Developing skills in clinical leadership for ward sisters

Keywords: Ward sister/Clinical leadership/Management skills

Ward sisters need time to work in a supervisory capacity and provide clinical leadership; organisations need to ensure this can happen

In this article...
- Historical development of the ward sister’s role
- Why nursing needs to modernise the role of the ward sister
- How ward sisters’ time can be freed up for clinical leadership

Historical development of the ward sister’s role

In 1980, Sue Pembrey described the ward sister as “the key nurse in negotiating the care of the patient because she/he is the only person in the nursing structure who actually and symbolically represents continuity of care to the patient. She/he is the only person who has

direct managerial responsibilities for both the patients and nurses. It is the combination of continuity in a patient area together with direct authority in relation to patients and nurses that makes the role unique and so important to nursing” (Pembrey, 1980).

While this quote is more than 30 years old, it remains as pertinent today as when it was written. Ward sisters (also known as charge nurses and ward managers) are the glue in the system, negotiating the boundaries of healthcare in increasingly complex hospitals. The ward sister is responsible for everything that happens on the ward 24/7, but often has little or no control over many of the staff who work on the ward or with patients.

The work of Pembrey and her peers in the early 1980s demonstrated that ward sisters have a complex role with three parts: clinical expert; educator; and manager. In reality, these elements are interrelated and interdependent, as illustrated in Fig 1.

Skilled leaders manage these overlaps, defining the boundaries and setting the priorities. However, many struggle to balance the complexity and competing demands of the role and this is reflected in research by the Royal College of Nursing (2009). This found that ward sisters are often unclear about expectations of them and believe they lack the time, resources and authority to lead effectively. National and international studies suggest ward leaders do not believe they have the power to set priorities and are often merely responding to the demands of the system (Fealy et al, 2011; McNamara et al, 2011; Regan and Rodriguez, 2011; RCN, 2009; Gould, 2001; Aroian et al, 1996). This can lead them to focus on management tasks

The ward sister should work alongside staff as a role model and mentor

5 key points
1. The ward sister role is vital for consistent, high-quality care
2. Lack of clinical leadership is a factor in poor care
3. The Francis report has called for a strengthening of the ward sister role
4. A critical analysis of healthcare organisations and a whole-systems approach to change is required to modernise this role
5. The role needs to be clearly defined and sisters need ongoing development
rather than providing clinical leadership.

A number of high-profile cases, most recently Mid Staffordshire Foundation Trust (Francis, 2013), have demonstrated failures to deliver safe and compassionate care. These failures have contributed to a lack of public confidence in healthcare providers and particularly the nursing profession. A lack of public faith in nursing is evident in high-profile reports by charities such as the Patients Association (2011), as well as the popular press.

These concerns have led to calls to review and strengthen the role of the ward sister (Department of Health, 2012; 2010; Nursing and Care Quality Forum, 2012; RCN, 2009). Arguably, this will help to restore public faith in both the profession and our hospitals. However, any such efforts must not only include learning from these heartbreaking stories but also focus on the core values of nursing, taking the best from our past and our present.

The 6Cs strategy, recently launched by the chief nursing officer (DH, 2012), seeks to do just this. It aims to reaffirm the core values of nursing and suggests these be delivered through six action areas based on initiatives such as Energiise for Excellence (NHS Institute for Innovation and Improvement, 2010) and the High Impact Actions (NHS III, 2009). The strategy calls all nurses to action to improve care, identifies the need to strengthen nurse leadership at all levels and proposes a values-based ward leaders’ programme.

A historical perspective

The ward sister role has existed since the inception of modern nursing, underpinned by the Nightingale vocational tradition. It developed in a historically hierarchical nursing culture based on military and religious orders, where an autocratic approach was valued and nursing was based on task allocation (Marquis and Huston, 2006; Moiden, 2002; Widerquist, 2000). Key elements of the role were the direct supervision of nursing staff and learners, and the coordination of care delivery (Bradshaw, 2010). Sister had direct control of the entire ward, including staff and resources. These authors suggest a surveillance role, an all-seeing figure revered for her clinical excellence.

Until the 1960s, the role of the ward sister changed little. However, the Salmon report (Ministry of Health and Scottish Home and Health Departments, 1966) and the subsequent Briggs report (1972) resulted in a restructuring of the NHS as a whole and nursing saw some direct management responsibilities devolved to others; this reduced sisters’ direct authority. Responsibility for clinical standards remained key to the ward sister role but evidence suggests the focus on management in these restructures affected both organisational understanding of the sister’s role and the ability of sisters to maintain these clinical standards (RCN, 2009). Changes in title added to this role confusion and it could be argued that the disparity between the title ward sister and ward manager is not simply terminology but concerns the values underpinning nursing. This has contributed to the current nursing leadership crisis (Bradshaw, 2010).

Essentially the role has always and continues to comprise three key elements:

» Clinical nursing expert;

» Manager and leader of the ward staff team and the ward environment;

» Educator (of nursing and nurses, other health professionals, patients and carers).

What has changed is the increasing complexity of the healthcare organisations in which ward sisters operate. These complexities include an increasingly frail and older patient population, a larger number of professionals involved in patient care, multiple ward consultants, and multiple ward rounds that often take place at the same time. All these factors increase the challenge of ensuring effective communication on the ward.

Large and often far-removed corporate services make it difficult to resolve day-to-day issues and necessitate multiple phone calls and emails. High bed occupancy leads to pressure to discharge patients and turn their beds around rapidly for the next patient.

The welcome focus on quality targets has led to a move to understand the unique contribution of nursing to the quality of care (Griffiths, 2008). The development of measures that identify, quantify and make visible the impact of the nursing workforce on care quality outcomes increases the requirement for audits. This also brings additional work as the burden of audit and paperwork increases and many report difficulty in prioritising clinical leadership (RCN, 2009).

All these pressures, along with the demands of managing a budget, ward resources and a large team of nursing staff, make the job almost impossible.

FIG 1. THE WARD SISTER ROLE

FRANCIS ON...
WARD SISTERS

Ward sisters and nurse managers should operate in a supervisory capacity and should not be office bound. They should:

● Know about the care plans relating to every patient on their ward and should be visible and accessible to patients and staff

● Work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team

● Ensure that the caring culture expected of professional staff is consistently maintained and upheld
Recently the complexities and challenges of the role have been recognised by the profession and policy makers, which has led to calls to review and strengthen the ward sister role. However, increased political pressure creates a danger of rebranding without addressing a fundamental element to ward leadership – namely the organisation in which the leader operates.

The culture of traditionally hierarchical and bureaucratic organisations is enshrined in the structure of corporate services and a surveillance culture that does not make the demands of ward leadership easier. Evidence suggests that the way we structure our organisations has an impact on how effectively we can lead (Senge, 1990). Arguably, any efforts to enable sisters to lead must address the complexity of the system they work in. A whole-systems approach to change is required, focusing on all elements of the system (Burke, 2011).

**Capacity to lead**

Florence Nightingale said: “Let whoever is in charge keep this simple question in her head... how can I provide for the right thing to be always done?”

At UCLH we are asking this question collectively as an organisation. We are considering how to develop individual ward sisters, as well as looking at creating organisational strategy, values, systems and structures that enable ward sisters to lead.

Turnbull-James (2011) noted that “the NHS needs people who think of themselves as leaders not because they are exceptionally senior or inspirational to others, but because they can see what needs doing and can work with others to do it”. This resonates with and builds on Florence Nightingale’s quote of over 150 years ago.

Ensuring the right thing can always be done for patients is best achieved by working collaboratively as an organisation to tackle the issues that constrain individual efforts to do the right thing. At UCLH, this has led to a whole-systems approach to a number of projects that address the ward sisters’ capacity to lead, as well as the organisation’s ability to enable effective ward leadership.

**Liberating sisters to lead care**

In 2009, the RCN called for ward sisters to be supernumerary. These calls have been echoed by many (Francis, 2013; DH, 2010). At UCLH, the term “supervisory to practice” is used. It is in being supervisory that ward sisters can clinically lead using their skills as clinical experts and educators to develop their teams and ensure excellence in care. We found our ward sisters were spending less than 40% of time in clinical leadership, with 35% spent on administrative tasks. Fig 2 illustrates the breakdown of their daily activities; while many are essential to the ward sister role, such as budget and staff management, they are not streamlined to minimise the time away from the bedside. Add in audit and reporting requirements and it becomes apparent that the role has become so vast that it is impossible to dedicate the clinical leadership time necessary to ensure consistency in patient care and experience.

To redress the balance, organisations need to have all their elements aligned to reduce essential but time-consuming non-clinical workloads to free sisters to lead. This has been recognised by the Health Foundation, whose Shared Purpose improvement programme seeks to address organisational design, aligning corporate and clinical services around common quality goals to improve patient experience (Health Foundation, 2013).

We have designed and are undertaking one of these nine Shared Purpose projects, Liberating Sister to Lead. Its objective is to remove the burden of corporate processes on ward sisters, freeing them up to be visible leaders of their wards with a focus on improving all elements of quality. A review of corporate services, such as human resources and finance and estates, from the ward sisters’ perspective led to an objective to increase clinical leadership time to 75% (Box 1). An example of this is the introduction of a concierge service to take on many of the administrative tasks that take sisters away from the important job of leading patient care.

Liberating Sister to Lead is a natural progression from the work on organisational values and behaviours we have been undertaking over the past year. Through a series of events across the trust that involved staff, patients and the public, shared values were defined and the Making it Better Together campaign was launched. These values are: safety; teamwork; kindness; and improving. Shared values support efforts to align all parts of the organisation around excellent patient care and liberate sisters to lead.

Each member of staff must demonstrate these shared values in their behaviours, whatever their role and wherever they work. The aim is to ensure these collectively defined values and behaviours are embedded in trust processes, such as recruitment and appraisal, in the next stage of the campaign to support individual staff to live these shared values in their interactions with each other and patients.

**A personal capacity to lead**

It is evident that the ward sister role of old is not fit for purpose in today’s complex healthcare organisations. To date, much effort has been focused on finding or developing the ideal person to lead, based on this shared outdated image of the all-powerful ward sister, although it has been demonstrated that ward sisters struggle to live up to this image. Despite the challenges, many ward sisters continue to do an excellent job and this suggests personal leadership capacity also has a role to play.

![FIG 2. WARD SISTERS’ ACTIVITY 2011](image-url)
In addition to developing ways of supporting ward leadership, each healthcare organisation and the nursing profession as a whole must seek to identify and nurture people with the capacity and resilience to lead consistently excellent care.

Research conducted by the Hay Group (2006) found that wards where sisters exhibited transformational leadership skills had fewer safety incidents, and staff absences and turnover were lower. The challenge is to ensure this exemplary leadership happens consistently. Studies have suggested role complexity, lack of role clarity and inadequate preparation make it a challenge for ward sisters to do the right thing all the time (Fealy et al, 2011; RCN 2009; Chase, 1994).

To address these challenges, we are working to define clinical leadership and have agreed key elements of the ward sister’s clinical leadership role (Box 1). This will lead to the articulation of clear expectations, competencies and programmes that ensure a shared understanding of the ward sister role.

These developments will be underpinned by the shared organisational values of safety, teamwork, kindness and improving, which are essential for effective leadership. Appraisal and recruitment processes will require ward sisters to demonstrate these values through their interactions with patients and staff, making everyone feel valued. This has been shown to contribute to excellence in patient and staff experience.

While these innovations will support the development of existing ward sisters there is also a need to recognise and nurture future nurse leaders early. University College London Partners has created an accelerated development programme to make this a reality. Thirteen outstanding newly qualified nurses have been through a rigorous recruitment process that includes assessing their values and behaviours alongside clinical competence and academic achievement. Those selected are undertaking a four-year programme leading to a ward leadership role and a master’s-level qualification.

The programme is grounded in practice and underpinned by clinical, educational and leadership competencies reflecting all elements of the role. These nurses will have had the opportunity to work across all hospitals in the UCLP alongside excellent ward sisters before taking up their leadership positions. This is a significant change from the experiences reported by many ward sisters (RCN, 2009) of finding themselves in leadership positions without the opportunity for targeted leadership development beforehand.

Conclusion
The ward sister role is and will remain central to consistently high-quality care and an outstanding experience for patients. It has been recognised that while nurses deliver a great deal of excellent care every day, too often care falls below the standard expected. A lack of clinical leadership is often a factor in these failures and there is an increasing call to strengthen the ward sister role.

This creates the risk of overemphasising the individual qualities of ward sisters and romanticising the ward leadership of the past. To truly ensure excellent ward leadership requires a more holistic approach to tackling the issues. This involves looking critically at healthcare organisations and taking a whole-systems approach to change. Such an approach will ensure all elements of the organisation are designed to make it easy to do the right thing and to lead others in doing the right thing. It means making changes at all levels of the organisation including addressing individual capacity and performance as well as systems, structures, culture and strategy (Burke, 2011).

In the words of Pembrey (1980): “The ward sister is a complex and senior nursing role... of vital importance to the proper nursing of patients: it is a role that the profession should not neglect.”

References

“Education gives nurses the power to influence others” Wendy Ness p24

BOX 1. PLAN FOR CLINICAL LEADERSHIP

Clinical leadership to account for 75% of sisters’ time:
● Present on all ward rounds
● Supervising junior nurses
● Setting standards and expectations
● Monitoring evidence-based care
● Introducing improvements
● Leading mealtimes
● Talking to patients and families
● Leading and developing the team
● Offering clinical expertise
● Challenging behaviour when necessary

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References

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