bolton 2005). Clinical expertise Government policy initiatives have also served to break down aspects of the clinical hierarchy of allocation of tasks, in particular between medical and nursing staff. This has been evident in the
expansion of specialist nurse posts (Lipley 2002), creating an alternative clinical career pathway for nurses. While this expansion may have led to greater satisfaction for the specialist nursing workforce and enhanced the status of nursing as an occupation (Buchan 1999, Tye and Ross 2000, Collins et al 2002), it may also have further reduced the professional, ‘expert practitioner’ component of the ward sisters’ job.

Ward sisters would in the past have been perceived by other clinicians as clinical experts (Nerlie and Olsen 2006). Although ward sisters may consider this still to be the case (RCN 2009), it may be more an aspiration than a reality, especially in acute care. As with other public sector practitioner-managers, expert supervision of clinical practice has been increasingly undertaken outside the line management structure (Syrett et al 1996, Butterfield et al 2005).

In attempting to balance their managerial and clinical roles, ward sisters have found themselves unable to expand, or even satisfactorily maintain, their clinical skills and have become increasingly concerned that they cannot do either job sufficiently well (Doherty 2007). Ward sisters may find that, because of their central co-ordinating role, they are unable to work clinically for a sustained length of time and may be subject to constant interruptions. For example, in a recent interview, a ward sister described to the authors how she had to interweave a recruitment interview with administering a nebuliser to a paediatric patient and concluded that ‘when I was doing it, I was thinking “Oh I’ve got to do [this]” so it’s difficult to do your clinical and your management and not switch off either because ... you’ve still got your fingers in everything and you’re still thinking about both aspects of it’.

Ward sisters have thus had to dip in and out of clinical practice, making it difficult to provide a complete episode of care for an individual patient and to stay up to date with developments in clinical practice. As a result, other clinicians, such as staff nurses and junior doctors, have in some cases turned to specialist nurses for clinical advice, rather than to the ward sister.

Questions of authority The RCN (2009) has identified a further area of conflict for ward sisters, relating to the authority they have to manage their wards. Once again, broader workforce developments in the form of creation of new roles or strengthening of existing roles have contributed to this situation.

The new modern matron role has potentially overlapped with ward sisters’ responsibilities (DH 2003), and this may have added to uncertainty and role conflict. For example, with increasing financial pressures facing trusts, modern matrons may not only have taken over authority for management decisions about staffing levels but also have done so without consultation with the ward sister (Doherty 2007). Thus a ‘taller’ nursing hierarchy has had the unintended consequence of weakening the ward sister’s position (RCN 2009). Further, the urgency to meet access targets has resulted in bed managers in some trusts acquiring the authority to override ward sisters’ clinical priorities, to meet performance targets.

Ward sisters have been subject to continual redefinition of their role, both the role itself and in relation to others. Consequently, they have been obliged to juggle multiple identities. In such situations of uncertainty, people generally try to make sense of who they are, what they do, how they feel, what problems they face and how to act in order to settle on and sustain a coherent sense of identity and a positive self-image of efficacy and consistency (Weick 1995).

However, this can prove difficult. In the case of ward sisters, adherence to the historical professional culture of the ‘nurturing mother’ (Vitanen et al 2007), with an emphasis on caring and concern for patients and colleagues, has been increasingly difficult because of the competing management logic of rational efficiency. It has also limited ward sisters’ capacity to meet the expectation that they act as leaders of self-directed teams operating in more ‘enterprising’ ways (Vitanen et al 2007). At the same time, embracing their role as ‘manager’ too enthusiastically may have undermined their professional identity.

This has served to destabilise ward sisters’ interpretations of their professional and personal identity (Bolton 2003). In this situation, nostalgia for an idealised past in which the ward sister is imagined as a commanding figure with status, authority and a strong clinical role may have helped to reduce anxiety during periods of organisational change, as well as offering a basis for resisting the power of doctors and managers (Brown and Humphreys 2002, Coombs and Ersser 2004). Sustaining a positive self-image has meant associating with certain actions and disassociating from others (Weick 1995). For example, ward sisters may have disregarded what they consider to be unnecessary paperwork and avoided using the term ‘ward manager’ (Bolton 2003, RCN 2009). They may also have placed greater emphasis on defending and justifying behaviours rather than on openness and learning (Weick and Sutcliffe 2003).
Conclusion and implications

Developments in the ward sister’s role as a result of successive government policy initiatives and their ramifications have both offered opportunities and posed threats to ward sisters’ own perceptions and experiences of their role. In particular, these developments have set up tensions between the managerial and clinical elements within the ward sister’s role and between the ward sister’s role and other roles, such as the specialist nurse, modern matron or bed manager.

Ward sisters have sought to make sense of this situation by attempting to stabilise and sustain a coherent and consistent professional and personal identity. That, however, has proved difficult. On the one hand, embracing a managerial identity can be at odds with ward sisters’ professional orientations, work satisfaction, and their credibility and effectiveness as clinicians; on the other hand, clinging to a traditional ‘nurturing mother’ identity is difficult to maintain alongside managerial imperatives.

One way to meet the challenges posed by this situation would be to reduce the hierarchy surrounding the post, coupled with the provision of greater administrative support for ward sisters: in short, simultaneously clarifying the role and enhancing the skills of those undertaking it.

For the first aspect, a much clearer division of labour among ward sisters, specialist nurses, modern matrons, bed managers and other managers is required. The alternative is that the boundaries between these roles are established informally and on an ad hoc – and therefore inconsistent – basis, as a result of interpersonal negotiation and the exercise of power.

Second, in common with many professionals who have managerial responsibilities, ward sisters may not have the appropriate education and training to perform this aspect of their role with competence and confidence and so face the challenge of meeting diverse, even divergent, performance targets in a rapidly evolving, interdisciplinary service. For that to happen, experience must be enhanced by education and training that can give meaning and coherence to experience. Further, if ward sisters are to re-orientate their role from ‘nurturing mothers’ to leaders of entrepreneurial teams, they should have sufficient support, security and psychological safety.

Both of these developments have important implications for organisational structures and

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human resource management policies and practices, which may be unappealing to managers. Clarifying roles in any organisation can be time consuming and perceived as threatening, while training and development cost money. However, cheap rhetoric alone has failed to convince ward sisters of the nature and worth of their dual role. Serious consideration has to be given to the roles and responsibilities of both ward sisters and those with whom they work, as well as to the nature and level of training and development they receive.

The NHS National Institute for Health Research, Service Delivery and Organisation programme has recently commissioned the authors to examine the continuities and tensions in how the first-line management role in health care is defined, perceived and carried out. Through this research, we hope to contribute to policy debates about the future of nursing in general and the ward sister in particular. Further details may be obtained from Carole Doherty: c.doherty@surrey.ac.uk

The views and opinions expressed in this article are those of the authors and do not necessarily reflect those of the National Institute for Health Research, Service Delivery and Organisation programme or the Department of Health.


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