A Grounded Theory of Directors’ of Nursing Perceptions on Caring: Post-Francis Paradoxes

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THESIS
Submitted for the degree of Doctor of Clinical Practice

PART ONE

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Statement of originality

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification.

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Date: 15th September 2015
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Abstract

This study explores the perceptions of Directors of Nursing from NHS acute Trusts in England, on caring practices. The aspiration of the NHS is to deliver good care to patients and their families. The NHS constitution states that the ‘NHS is there to improve health and wellbeing, and it touches our lives at times of basic human need, when care and compassion are what matter most’ (DH 2013:2). However, recent inquiries into poor care have created a searching debate regarding standards of nursing care, leadership, culture and practice. Directors of Nursing play a significant role in influencing care, as they are charged with responsibilities relating to providing assurance of standards of care within NHS Trusts. However, little is known about the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

The study aimed to construct a grounded theory of the perceptions of Directors of Nursing from NHS acute Trusts, on caring practices. The study also sought to understand the social, political, professional and organisational challenges facing Directors of Nursing. Twelve Directors of Nursing from NHS acute Trusts in England were interviewed between July 2013 and January 2014 using semi-structured questions. A constructivist grounded theory approach was adopted to support the co-construction of the theory by exploring how the participants construct their worlds or reality. Through the co-construction approach a theory of ‘Directors of Nursing Perceptions on Caring: Post Francis Paradoxes’ revealed that the participants are working within a paradoxical NHS system in response to findings from the Mid Staffordshire NHS Foundation Trust inquiry. The theory is supported by three categories of: ‘trusting my senses’; ‘avoiding becoming collateral damage’; and ‘being in a different place’.
The three paradoxes that emerged were: the need to produce reliable high-quality assurance about standards of care in the NHS which detracted from and impacted on the Directors of Nursing roles in supporting internal assurances processes. Secondly, external monitoring standards did not capture the ‘real’ warning signals of care failings as intended. Thirdly, the reliance on intuitive skills to give assurances of caring practices was considered necessary to support the demanding monitoring and assurance processes. This study captures a challenge, as perceived by Directors of Nursing, regarding how external regulatory demands can be accommodated alongside the internal organisational requirements to lead the improvement agenda of patient care standards. Directors of Nursing need then to balance the competing priorities in their roles whilst supporting and leading a nursing workforce to deliver ethical caring practices. Recommendations are made for research, education and practice.
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PART ONE
Chapter 1: Introduction to Thesis

There are two main parts to this thesis: part one comprises the research project, research log and overview of the integration of knowledge, research and practice; part two presents a policy review, advanced research methods, leadership and service evaluation critique and clinical academic paper. Notably, both parts of the thesis are interlinked because the justification and rationale for undertaking this research study has evolved throughout the taught elements of the Doctorate, and culminating with the research project.

1.1 Introduction Chapter

In this introduction chapter, there will be justification and rationale for undertaking the research study, and also an identification of the current gap in knowledge about the perceptions of Directors of Nursing in NHS acute Trusts on caring practices. There will also be an outline of the remaining chapters within this thesis, giving the reader an overall summary of part one of the thesis. The next section of the introduction chapter begins to build the justification for the study and provides an overview of the thesis. My clinical credentials are presented, followed by the contextual background and clinical origins for undertaking this study.
1.2 Aim of the Research

The aim of this study was to develop a theory to gain a deeper understanding of the perceptions of Directors of Nursing in NHS Acute Trusts, on caring practices. The study approach selected was a constructivist grounded theory, which facilitated an interpretation of the situation or phenomenon between me as a researcher, and the research participants. In a constructivist grounded theory approach, the researcher is an integral part of the research process, as data are interpreted and co-constructed between the researcher and the participants (Charmaz 2006). The approach to co-construction of the data was an important consideration and supported the rationale for choosing this approach. A considered decision has been taken to write in the first person in this thesis, as a method of ‘writing myself’ into the research. The rationale for this is that the constructivist grounded theory approach is an interpretive research approach and the process of co-construction is a cornerstone in this approach. Webb (1991) advocates the use of the first person, when the researcher is working in an interpretivist method.

Constructivism is derived from the work of Egon Guba and Yvonne Lincoln (Guba & Lincoln 1981) and allows for research focusing on people’s experiences and behaviours within their own social worlds. A central principle of the constructivist approach is that concepts are constructed as opposed to discovered as with classic grounded theory (Evans 2013). This approach intends to provide explanations and make sense of experiences, by attempting to answer the why as well as the what and how questions (Charmaz 2006). Constructivist grounded theory aims to develop a detailed understanding of the underlying social or psychological processes within a certain context by exploring in more detail social interactions and social structures (Gardner et al 2012). In agreement, Charmaz (2006) acknowledges that
constructivist grounded theories are contextually orientated, to a defined culture, time, place and situation.

This research study forms part of the Doctorate of Clinical Practice programme and was undertaken during 2013 and 2104.

1.3 The Study Rationale and Personal Motivation

Over the last few years, several high-profile reports pertaining to patient and carer experiences of poor standards of care in the NHS and social care have begun to emerge. A significant example was the public inquiry into the Mid Staffordshire NHS Foundation Trust and the publication of the Francis Report in February 2013 (Francis 2013), which included 290 recommendations for improvements to care delivery and systems.

My motivation for identifying this research area about caring practices was to understand whether these reports of care failings were signalling that there was an emerging systemic failing across the NHS, or if failings had existed for many years and earlier cases had been less prominent in the media. I was very curious about this point in particular, because of the high profile of the scandal at Mid Staffordshire NHS Foundation Trust. Moreover, I was questioning whether in nursing there had been a decline in standards of care since I had entered the nursing profession in the late 1980s. I struggled to understand or come to terms with, the harrowing reports of nurses neglecting patients and the accounts of cruelty towards patients detailed at the hospital. A further area of interest for me was the shift in the direction of nursing as a profession, and crucially the role that nurse leadership might have in influencing and sustaining caring practices. I hold a belief that nurse leaders have a
responsibility to the nurses that they lead. They also have a duty of care to the patients under the care of their teams.

There is a dearth of published research relating specifically to the role of Directors of Nursing and caring practices. Establishing the perceptions of Directors of Nursing of caring practices was important in identifying the potential levers and drivers in promoting and sustaining caring practices, as well as distinguishing the specific Board role that Directors of Nursing have in strategically driving improvements in patient care. Johnson (1990) supports the view that Nurse Executives play an important role in creating a nursing culture within their organisations. Nursing culture can be viewed as the collective behaviours and values shared by the nursing workforce.

1.4 My professional background

I am a qualified Registered Nurse and I have experience working as a Research Fellow. My main nursing clinical specialty is oncology nursing and palliative care. During my Doctoral studies I have worked in more senior management roles in the NHS, including being a former Nurse Director in a Cancer Network. This role provided strategic commissioning advice to commissioning organisations and developing cancer services in providers of care such as NHS acute Trusts. In my role as a Nurse Director and as a senior nurse leader, I became more acutely aware of the potential impact that the strategic role of Nurse Directors can have in leading and influencing the standards of patient care. My view and perspective of nurse leadership was that successfully leading a nursing workforce and setting good standards of patient care within an organisation can have an important influence in the quality and safety of patient care, patient experience and staff morale. In more
recent years there has been significant media interest into failings of care standards and a subsequent focus on nursing standards within the nursing profession (Aiken et al 2002a; McSherry et al 2012; Morris-Thompson et al 2011; Taskase et al 2006).

In the taught element of the Clinical Doctorate, I undertook an assignment (in part two) exploring the power, political and policy influences on caring standards within NHS acute Trusts and in particular the implementation of *Essence of Care: benchmarks for the fundamental aspects of care* (DH 2010a). Benchmarks were used to encourage consistency of care and to drive up standards of care across and between organisations, with a premise of focusing on respect and dignity. This assignment explored a benchmarking approach aiming to improve standards of care. In the latter stages of the Doctorate, I embarked on an assignment to explore Board cultural influences and leadership on standards of care. Examining the literature which connected effective leadership, the impact of Board cultures and patient experience was an important juncture in influencing the research proposal. On reflection the learning from the taught modules informed the premise of this research proposal, both exploring methods to improve caring practices and the influence of Board cultures on patient experience.

**1.5 Background to Study**

**1.5.1 Current challenges in care**

In recent years, there have been a significant number of high-profile exposés of undignified care, neglect and poor practice, which have been a catalyst for a searching debate into standards of care, practice and the nursing profession (Andrews & Butler 2014; Care Quality Commission 2011; Department of Health (DH) 2012b; Francis 2010; Francis 2013; Parliamentary and Health Service Ombudsman (PHSO) 2011; The Patients Association 2010; Tadd et al 2012).
1.5.2 Caring

The definition of caring has evolved to ‘the work or practice of looking after those unable to care for themselves, especially on account of age or illness’ (Oxford Dictionaries Online 2014). Van der Cingel (2014) draws upon the interpretation that caring is putting someone else’s need before your own needs. Chinn (1991) defined caring practices as being the vanguard of nursing and requiring commitment from the care-giver to provide caring. However, this view is more one-dimensional than other perspectives of possible influencing factors on caring practices. Other considerations such as leadership and organisational cultures have a significant impact on caring practices. The literature pertaining to caring practices will be examined in further detail in chapter 2.

Organisational culture and behaviours are defined as how influence and shared beliefs and common practices are used within an organisation, often preserved in folk tales, customs and rituals (Garratt 2010). Francis (2013) in describing the failing at Mid Staffordshire NHS Foundation Trust described the culture as ‘the predominating attitudes and behaviour that characterise the functioning of a group or organisation’ (Francis 2013:152). Alimo-Metcalfe (2012) has argued that organisational culture can have a direct impact on patient care. Themes of poor organisational culture, ineffective leadership and disengagement with patient feedback and experience are consistently found in many of the reports and inquiries into care failings (Walshe 2010). Therefore, this would suggest the link between standards of care and organisational culture.

1.5.3 Nurse leadership

In the twenty-first century many of the nursing values from Florence Nightingale, including care, kindness and compassion, are described through the narrative of
today’s nursing profession (Como 2007). Since the time of Florence Nightingale, nursing roles have developed and played a central role in the development of the NHS, significantly in the 1990’s and in response to the reduction to waiting list initiatives and reduction in junior doctors’ working hours (Read & Graves 1994).

‘Images of angels in starched skirts and nursing caps eagerly awaiting guidance from physicians has long since been replaced by images of competent, independent men and women of diverse backgrounds.’ (Rhodes et al 2011:1)

In 1990, the profile of the Director of Nursing role was raised following the publication of the National Health Service and Community Care Act (DH 1990), and in 1991, the establishment of a corporate role for nurses on Trust Executive Boards was signalled (National Health Service Management Executive 1991). The remit of these newly created executive roles was designed to strategically advance nursing’s contribution to care, and to act as a nursing figurehead for the profession in the Trusts. Notably, the Director of Nursing role was also created to support significant changes in the organisational structure of the NHS (Cameron & Masterson 2000). However, in more recent years the role of Director of Nursing has become increasingly complex with a growing corporate remit, as the NHS has evolved with significant structural changes. In 2006, the Health Care Commission investigation into failings of care at Stoke Mandeville Hospital raised concerns about the Director of Nursing’s lack of response to the concerns being raised by the nursing workforce about care standards. In 2013 the investigation into the Mid Staffordshire NHS Foundation Trust failings in care also raised similar concerns. It is proposed that Directors of Nursing in NHS acute Trusts have an important role in both providing leadership to the nursing workforce, and for setting and maintaining high standards
of caring practices within the organisations. The Director of Nursing role also leads the Board assurance function, through ‘ward to Board’ assurance processes.

1.5.4 The gap in the literature

Following a literature review, the gap that was identified was an understanding of the specific role and perceptions of the Directors of Nursing, regarding caring practices in NHS acute Trusts. Caring practices are defined as the nurse–patient interaction (Baillie et al 2008), and the behaviours and attributes of the nursing staff carrying out nursing care in the clinical areas. A gap exists in identifying the experiences and values that underpin the Directors of Nursing’s perceptions and interpretations of caring practices. Perceptions have an important role in influencing behaviours and responses to situations; hence a greater awareness of perceptions and beliefs can offer a greater understanding of values and belief systems.

In response to emerging policy directives and current gaps in the research, it is important to explore the perceptions of the Directors of Nursing, to understand the possible challenges and impact on their role in sustaining and improving standards of nursing care, and, moreover, to explicitly identify the contribution that Directors of Nursing can make in leading change and improvements to patient care. The overall aim of the research was to develop a theory to gain a deeper understanding of the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

In the next section, there will be an overview of the structure of the remaining chapters in part one of the thesis.
1.6 Structure of the thesis

Chapter Two: Preliminary Literature Review

Chapter two presents a preliminary literature review, which introduces a review of the broad spectrum of relevant literature, aiming to outline the existing knowledge related to the research area. In keeping with the grounded theory approach, a secondary literature review was undertaken during the data collection and data analysis and this literature will be interwoven throughout the discussion chapter.

The literature was also used to inform the discussion chapter. Evans (2013) advocates a preliminary literature search being undertaken in grounded theory. Further, this chapter will make the case for the research study, including the justification for the research in conjunction with setting out the aims of the research.

Chapter Three: Research Methodology

In chapter three, the research aims and objectives will be outlined and the rationale for adopting the constructivist grounded theory approach that was used in this research study. Charmaz (2006) describes the constructivist approach as the co-construction of data, where the researcher, rather than being seen as neutral in the research process, is instead part of the process of interpretation, where data is co-constructed between the researcher and the participants leading to the development of a substantive grounded theory. Also in this chapter there will also be a critique and rationale for the methodological choice of grounded theory, including an exploration of my own journey into my ontological and epistemological positioning which influenced the choice of methodology and approach. Hence, a rationale will be presented which sets the specific choice of constructivist grounded theory approach.
In the final section of this chapter, the methods will be established and the practical aspects of undertaking this research will be explored. This will include the interview process, sampling considerations, and recruitment issues and data collection. The ethical considerations for undertaking this study will also be outlined. Applying the constructivist grounded theory, analytical processes and procedures as described by Charmaz (2006) will be demonstrated as an evolving, iterative and non-linear process of data collection and analysis. This will include the illustration of the use of ‘memos’ in the co-construction of the data. This will culminate in the presentation of an interpretation of a grounded theory of Directors of Nursing in NHS acute Trusts, perceptions on caring practices.

Chapter Four: Findings
In chapter four, the research findings will be presented. In keeping with a constructivist grounded theory, memos, diagrams and codes were an integral component of data analysis and used to determine the findings leading to the co-construction of the theory from the data. A systematic process was adopted of coding firstly line-by-line, then focused coding, followed by theoretical coding leading to the interpretation through the sub-categories and categories. The findings are illustrated with citations from the transcripts with the participants. The interpretation of three categories is presented: ‘trusting my senses’, ‘avoiding becoming collateral damage’ and ‘being in a different place’. Finally, the grounded theory of ‘Directors of Nursing perceptions on caring – post-Francis paradoxes’ is presented.

Chapter Five: Discussion
The focus of chapter five is a discussion of the findings arising from the study, presented in conjunction with the literature. The framework for this chapter centres on the impact on caring practices in the context of micro, meso and macro levels:
micro impact of individual responsibility for caring practices, meso organisational and cultural and thirdly the macro regulatory and political impact (Baillie et al. 2008). This is supported by the findings evidenced from this research study. This chapter will also identify the areas of this research that either confirm or extend existing knowledge, and those areas where a distinct contribution has been made arising from the findings of this research.

**Chapter Six: Conclusion and Recommendations**

This chapter completes the research study and provides a summary of the key findings from this research, and presents a summary of the distinct contribution to current knowledge that this study offers. There will also be an exploration of the strengths and limitations of the study, and recommendations for further research, education and clinical practice.

In the second part of the chapter there is a critique of the grounded theory approach used in this study, and recommendations for integration of knowledge, research and clinical practice will be suggested.

**Chapter Seven: Overview of Integration of Knowledge, Research and Practice**

In this final chapter of part one, there is a focus on the integration of knowledge, research and practice and a critical analysis of the influence that the Doctoral programme has had on my development as a nurse, a nurse leader and a researcher. The Research Log (Appendix 14) outlines my four-year journey as a Doctoral student at the University of Surrey, including a focus on my development as a researcher and in my clinical practice, as a result of the knowledge I have gained by undertaking the taught elements of the programme and more latterly the research study. A reflective diary and field notes including memos were used throughout my research project, to demonstrate rigour throughout the study.
Chapter 2: Preliminary Literature Review

2.1 Introduction

The purpose of this chapter is to present the existing literature relevant to this area, and also identify the gaps in the current literature and thereby present the justification for research. This will support the development of the research question and research aims. The justification for undertaking this research is to contribute to the body of knowledge. The overall aim of this research is to explore the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

This chapter contains a preliminary literature review. A preliminary literature review in grounded theory is supported in revealing gaps in knowledge, whilst a secondary literature review can be used to confirm or dispute existing theories during the data analysis and discussion (Hutchinson 1993; Hickey 1997). Evans (2013) advocates a preliminary literature search being undertaken in constructivist grounded theory. Additional literature will be explored in the discussion chapter (chapter 5).

This chapter examines the literature, both books and articles, concerning historical perspectives of caring, the professionalisation of nursing, caring theories and nursing as moral practice. Furthermore, there will also be a critique of the literature regarding the contemporary healthcare issues focusing on historical reports of uncaring and unethical caring practices. In the final section of the chapter the evolving role of Directors of Nursing as nurse leaders will be examined, and finally a critique of the existing nursing research pertaining to Nurse Directors’ roles in supporting caring practices.
2.2 Search Strategy and Findings

In the literature review, electronic searches were carried out using databases, Google Scholar © and the Royal College of Nursing Library catalogue. The databases searched were CINAHL (Cumulative Index to Nursing and Allied Health Literature), Medline, PsychINFO, British Nursing Index and PubMed (see Appendix 1). Appendix 1 tabulates the systematic method applied to the literature search, including the initial and expanded terms. The initial area of research interest focused on caring practices in nursing; hence the first two searches were focused on theories of care and nursing, followed by searching for standards of nursing care. The subsequent searches were focused on the contrasting key areas of uncaring practices, and caring practices, and finally the role of Directors of Nursing and caring practices. Searching the literature in this way supported a systematic review of articles for inclusion in the literature review. Notably the fewest results were found in the last search, that of Directors of Nursing and caring practices.

The inclusion criteria were:

- Articles published in English;
- Human species only (applied to PubMed);
- No date restrictions were applied to prevent important literature being excluded;
- Open to all research methodology and designs.

2.3 Summary of the Findings of the Preliminary Literature Review

The search returns yielded a large number of articles on caring and nursing; the titles were sorted for eligibility. Relevant abstracts were reviewed and the full text saved for review if considered to be relevant to the study. Key articles were marked
for notification for future citations. There were some research studies which focused on the perceptions of Directors of Nursing in the United Kingdom, but there was a dearth related to the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

In order to set the context, the next section will focus on an exploration of the literature pertaining to the historical perspectives of caring and the development of nursing.

2.4 Historical Perspectives on Caring

The term ‘caring’ is believed to have originated from Middle English during the period between the twelfth and fifteenth centuries (Oxford Dictionaries Online 2014). At that time the word ‘care’ was known as caru or cearu and its meaning was care, concern, anxiety, or trouble (Oxford Dictionaries Online 2014).

Caring is embedded in cultures where there was a close association of caring and maternal instincts. In some societies there was a view of women being seen as nurturers of babies and infants, transferring their skills to the sick and injured, whilst in others it was the men folk who were assigned to tend to the sick (Egenes 2009). Reverby (1987:199) asserts that the trait and virtue of being a woman caring for others ‘became an important manifestation of women’s expression of love of others’. Hence the notion emerges of caring being seen as a duty involving the woman’s altruism and self-sacrifice. Altruism is often seen as being closely aligned with self-sacrifice, and it has been argued that altruistic behaviours and gestures can be positive for both parties: ‘overall good, to do good’ (Dillon 2009). The definition of caring has evolved to ‘the work or practice of looking after those unable to care for themselves, especially on account of age or illness’ (Oxford Dictionaries Online
Van der Cingel (2014) suggests that caring is putting someone else’s need before your own needs. Caring practices are associated with the notions of ‘nourishing, cherishing, fostering, tender caring, conservation of energy, and providing curative care’ (Wagner & Whaite 2010:226). However, Gaut (1981) questioned the motivation to create a definition of caring in relation to nursing and posited whether it was created by a will and need to professionalise nursing in some way.

Accordingly, caring is seen as ‘a moral and human imperative to protect people when they are weak and vulnerable; to strive towards recovery and healing; and to ensure humanity of care’ (Goodrich & Cornwell 2008:3). In the Tudor period, following the abolition of the monasteries, caring was traditionally carried out by women considered to be in the ‘lower social classes’. This view of caring, and more specifically nursing, was subsequently reinforced during the Victorian era, with the Dickensian characterisation of nurses, seen as lacking in moral fibre and drinking excessive amounts of alcohol (Egenes 2009). In agreement, Sellman (2011) argued that the vivid depiction by Charles Dickens of his character ‘Sairey Gamp’, the alcoholic nurse midwife who ‘laid out’ the dead, did little to change the perception of nursing at that time. Traynor (2006:229) depicts this era as one of ‘growing urban poverty and attendant problems of poor housing, alcoholism and exploitation of child labour’. Care-giving and nursing were still carried out by women in their own homes in the 1800’s (Como 2007). The women dispensed cures and tonics and were characterised by caring practices such as tending to the sick; these caring skills were handed down through the female generations and sometimes passed to the female servants in the household (Como 2007). Caring work has also been associated with ‘slaves, servants and women in western history’ (Tronto 1993:113). This has manifested into a perpetual cycle where caring work may be devalued by society, leaving ‘care-giving and care-receiving … to the less powerful’ in society.
In the nineteenth century women could expect to spend some of their lives caring for sick and infirm family members (Reverby 1987).

The terms caring and nursing are often seen as entwined and interchangeable (Lachman 2012). Saewyc (2000:114) stated that ‘caring has emerged as a central paradigm in nursing’. In agreement, the concept of nursing has been at the forefront of nursing literature, and caring has been defined as being symbiotic with nursing (Newman et al 1999). There is widespread agreement with the view that from a historical perspective caring is the central core and foundation of nursing (Cheung 1998; Roach 2002; Sargent 2012; Schorr & Kennedy 1999; Watson 1979; Watson 1985).

In 1860, Nightingale (1860: preface) outlined a woman’s affinity with nursing and declared that ‘every woman, or at least almost every woman, in England has, at one time or another in her life, charge of personal health of somebody, whether child or invalid, – in other words, every woman is a nurse’. This view offers an insight into Nightingale’s perception of the natural evolution from caring to nursing roles during that era. At that time care-giving was seen as part of the dutiful role of the woman in caring for her family in the home. Reverby (1987:199) claimed that nursing then shifted from an expression of familial love to a ‘labour’. The shift from women carrying out caring at home to emerging nursing roles was influenced by Florence Nightingale, who hoped to create a cohort of educated women nurses. Selanders and Crane (2012:1) affirm that Florence Nightingale was responsible for transforming nursing ‘from that of domestic service, to that of a profession identity’.

Historically, nurses either came from the lower social classes or from nursing sisterhoods (Van der Cingel 2014). Hospital nurses were treated as ‘maids of all
work’ and carried out tasks including washing and cookery (Helmstadter 2009:136). Many nurses worked in the poorhouses of the time, and sometimes entered prostitution to provide some additional menial income to support themselves and their families (Van der Cingel 2014). This view of nursing persisted for many years; when women of higher social class wished to enter into nursing, it was only sanctioned as a ‘vocational’ passage (Van der Cingel 2014). Lewis (2003) confirmed that over a hundred years ago nursing was seen as a ‘calling’. Van der Cingel (2014:3) also indicates that the early professionalisation of nursing was closely tied to ‘liberation, compassion and became equivalent to self-sacrifice’. It was argued that the vocational rhetoric of nursing was unhelpful in later years when seeking better wages and equality with the other professional groups, and as such maintained a subservient lens on nursing (Van der Cingel 2014). It could be suggested that traditionally nursing may have been seen as a subordinate profession, alongside midwifery and physiotherapy, to medicine, the dominant profession (Harrison & McDonald 2008). In agreement, Jasmine (2009) argues that historically nurses were seen as submissive and under the direction of the doctor.

Building on the premise that caring and nursing are intertwined, the next section explores how caring has become professionalised since the eighteenth century with the development of nursing.

2.5 The Professionalisation of Caring and the Development of Nursing

‘Florence Nightingale is recognised as the founder of modern nursing … with her compassionate view of humanity and her deep religious beliefs’ (Wagner & Whaite 2010:226). Her description of the ‘good nurse’ and the caring attributes of ‘attend to,
attention to, genuine, competent and nurture subscribe to her view that nursing is both an art and a science’ (Wagner & Whaite 2010:231). Her approach to radically and systematically reduce soldiers’ mortality rates during her wartime service in the Crimea, by introducing rigid hand-washing techniques, was seen as an important step towards the advent of evidence-based nursing practice (Egenes 2009). Florence Nightingale’s nursing legacy embodied the importance of the caring relationship between the nurse and the patient (Wagner & Whaite 2010).

In the early nineteenth century, there was some early nurse instruction led by Elizabeth Fry who founded the Protestant Sisters of Charity. This religious order supported nurses to receive some limited formal nurse training, but with a continued commitment to nursing duties alongside adherence to religious activities such as prayer (Egenes 2009). The introduction of the nursing sisterhoods was aimed at improving standards of care (London Metropolitan Archives 2008). Led by Florence Nightingale, nursing was at an important juncture in the 1850s. The nurses who had been a vital support to the Crimean War effort demonstrated that nurses could provide nursing care in a very different way from that of the home environment (Helmstadter 2009). This issue created an important turning point for nursing, whether to remain as a religious calling, to continue disempowered in the home environment or to evolve into an assistant to the medical profession (Helmstadter 2009). However, a tension arose between the religious self-sacrificing portrayals of the nurse, to nurses becoming independent, empowered, educated, wage-earning professionals (Van der Cingel 2014). It could be argued that at that time ‘the boundaries between medicine, religion, nursing and domestic service were fluid’ (Helmstadter 2009:133) as the roles were not always distinct from each other, overlapping in some areas. Notably, there was another emerging divergence between a growing body of scientific knowledge as opposed to contrasting religious
views of illness and disease. The predominance of religious-based views of illness was shifting to a greater acceptance of the emerging anatomical version of illness and evidence-based medicine (Helmstadter 2009).

In recognition of Florence Nightingale’s work in the Crimean War, money was raised from public donations to establish a pioneering training school for nurses at St Thomas’s Hospital in London in 1860 (London Metropolitan Archives 2008). Florence Nightingale believed that the professional work of nursing should be supported by ongoing education and training (Sellman 2011). A political shift occurred after the First World War; in response to women’s role in the war effort coupled with women’s demand for the vote, the Government accepted nurse registration in principle (Abel-Smith 1960:92). Shortly afterwards more training schools for nurses were established and, in 1919, the Nurses Registration Act marked the formation of the General Nursing Council. This Act signified an important step in the professionalisation of nursing. By 1948, and with the advent of the NHS, most of the acute and mental illness hospitals were under the management of the NHS system and structures (London Metropolitan Archives 2008). This shift created a more standardised nurse training; as hospital Boards and training committees were established, nursing came under closer regulation and in turn professionalisation (London Metropolitan Archives 2008).

Selanders and Crane (2012:1) proposed that ‘Nightingale’s lasting legacy is a composite of her accomplishments, and her vision of what can and should be undertaken by the profession’. Reverby (1987) depicted this vision enshrined in values of courage, compassion, reverence and altruism. It could be argued that in twenty-first century nursing these values of Florence Nightingale permeate through to the narrative of today’s nursing profession in nursing theories of caring (Como
Como (2007) however has contended that there were fundamental distinctions in caring practices in the nineteenth and twentieth century’s, with the nineteenth-century model founded on duty and responsibility rather than caring practices founded today on the professional role of a nurse. Davis et al (2010:32) have described nurses as ‘moral agents’ in that it was their character that defined them as good and supported the delivery of good care accordingly. This notion of ‘morality’ associates goodness in the nurse with showing caring and nurturing behaviours.

Caring is a concept that does not exclusively belong to nursing (Roach 2002). Caring originates from different disciplines and ‘can have multiple meanings which stem from disparate assumptions’ (Vezeau & Schroeder 1991:1). Lewis (2003) also refuted the position of caring as being ubiquitous to nursing and argued that other professional groups, as well as nurses, are caring and that caring is also a basic human value. Phillips (2012:56) has suggested that whilst there are differing interpretations of the concepts of caring, there is an acceptance that knowledge about caring is ‘central to understanding human life, healing and quality of care’. Wagner and Whaite (2010) concluded that there have been numerous definitions of nursing in an attempt to describe the role and contribution that nurses make to caring, but all definitions are indistinguishable from the term caring. However, it could be argued that exhibiting good caring practices and compassionate nursing care are at odds with the exposés of cruelty and neglect that nursing has been associated with over the last century.

In 1983, a shift to regulation and professionalisation came through the regulatory changes with the advent of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (Harrison & McDonald 2008). In recent times, care,
compassion and the conduct of healthcare professional groups have been enshrined in value statements, including those of the General Medical Council (General Medical Council 2007) and the Nursing & Midwifery Council (Nursing and Midwifery Council 2015). The NHS constitution was updated following the report into the failings at Mid Staffordshire NHS Foundation Trust, to include reference to behaviours and values of care and compassion. The NHS is there for the people: ‘It touches our lives at times of basic human need, when care and compassion are what matter most’ (DH 2013:2).

It could be argued that, over time, nursing as a profession has developed and the pervasive imagery of Florence Nightingale continues within the profession. Although, some nursing development has focused on modern, highly-technological, task-focused roles of advanced nurse practitioners alongside that of less technology-centred roles such as nurse specialists in fields including palliative care and elderly care settings. In summary, there have been many changes to nursing over the last one hundred and fifty years, evolving from the role of caring practices in the home, to the professionalisation of nursing including the advent and development of education and training.

In the next section explores the literature pertaining to the practice and philosophy of nursing, which builds on the review of the development of nursing.

### 2.6 The Practice of Nursing & Theories of Caring

In the last fifty years, there has been increased interest in the development of theories of caring to inform and guide nursing practice and to further the development of nursing as a ‘caring science’ (Law-Harrison 1990; Phillips 2012).
‘Nursing is known as a scientific profession based on research, theory, and concepts centred on the art of caring and focused on health care outcomes’ (Jasmine 2009:415). However, there is an apparent lack of clarity about the meaning of caring which may stem from a range of issues. These include differing perspectives on caring, a lack of consensus about defining caring leading to an inherent difficulty in defining what caring is and what it feels like to patients and nurses (Law-Harrison 1990). Leininger (1981) stated that ‘caring’ as a concept in nursing was seldom explored in the past. Caring as a concept has been viewed as being aligned with health (Newman et al 1999). There have been various differing philosophies of nursing, from Nightingale’s legacy of caring, to more recent philosophies including Henderson’s (Henderson 1966) definition of nursing and Watson’s (Watson 1988) philosophy and science of caring.

The nursing models that have emerged in the last fifty years are diverse and focus on differing perspectives and standpoints of care, but broadly consider the four main elements of person, health, environment and nursing care (Royal College of Nursing 2014). These nursing models include Orem’s self-care deficit theory (Orem 1995), the Roper, Logan and Tierney model of living (Roper et al 1996) and Leininger’s transcultural care model (Leininger 1981).

Two major theories of caring include Leininger’s (1990) view that cultural caring supports health and well-being and Watson’s (1988) perspective that caring is interrelated with healing and is known as ‘caring-healing’. Leininger’s (1981) cultural theory is premised on holistic caring and established that ‘care’ and ‘caring’ are synonymous terms used in nursing and that culture has an impact on caring. Leininger’s (1981) theory of transcultural care includes the classification of twenty-
seven differing caring constructs including concern, empathy, compassion and trust. The care of the body and mind are seen in the context of the cultural impact of care. An alternative theory of caring was introduced by Watson (1985) and is known as the ‘metaphysical theory of nursing care’ (Saewyc 2000:116). It is based on the view that caring is pivotal to nursing. Watson’s (1985) model of human caring centres on the therapeutic interaction of the nurse–patient relationship, which was said to be founded on love and caring ‘where the caring relationship reaches a higher level’ (Wagner & Whaite 2010:226). Watson (1985) agreed that the connection between the nurse and the patient is a key part of the caring practice and demonstrated this as transpersonal caring in nursing practice. Como (2007) claimed that Watson’s model of human caring is based on the premise of caring and healing as opposed to a positivist biomedical model of care. Watson’s theory centred on ten carative factors that provide the framework for nursing (Saewyc 2000:116):

- Formation of a humanistic/altruistic system of values;
- Instillation of faith/hope;
- Cultivation of sensitivity to self and others;
- Development of a helping trust;
- Relationship; acceptance of positive and negative feelings;
- Use of the scientific problem-solving method for decision-making;
- Promotion of interpersonal teaching-learning;
- Provision for a supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment;
- Assistance with gratification of human needs; and
- Allowance of existential-phenomenological forces.
Leininger’s and Watson’s theories of caring offer conflicting views, but have similarities in that the patient is seen as having a holistic care need. In contrast, Mayerhoff’s (1971) assumption of caring is conceptually different, focusing on the premise of caring for the aim of self-actualisation compared to Watson’s (1985) view of holistic ‘caritas’ nursing. Leininger’s (1981) theory of culturally congruent care more closely aligned with Watson’s (1985) theory of caring is the view that caring is based on receptivity.

Other more recent theorists include Chinn (1991), who described caring practices as both at the forefront of nursing and as the moral ideal of nursing, requiring commitment and conviction from the care-giver to providing caring practices. This definition seems to proffer that caring practices necessitate both a disposition and desire to care for a patient. This view offers a two-fold explanation of both a personal inclination or a caring personality, and a behaviour trait to willingly engage in caring practices. It could be argued that nursing theory and models of caring appear to have had more prominence in the past, compared with the more recent emergence of ‘care bundles’ which are orientated around a disease or illness, e.g. diabetes or myocardial infarction.

Alternatively, Lewis (2003:37) proposed ‘that caring and healing are core processes of nursing and essential to our central mission’. These factors evolved over time to become the transpersonal care model based on moral ideals in caring (Saewyc 2000), in addition to the view that nursing care supports the patient to gain a holistic harmony within the mind, body and soul.
2.7 Nursing Ethics

In considering caring practices in nursing it is important to also include the position of nursing ethics because nursing ethics are the cornerstone of nursing practice and first emerged in the Unites States in 1870, influencing clinical practice, codes of ethics and nurse education (Fowler 1984). ‘Professional ethics does for the most part focus on the actions or the character or the dispositions of individual professionals (dispositional approach)’ (Baillie et al 2008:45). Although nurses may have different values, their professional conduct is defined by the Nursing and Midwifery Code of Professional Conduct, through the standards of conduct, performance and ethics (Nursing and Midwifery Council 2015). Gallagher (2014:141) stated that professional codes are interwoven with ‘professional obligations and duties’. Early ethics in the 1900s concentrated on the duty and virtues of the character of the morally good nurse. Virtues such as cleanliness, loyalty and wholesomeness were considered vital characteristics of the nurse. However, in the 1960s, following changes to society, there was a shift from virtue to duty-based ethics (Fowler 1984). ‘Virtues lead a person to act, from inclination, in ways consistent with that virtue, and a person’s character is illustrated by the exercise of the virtues’ (Sellman 2011:39). However, Fowler (1984) warned that it is not a case of either a duty or a virtue approach to ethics, but ethics should instead been seen as symbotic; for flourishing to occur, the meso organisational impact on behaviours must be considered. She thus questioned: ‘can the virtues of knowledge, skills, patience and caring flourish in an environment where the nurse’s workload is so large that competence and safety are the surpassing concerns?’ (Fowler 1984:34).

Roach’s (1984) theory of ‘caring in the human mode of being’ centres on the five Cs of caring: ‘compassion, competence, confidence, conscience and commitment’.
Roach (2002) put forward that all the five characteristics of caring were interwoven in nursing practice. A further component of ‘comportment’ was a later addition to this model (Roach & Maykut 2010). Notably, Roach and Maykut (2010:23) suggested that ‘intentional nursing practice is an expression of caring from the core of one’s being in response to a shared connectedness with another’. This creates a picture of emotional bonding between the nurse and patient.

Nursing theories and models of care may have a beneficial impact by guiding nursing practice (Lukose 2011). Likewise, an ‘understanding of the historical, ethical and theoretical viewpoints of care and caring are important’ to guide care (Como 2007:44). However, it could be argued that the variations in definitions of caring practices may lead nurses and other healthcare professionals to have different interpretations, values and beliefs about caring practices. This may then impact on the variations in standards of quality of care and patient experience.

2.8 Nursing as a Moral Practice

Joan Tronto is a political philosopher who defined care as a ‘common word deeply embedded in our everyday language’ (1993:102). Tronto also defined ‘care as both a practice and a disposition’ (1993:104). This definition goes further than simply seeing caring as a character trait, which is of significance to this research study which explores perceptions of caring practices. The perception of caring solely as a disposition is problematic in that it permits a notion of care being controlled by the care-giver, and hence promoting a notion of care to be ‘sentimentalised and romanticised’ (Tronto 1993:118). Drawing on Sarah Ruddick’s work, Tronto (1993) suggested that the full context of caring must encompass the notion of caring as a practice including the competencies of the care-giver and the care needs of those receiving care. It is therefore suggested that caring work can be conducted in a non-
caring manner, such as disengaged behaviours, and thereby not sustain the ideal of caring practices. Tronto (1993) defined ‘practice’ as having inherent integrated ‘thoughts’ and ‘actions’ aimed at achieving an outcome of care. A further component in Tronto’s (1993:157) definition of caring is perceptions of caring as a political idea, where caring is devalued by society as it is usually offered by undervalued groups in society.

Tronto’s (1993) description included the four phases of caring, namely caring about, taking care of, care-giving and care receiving:

- **caring about** – acknowledging there is a need for care;
- **taking care of** – recognising that patients might have unmet needs;
- **care-giving** – direct one-on-one patient care; and
- **care receiving** – seeing the impact of care-giving.

In Tronto’s model the emphasis is both on the separate aspects of caring phases whilst recognising the interconnectedness of the phases (Tronto 1993). ‘The four phases of care can serve as an ideal to describe an integrated, well-accomplished, act of care’ (Tronto 1993:109). This definition of caring practices resonates with my own perceptions of caring practices.

It is generally accepted that caring is a foundation of nursing, and that nurses motivated by altruism come into the nursing profession to do a good job (Sellman 2011). As a nurse, I share this view myself. Sellman (2011:101) goes further by stating that ‘nursing is thus a caring practice that aims at the good of those who find themselves in receipt of nursing’. Caring and showing compassion to those who are most vulnerable and need care can be traced to ancient Greece (Porter 2002). Irwin (1999) described the roles of ‘virtues’ or qualities recorded in ancient Greek philosophy. Virtue ethics is based on the person rather than the action, seeking for
the moral character rather than duty based (BBC 2014). Sellman (2011:39) argues that the Aristotelian account of a virtue is ‘understood as a general disposition the possession of which leads a person to act’. Hursthouse (1997) concurs with this view that a kind person will act with kindness, and a compassionate person will act compassionately. Sellman (2011:39) again refers to Aristotle and proffers that in order to become a virtuous person they ‘must act in the right way, in relation to the right person, at the right time’. However, Begley (2005:627) refutes this position, stating that virtue ethics does not offer guiding principles about individual behaviours.

‘A good nurse or a good doctor performs their functions well, and this requires excellence in skills, in theoretical knowledge and in moral virtue (excellence of character). Virtues can also be described as attributes, character traits, or excellences of character.’ (Begley 2005:623)

Sellman (2000:27) described Alasdair MacIntyre’s (MacIntyre 1984) vision to create a consistent cohesive concept of virtue ethics. This concept incorporates the triumvirate strands: the element of a practice, a narrative and a moral tradition (MacIntyre 1984). The element of nursing practice requires commitment to care for an individual patient or group of patients to excel in the practice whilst achieving ‘internal goods’ which have value to the nurse (Sellman 2000). Sellman (2000) used the example of the chess player as depicted by MacIntyre, and argues that nursing practice differs in that there is a ‘commitment’ to care for the individual. Sellman (2000:29) described this as ‘professional practice’, and as ‘having two elements: the MacIntyre definition of practice and a commitment that transcends the commitment to a practice’.
'External goods' are outlined as goods available outside of practices such as prestige and money (MacIntyre 1984). In applying MacIntyre’s (1984) description of practice in relation to this research study, it could be argued that internal rewards would be of importance in caring practices. Internal goods are defined as rewards found within practice, which require engagement and a desire for the best outcomes for the patient (Sellman 2000).

In the next section there will be an exploration of the historical accounts of uncaring and unethical caring practices and a consideration of the causes of these failings of care. Later in this section the impact on caring practices will be described in the context of micro, meso and macro levels: micro impact of individual responsibility for caring practices, meso organisational and cultural and thirdly the macro regulatory and political impact (Baillie et al 2008).

2.9 Contemporary Healthcare Challenges

The NHS constitution states that the ‘NHS is there to improve health and wellbeing and it touches our lives at times of basic human need, when care and compassion are what matter most’ (DH 2013:2). Whilst it is accepted that the majority of care is of good standard, there has been an extensive history of poor caring practices and neglect both in the United Kingdom and internationally (Appendix 2). The standards and quality of care are fundamental for organisations providing care; however, potential conflicts exist between the provision of quality care, individual organisations and professional groups (Roberts 2013). Historical challenges to poor care standards are ubiquitous and examples are cited in other countries as well as the United Kingdom. Poor care has been described as an international problem
Poor standards of care, misdiagnosis and failings in communication can have a profound life-changing impact on patients and families (National Audit Office (NAO) 2008; PHSO 2011). There has also been an extensive public and media response to failings of care and the impact of poor standards of patient care. The Parliamentary and Health Service Ombudsman (PHSO 2011) report identified the profound impact of individual and institutional attitudes, on standards of care and basic humanity.

Basic humanity is described as being shown humanness, kindness and benevolence (Oxford Dictionary online 2014). Standards of care are laid out and are fundamental; the Nursing and Midwifery Council Code (Nursing and Midwifery Council 2015:4) is unequivocal: ‘treat people with kindness, respect and compassion’.

The first modern hospital inquiry in the NHS was an inquiry in 1969, into allegations of mistreatment and cruelty of patients in Ely Hospital, Cardiff. In 2001, in response to the deaths of an estimated 30 to 35 babies at the Bristol Royal Infirmary, it was stated that the NHS would be ‘all changed, changed utterly’ (Newdick & Danbury 2013). However, following the Mid Staffordshire NHS Foundation Trust public inquiry, Robert Francis QC argued that changes had not taken place in the NHS as a result of the lessons from Bristol Royal Infirmary. Newdick and Danbury (2013:1) contended that in ‘Mid Staffordshire NHS Foundation Trust 400–1200 patients died as a result of sub-standard care, with stories of indifference and neglect that are harrowing’. Anna Dixon, director of policy at the King’s Fund, was quoted as saying that the failings of care can be traced back from the Francis Report to the care scandals at Ely Hospital (Campbell 2013). There are some commonalities in both

(Clarfield et al 2001); Walshe (2010) noted examples of care scandals in the USA, Australia and Canada.
the findings and recommendations from the reported scandals that are found throughout these reports, including organisational cultures and leadership behaviours (Walshe 2010).

The Francis Report into the failings of care at Mid Staffordshire NHS Foundation Trust stated: ‘[there was] a failure to listen to those who have received care through proper consideration of their complaints and a corporate focus on process at the expense of outcomes’ (Francis 2010:24). The emerging themes in reports over the years were the apparent lack of Board attention to the patients’ experiences, potentially seen as a barometer of quality and early warning system within the organisations. Access to clinical metrics may not have been available in the 1960s at Ely Hospital, to monitor care standards systematically. It could be argued that there are some commonalities in both the findings and recommendations from the reported scandals that are found throughout these reports (Walshe 2010).

Next, the impact on caring practices will be described in the context of micro, meso and macro levels. Micro level context relates to the individual behaviours and responsibility for caring practices; meso-level context relates to the organisational and cultural impact; and thirdly the macro-level context describes the regulatory and political impact on caring practices (Baillie et al 2008). These levels will be explored in greater detail in the findings chapter (Chapter 5).

2.9.1 Micro individual caring level
At the micro level and meso level of patient experience of individual caring practices, complaints about health care are an indicator of poor quality of standards of care. Machell et al (2009) warned that the failure to deliver the fundamentals of care can
have a major impact on NHS Boards, sometimes more than failures of either finance or performance. However, there are still serious concerns about the lack of attention some NHS Boards pay to the quality of clinical care. Garratt (2010) proposed that developing a healthy organisational culture is fundamental to a responsive organisation. ‘To fail to attend to the promotion of kinship, connectedness and kindness between staff and with patients is to fail to address a key dimension of what makes people do well for others’ (Ballatt & Campling 2013:3). At a micro and meso level there are accounts of poor caring practices and numerous examples of the impact of leadership skills, organisational culture and professional behaviours on virtuous people.

Frost (1999) identified that compassionate care requires a significant amount of emotional investment from the care-giver. Emotional ‘burnout’ can be a response to high levels of emotional upheaval; the response during burnout can be to become detached in the caring practice as a form of self-preservation from the distress (Frost 1999). NHS targets may have had a ‘blunting effect’ on compassion by focusing on the targets to maintain financial viability at the expense of the patient experience (Newdick & Danbury 2013). In relation to nursing and caring practices, it is important to understand how practitioners come to act in an unvirtuous way, if we wish to improve standards of care. Begley (2005:635) claimed that ‘sometimes good people can behave badly’.

Tronto (2010) argued that caring organisations should focus on the whole caring process, focusing on the care of the patients in tandem with the staff. Negative behaviours and attitudes may then manifest as being devoid of compassion or true engagement in the nurse–patient relationship. A further facet to this is the issue of moral distress, where staff may exhibit behaviours of disengagement and disinterest
with colleagues and patients, leading to poor patient experiences. There is a significant body of literature outlining moral distress which will be examined in chapter 5. Jameton (1993) declared that moral distress can be founded on wishing to do the right thing for the patients but having constraints which inhibit good caring practices.

2.9.2 Meso organisational level

At a meso organisational cultural level a further facet to failings of care has been suggested as organisational cultures and behaviours. Culture is defined as how influence and shared beliefs and common practices are used within an organisation; they are often preserved in folk tales, customs and rituals (Deal & Kennedy 1992; Garratt 2010). Geertz (1973) however described more fully the interplay in cultures as a ‘historically transmitted pattern of meaning’. This outlines the potential for an organisation’s moral climate to develop.

The notion of culture as a predeterminant of performance has emerged (Deal & Kennedy 1982; Scott et al 2003). In agreement, Firth-Cozens and Cornwall (2009) warned that failings attributed to poor standards of care are the most common cause of the failure of an organisation. Francis (2013), in depicting the failing at Mid Staffordshire NHS Foundation Trust, described the culture as ‘the predominating attitudes and behaviour that characterise the functioning of a group or organisation’ (Francis 2013:152). He went on to observe the impact of organisational culture on failings of care, which occurred at a time of low staff morale, a lack of candour and cultural acceptance of individual behaviours.

Metcalf et al (2011) suggested that the culture and environment of care can have a direct impact on poor standards of care, with increased co-morbidity and mortality
rates. A relationship therefore exists between organisational failure, patient care and safety. The Board’s ability to listen to patients’ experience is another key theme from organisational failures. There was a ‘failure to listen to those who have received care through proper consideration of their complaints’ (Francis 2010:24). This illustrates the impact of a culture which is either unable, or does not want, to listen to patients’ experiences of care.

The impact of effective leadership, alongside an organisational culture of engagement and improvement, is acknowledged to shape and improve organisational performance (Alimo-Metcalf 2012). In Shipton et al’s (2008) study there was a significant correlation between poor leadership and a high level of patient complaints. Schein (2010) argued that organisational culture and leadership are intertwined and inextricably linked. In support, governance is endorsed through leadership which affects the organisational culture (Alimo-Metcalf 2012). It could be argued that Directors of Nursing are in potentially significant nurse leadership positions and, as Executive Board members, able to support local implementation plans to improve caring values and behaviours, such as the CNO Vision (NHS England 2013) within their organisations.

2.9.3 Macro organisational level

Scandals of poor care have pushed quality to the centre of healthcare policy at a regulatory government macro level (Davies 1999; Smith 1998; Payne 2011). There has also been policy repositioning and a shift to delivery of targets, processes, ‘pace setting’ and ‘command and control’ leadership (King’s Fund 2012). This describes how health targets and expenditure can be controlled and monitored by central government. Health policy in the United Kingdom is also focused on improving quality of care and improving outcomes whilst achieving significant efficiencies
within the system (DH 2010b). The Royal College of Nursing’s report, *Defending dignity: Challenges and opportunities* (Baillie et al 2008) revealed the impact of bureaucracy and a businesslike approach to patient care, coupled with the ‘culture of rushing’ and performance targets. It has emerged that the NHS is at risk of being diametrically oppositional, with significant savings targets posed against unprecedented demand for high-quality services (Shipton et al 2008). The situation is further tested with an increasing ageing and frail population with complex health needs; and traditional spending patterns which have been lower in primary and community care settings. Further drivers include the regulators – the Care Quality Commission (CQC), Trust Development Authority (TDA) and Monitor – to assess and report the quality of care, the evidence if supported by the number of patients’ complaints and patient experience surveys (DH 2010b). However, regulatory bodies have come under criticism for failing to recognise and intervene in a responsive manner in NHS Trusts with poor and failing care such as Mid Staffordshire NHS Foundation Trust (Francis 2010).

In summary, the complexities of the macro regulatory system, the meso organisational cultural impact and the micro individual responses to caring practices have been presented. Gallagher (2014) argued that the complex causes of uncaring practices need to be viewed from the micro, meso and macro perspectives to see the fuller explanations.

In the next section there will be a consideration of the evolution of the nurse leader’s role to the current-day Director of Nursing, establishing the role that Directors of Nursing have in supporting and leading caring practices within their organisations.
2.10 Evolution of Nurse Leadership

Girvin (1998) claimed that there is limited nursing literature related specifically to nurse leadership before the 1980s, although it is acknowledged that there have been nurse roles in the NHS since 1948. During the 1960s nursing was reported to be experiencing a recruitment crisis (Girvin 1998). The Salmon Report (Salmon 1966) set out a vision of an ambitious nursing hierarchy aiming to promote recruitment to the profession. However, Girvin (1998) argued that this model created a ‘perfect storm’ where nurses were often ill-prepared for newly created management roles, sometimes promoted without the necessary skills and experience. The impact of this was that some nurses, struggling and unsupported in the new roles in management, left their positions and the profession. But this new management structure did give opportunities for nurses to become involved in strategic decision-making. A far-reaching new shift occurred with the dismantling of the nursing leadership structures which came into effect following the recommendations of the Griffiths Report (Griffiths 1983). It was argued that, as a result of the reduction of nurse leadership roles from NHS management hierarchies, so a predominantly male management culture was created (Clay 1986). Girvin (1998:47) declared that ‘nurses were in danger of being completely marginalised’ following the impact of the reforms arising from the Griffiths Report (Griffiths 1983), and many nurses returned to clinically facing roles or left for roles in education or research.

in 1966 by the Committee on Senior Nurse Staffing Structures (DH 2002:1). Girvin (1998:44) questioned the impact of the power and leadership of these roles, stating that this approach was not conducive to professional development and relied on ‘borrowed power from medical colleagues’. Some years later, the matron role re-emerged and was seen as synonymous with strict management of standards and control (Griffiths 1983). A popular public message was incorporated into the NHS Plan (DH 2002:15) to set out to invest public money by reintroducing the modern matron roles. These roles were seen as pivotal in exercising nurse authority to get the standards of care and cleanliness right on the wards NHS Plan (DH 2002).

In addition to the reintroduction of the matron roles in hospital was the mandate that every hospital Trust must have a Chief Nurse or Director of Nursing on the Board (DH 2002). The role of Chief Nurse or Director of Nursing was seen as a way of providing professional leadership in NHS acute Trusts. Nurse leadership was formally validated through the establishment of Directors of Nursing posts during the first wave of NHS Trusts in 1991 (Kirk 2009). The structure of the NHS has evolved considerably since then, with emerging Clinical Commissioning Groups and Foundation Trusts (FTs). FTs are required to have a Registered Nurse or midwife among their Executive Directors (DH 2006). Since then the role of the Director of Nursing has been synonymous with the role of clinical quality champion at the Board (Machell et al 2009). However, in more recent years the role of Director of Nursing has become complex and more multifarious, providing the Board with ward quality assurances. It has been argued that the role and the skill required of the Nurse Director are both to articulate the quality agenda and to balance competing Board priorities such as finance (Machell et al 2009).
2.11 The Role of Directors of Nursing

Read and Graves (1994) have stated that a significant contribution has been made to the NHS from nursing roles. However, there has been widespread concern in the UK and other parts of the western world that there are worrying deficiencies in the nursing contribution to care (Aiken et al. 2002a; McSherry et al. 2012; Morris-Thompson et al. 2011; Taskase et al. 2006). Further responses to the documented failings in care have been from the Prime Minister’s Office and the Department of Health led by the Chief Nursing Officer (CNO) for England. In 2013, the CNO published *Compassion in Practice: One Year On* (NHS England 2013:3); the aim was to engender a ‘grassroots’ response from nursing to improve standards of patient care. This three-year strategy was seen as a direct response to the findings and recommendations of the Francis Report (Francis 2013) alongside the Keogh Report (Keogh 2013), the Cavendish Review (Cavendish 2013) and the Berwick Review (Berwick 2013). The strategy set out the CNO’s aim to create a social movement to promote behaviours and values and to provide high-quality compassionate care (NHS England 2013). The framework of the 6Cs focuses on improving values and behaviours in relation to care, compassion, competence, communication, courage and commitment (NHS England 2013). It is important to explore and examine whether policy directives such as the CNO strategy can make a positive impact on improving standards of nursing care; moreover, what role Directors of Nursing can play in leading the change; additionally, what complexities exist for change to happen; and finally, to identify the barriers and enablers from political, organisational, cultural and social perspectives. Although historical examples of poor care go back to the seventeenth century, recently there have been unprecedented levels of public and media scrutiny of the nursing profession and the NHS following the more recent exposés of care failings.
Kirk (2009) studied the factors identified by Nurse Directors in their roles as important to their success. The findings revealed that the factors viewed as important in determining the effectiveness of the Nurse Directors’ roles included communication skills, being a visionary leader, political astuteness and collaborative working with the multidisciplinary team. The findings also illustrated that the Nurse Directors found it difficult to define their individual contribution to patient outcomes. This research did not explore their experiences or perceptions of managing challenges to maintaining standards of patient care.

Carney's (2004) grounded theory research focused on the possible impact of organisational structures on the roles of twenty-five Nurse Directors in Northern Ireland. The findings disclosed that organisational structure had a key impact on the effectiveness of these roles. Positive and negative impacts on the role were associated with the type of organisational structure, more complex structures having the most negative impact. Machell et al (2009) observed a paradox emerging, whereby Nurse Directors can be seen as the ‘guardians of quality’ at the Executive Board but they may be left to take the entire responsibility for the agenda, rather than quality being seen as the responsibility of the whole Board. The paradox for the Executive Board and the Nurse Director has become more challenging in recent times, with the requirement to balance the quality agenda with greater fiscal controls on organisational spend and regulation. Kirk (2009) concluded that Directors of Nursing were associated with the quality agenda rather than the hospital’s productivity and efficiency agenda.

The King’s Fund’s Ward to Board (Machell et al 2009) report focused on the observational and development work of Boards, coaching and feedback. The findings revealed the importance of the role of the Nurse Director and the skills
required in driving the quality agenda forward. There are high levels of public and media scrutiny on the nursing profession and the NHS, following the media interest in recent public inquiries into failings of care. There is also a newer dominance of social media in capturing real-time examples of perceived care failings and poor standards of care.

### 2.12 The Research Gap

In summary, Kirk’s (2009) and Machell et al’s (2009) research revealed some of the key attributes in effectiveness as a Nurse Director and also the experience for Directors of Nursing on Trust Boards. In addition, Carney’s (2004) research focused on the possible impact of organisational structures on the roles of Nurse Directors in Northern Ireland, but it did not explore their experiences or perceptions of managing challenges to maintaining standards of patient care. The gap in the research is in understanding the perceptions of the Directors of Nursing on caring practices within their organisations. Caring practices are defined as the micro-level nurse–patient interaction, and the behaviours and attributes of the nursing staff carrying out nursing care in the clinical areas (Baillie et al 2008). Further, a gap exists in identifying what enables and inhibits Directors of Nursing in sustaining caring practices in their organisations. There are additional areas of interest to both explore the macro regulatory and political impact on caring practices, along with the meso organisational Board culture impact on caring practices. It is important to explore the possible complexities and interdependencies that may exist through the levels of meso, macro and micro impact so as to gain a fuller picture of the role of Directors of Nursing in relation to caring practices.
In response to emerging policy directives and current gaps in the research, it is essential to explore the perceptions of the Director of Nursing, and to understand more about the impact of their role on improving standards of nursing care. Moreover there is a need to explicitly identify the contribution that Directors of Nursing can make in supporting improvements to patient care. The overall aim of this research was to understand the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices. A further aim was to explore the social, political, professional and organisational challenges facing Directors of Nursing in relation to caring practices. The rationale for this research is two-fold: Directors of Nursing are in a unique position to provide professional leadership to nursing and care staff at NHS Trusts; and there is a dearth of literature specifically exploring the role of Directors of Nursing in NHS acute Trusts in caring practices.

2.13 Conclusion

Although the focus of this research study is the perception of the Directors of Nursing on the caring practices of nurses, it is acknowledged that caring is not unique to nursing. Differences still exist within the ‘body of literature for its lack of conceptual clarity, there seems to be growing international consensus in nursing that knowledge about caring is key to understanding human health, healing and quality of life’ (Phillips 2012:56). There are consistent themes of poor organisational culture, ineffective leadership and the disengagement with patient feedback and experience that are evident in many of the reports and inquiries into failings of care (Walshe 2010).

Directors of Nursing have an important role in understanding and recognising the potential impact and influence of caring practices and standards within their
organisations. Directors of Nursing also have responsibility and accountability as strategic nurses and as Board leaders to improve the quality of patient care. The impacts at either a macro, meso or micro level are interwoven and interlinked, with the impact of one area being seen in another area such as the impact of poor organisational culture on individual behaviours. Johnson (1990) argues that Nurse Executives have an important part to play in leading the mutual values of their nursing workforce. Consequently, the perceptions of Directors of Nursing and their responses to challenges in caring practices are vital in improving patient care.
Chapter 3: Research Methodology

3.1 Introduction

In chapter 2 and in keeping with the chosen research methodology of grounded theory, a preliminary literature review was conducted. This focused on critiquing the literature pertaining to differing theories of caring practices and values, and highlighted some of the more recent challenges pertaining to caring practices. Further, there was a brief overview of the literature on the social, political, professional and organisational challenges facing Directors of Nursing in NHS acute Trusts in response to care practices.

In this chapter, the research aims and objectives will be outlined, alongside a reflection of how the research evolved throughout the four years of study and the decisions that I made to influence this research. There will also be a critique of the methodological choice of grounded theory, including an exploration of my own ontological and epistemological assumptions and positioning. Furthermore, there will be a rationale and discussion regarding the specific selection of a constructivist grounded theory approach and the relationship to this approach with co-construction and reflexivity. In the final section of this chapter, the methods will be established, including interviews, sampling, recruitment and data collection. The ethical considerations and the constructivist data analysis processes will be outlined.

3.2 Journey, Aims and Considerations

3.2.1 Journey to the research topic

In the beginning of the Doctorate in Clinical Practice, I critiqued the introduction of the policy of *Essence of Care: Benchmarks for respect and dignity* (DH 2010a). This
policy was introduced as a response to the high-level exposés of care failings in the NHS. It presented a national benchmarking system that could be implemented across similar NHS settings, aiming to systematically measure indicators pertaining to respect and dignity across NHS acute Trusts. The rationale for choosing this policy was to critique an example of a policy driver that had been implemented to address the issue of variability in standards of care. I had a keen interest in politics in healthcare, but on reflection, having undertaken this assignment I started to more fully appreciate the link between government politics and the application of health policy. The political context of care failings was a theme that continued throughout the four years of study, in the aftermath of the enquiry at Mid Staffordshire NHS Hospital. Notably, a further reflection on this topic area was the question of whether ‘compassionate care’ could be mandated or improved through policy or political drive. It could be argue that this approach may be viewing caring practice through a one-dimensional lens, which does not encompass other complex interdependencies such as the impact of organisational culture and leadership on caring practices. The potential relationship between politics, policy and power and caring practices has remained an area of interest for me during the Doctoral programme and informed my thinking for the research proposal.

I had some searching and critical questions regarding how caring practices between nurses and patients could become, in some way, uncaring and unethical. The accounts of human suffering and neglect that had been recently reported as everyday patient and family stories, and also the high-profile inquiries, had a profound impact on my thinking about nursing and caring. This was at my core and a searching question for me, as a nurse and in a leadership role, is ‘how could nurses be anything other than caring and kind when faced with patients’ suffering and distress?’
I also chose a leadership topic exploring the impact of Board cultures on quality of care. This area was of importance to my role as Nurse Director working alongside large NHS acute Trusts, as I considered the different Board cultures and the possible impact on quality of care. There were some organisations that seemed to consistently rank highly in staff and patient experience surveys, and others that did less well. This assignment also explored the potential different power bases at the Trust Board and in particular how power exists between professional groups and groups of managers. The conclusion from this assignment was that having an effective and supportive organisational culture was an important component in improving standards of care. The learning from the assignments led to the iterative development of my research proposal, focusing on the perceptions of Directors of Nursing in NHS acute Trust, on caring practices.

In selecting the methodology for the research I also had some experience as an MSc student and as a Research Fellow in conducting qualitative studies including grounded theory research. This experience influenced my thinking about exploring a grounded theory approach for the research study.

**3.2.2 Aims of the research**

The aim of the research was to develop a theory to gain a deeper understanding of the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices. Moreover, there also was an exploration of the social, professional and organisational challenges facing Directors of Nursing pertaining to managing and responding to caring challenges. Caring practices are defined as the nurse–patient interaction, and the behaviours and attributes of the nursing staff carrying out nursing care in the clinical areas (Baillie et al 2008). The literature pertaining to caring practices was outlined in the preliminary literature review in chapter 2.
Directors of Nursing have an important role in understanding and recognising the potential impact and influence of caring practices and standards within their organisations. Directors of Nursing also have responsibility and accountability as strategic nurses and as Board members to improve the quality of patient care. Therefore, it is argued that the perceptions of Directors of Nursing, and their responses to challenges to caring practices, are vital in improving standards of patient care and quality.

The rationale for the inclusion criteria of Directors of Nursing in NHS acute Trusts is that there is a gap in the literature for an England-wide study of the perceptions of Nurse Directors.

The research objectives were:

1. To describe and explore the perceptions of Directors of Nursing within NHS acute Trusts, focusing on their interpretations and perceptions of caring practices;

2. To gain an understanding of the Directors of Nursing’s perceptions on the values that underpin caring practices;

3. To explore potential conflicts in the values, roles and behaviours that may exist for Directors of Nursing in developing caring practices;

4. To elicit the macro-political factors, meso-organisational impact and micro-level impact on Directors of Nursing in response to care practices.
3.2.3 Research paradigm

In the 1970s, although still relatively young, nursing research began to develop, with a shift towards qualitative research (Holloway & Wheeler 1996). However, mixed methods have also found regard in more recent years, as an effective approach to looking at alternative views of the same phenomenon (Hutchinson & Webb 1991). Holloway and Wheeler (1996) outlined the origins of qualitative research as being from both anthropology and sociology. Qualitative research focuses on the daily lives of people and the worlds they live within (Polit & Hungler 1997). By observing and listening to people’s stories about their experiences and their lives, researchers begin to see the world from different perspectives and view knowledge as socially constructed (Holloway & Wheeler 1996). Within the qualitative paradigm there are three main strands of interpretative research approaches: grounded theory, ethnography and phenomenology.

In establishing the appropriate research paradigm for this research study, attention was given to the gap in current knowledge, the aims of the research and my own ontological and epistemological stances. It is contested that the preference of a researcher’s paradigm is influenced by their own ontological, epistemological and methodological assumptions (Norton 1990). Therefore, researchers are encouraged to select a paradigm that is “congruent with their beliefs about reality” (Mills et al 2006).

The gap in the current research pertained to the Directors of Nursing perceptions on caring practices, and what values underpin their perceptions and interpretations of caring practices in NHS acute Trusts. The aim of this research was therefore to gain an understanding and explanation of the experiences of Directors of Nursing in NHS acute Trusts, on caring practices. Hence a qualitative paradigm was thought to be
the most appropriate because such a research paradigm is focused on understanding experiences and creating meaning from the social ‘worlds’ of the Directors of Nursing. Holloway and Wheeler (1996) confirmed that a qualitative paradigm can be most appropriate, allowing participants to describe their social reality and the environments that affect their experiences.

My own ontological position is that of a relativist as I dispute the objective reality and that reality is socially constructed. The relativist ontological position claims that the truth and reality should be viewed in the context of the “world which consists of multiple individual realities influenced by context” (Mills et al 2006:2). Charmaz (2006) suggests that the relativist position must be viewed that truth and reality are positioned in the context of a certain time, place and culture. As a nurse and a researcher, I acknowledge that I bring my own experiences and knowledge pertaining to caring practices to this research, and therefore my epistemological position is that there is a subjective interrelationship between myself and the research participants. From an epistemological position (Mills et al 2006) describes this as “researchers in their humanness are part of the research endeavour, rather than objective observers”. Constructivist grounded theory offers the researcher to become the author of the research (Mills et al 2006). My position as nurse is that I hold a belief that patients should be cared for as we would wish for our own family members to be cared for if they were unwell. I have experienced recognising good caring practices when the nurse is being kind and considerate to their patients alongside delivering best practice in evidenced based care. I recognise this within myself as a nurse and through others nurses who I work alongside.

In summary, I recognise that my ontological position is that of a relativist alongside a subjective epistemological position. These positions are congruent in my selection of the constructivist grounded theory approach taken in this research. Mills et al
(2006) argues to make certain of a research paradigm, researchers must be compatible in their ontological and epistemological positioning.

3.2.4 Research methodology – grounded theory

Grounded theory was established from the school of symbolic interaction by George Herbert Mead in 1934 (Mead 1934). Symbolic interactionism as a research perspective was developed by Barney Glaser and Anselm Strauss in 1967. Symbolic interactionism is a fundamental feature of grounded theory; and is the process by which social interactions are understood and interpreted, with meanings created in language (Polit & Beck 2006; Suddaby 2006). Denzin (1970) coined symbolic interactionism as naturalistic inquiry, necessitating the researcher to see the participants’ world.

Anselm Strauss had experience with symbolic interactionist approaches, while Barney Glaser was experienced in quantitative research. Their grounded theory research was conducted at the University of Chicago and focused on exploring the interaction of health professionals and dying patients (Glaser & Strauss 1967). They published their seminal work The Discovery of Grounded Theory and defined grounded theory as ‘the discovery of theory from data research systematically obtained and analysed in social research’ (Glaser & Strauss 1967:1). Urquhart (2013) described grounded theory methodology as ‘derived human behaviour from empirical data’ (Urquhart 2013:14). Grounded theory methodology centres on systematically and inductively generating theory from data (Strauss & Corbin 1998; Thomas & James 2006). It is a method of collating and analysing data to generate ‘middle range theories, implementing a comparative, iterative and interactive method’ (Charmaz 2012:2).
In 1990, with the publication of the *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* (Strauss & Corbin 1990), a divergence or ‘diacritical juncture’ occurred between Glaser and Strauss, the two ‘architects’ of the grounded theory methodology. The divide centred on ‘the aims, principles, and procedures associated with the implementation of the method’ (Evans 2013:37). Centring on the philosophy behind the coding processes, Strauss offered a more prescriptive framework which went against the views of Glaser who did not agree with this method and saw it as potentially forcing the data (Urquhart 2013). This issue of potentially forcing the data extends the view that data should speak for itself rather than imposing a theory upon the data. A central tenet to grounded theory is not to explain participants’ behaviours, but to conceptually explain the problem that is being explored.

A further area of divergence came from the concept that the Glaserian researcher needed to have an ‘empty mind’ or ‘tabula rasa’ whereas the Straussian researcher claimed that a researcher may bring their own values and beliefs with an ‘open mind’ when embarking on their research (Jones & Alony 2011). In essence the issue for debate was whether it was feasible for the researcher to undertake research with no experience or values or whether these experiences in essence added to the research process. As two differing routes emerged, Strauss and Corbin then published *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (Strauss & Corbin 1998). Glaser’s original grounded theory was described as ‘Classic Grounded theory’ whilst Strauss and Corbin’s was ‘Straussian grounded theory’ (Ghezeljeh & Emami 2009). Variations of interpretations of the methodological traditions and philosophical standpoints have continued to surface over the years; however, the joint contributions of Glaser and Strauss were pivotal to the emergence of grounded theory (Strauss & Corbin 1990).
Since the development of grounded theory in 1967, the departure from epistemological shifting between the schools of grounded theory has evolved. The various iterations of grounded theory approaches fall broadly into four approaches: classic, Straussian, feminist or constructivist (Breckenridge et al 2012). Classic grounded theory aims for conceptual understanding of social behaviour, rather than a constructivist focus on interpretative understanding of participants’ meanings (Breckenridge et al 2012:3). Straussian grounded theory is the most recognised alternative to classic grounded theory. This approach supports the view that the researcher brings a general idea of the research subject to be studied. In Straussian grounded theory the researcher uses a ‘rigorous framework’ in coding (Jones & Alony 2011:100). It could be argued that the feminist approach to grounded theory is more compatible with the feminist perspectives of nursing (Plummer & Young 2010). However, Holloway and Wheeler (1996) argue that a limitation of feminist research may be the disregarding of the social research perspective, involving both genders. Mills et al (2006:25) define constructivist grounded theory as a ‘popular method in research studies primarily in the disciplines of psychology, education and nursing’.

Although there are similarities between the grounded theory versions, there are some distinct differences. Breckenridge et al (2012:1) goes further to describe the complexities and intricacies of the differing versions of grounded theory as ‘navigating through the methodological mire’. One criticism of ‘re-modelling’ original methodologies is the possible risk that the methodology becomes something new that does not resemble the original (Breckenridge et al 2012). Notwithstanding the differences, it could be argued that all grounded theory approaches sit together on a ‘methodological spiral and reflect epistemological underpinnings’ (Mills et al 2006:26). The ‘spiral’ begins with the classic grounded theory discovered by Glaser & Strauss (1967) and has developed to the distinctions found in the methods applied
in grounded theory research today. Grounded theory has continued to develop and evolve in the last forty years since the seminal work of Glaser and Strauss (Glaser & Strauss 1967), more latterly with the emergence of constructivist grounded theory defined by its proponent Kathy Charmaz (Charmaz 2006).

3.2.5 Constructivist grounded theory

Constructivism is derived from the work of Egon Guba and Yvonne Lincoln (Guba & Lincoln 1981) which emphasises research focusing on people’s experiences and behaviours within their own social worlds. A core tenet of the constructivist approach is that concepts are *constructed* as opposed to *discovered* as with classic grounded theory (Evans 2013). These constructions aim to provide explanations and make sense of experiences, by attempting to answer the *why* as well as the *what* and *how* questions (Charmaz 2006). Constructivist grounded theory aims to develop a detailed understanding of the underlying social or psychological processes within a certain context by exploring in more detail social interactions and social structures (Gardner et al 2012). In agreement, Charmaz (2006) acknowledges that constructivist grounded theories are contextually orientated, to a defined culture, time, place and situation.

Charmaz’s (2012) description of constructivist grounded theory follows the following principles:

- Reality is multiple, processual and constructed;
- Research process emerges through interaction;
- Takes into account the researcher’s position and that of the participant;
- Co-construction of the data;
- Research always reflects value positions.
In the early 1990s, the constructivist grounded theory approach was described by Charmaz (2006) as the middle ground between post-modernism and positivism and proffered as an alternative to both classic (Glaser 1978) and Straussian grounded theory (Strauss & Corbin 1998). The term positivism was described by the philosopher Auguste Comte as ‘knowledge’ that is objective and measurable and the researcher adopts a neutral position (Schwandt 2001). The aim of positivist research is to objectively describe the reality of a specific phenomenon, and post-modernism is an epistemology that acknowledges intuitive forms of knowing (Charmaz 2006:188). More recently, it has been argued that the constructivist grounded theory method has shifted from the positivist ground into the realms of interpretative inquiry (Gardner et al 2012). Interpretive theory is underpinned by symbolic interactionism: ‘Interpretative inquiry calls for the imaginative understanding of the phenomenon’ (Charmaz 2006:126). This supports the development of a shared reality of the phenomenon.

In the constructivist grounded theory approach, Charmaz (2006) underlines that the researcher is not neutral in the research process, as data are co-constructed between the researcher and the participants. I believe it is important to make my identity as the researcher visible, so as to create a transparent co-construction of data in this research study. We construct our theories through our past and present interactions with people, perspectives and research practices (Gardner et al 2012). By nature of the research area of perceptions of Directors of Nursing on caring practices, the areas explored are subjective areas including the social, political, professional and organisational challenges. Subjectivity supports my interpretation of the participants’ thoughts and actions. Charmaz (2014) suggests that grounded theory can also be advantageous for studying processes within organisations. It could be suggested that the exploration of the perceptions of Directors of Nursing on
caring practices, was conducive to me as the researcher being an integral part of the research and data, through the process of co-construction and co-authoring. It is contested that an interpretative approach, such as the constructivist grounded theory approach, was appropriate for the research area.

A constructivist approach puts ‘priority in the phenomenon of study and sees both the data and analysis as created from shared experiences and relationships with participants and other sources of data’ (Charmaz 2006:130). In support, Holstein & Gubrium (1997:114) suggests that “respondents are ... constructors of knowledge in collaboration with interviewers”. Therefore, a co-construction of reality and understanding is created between the researcher and the participant. Consequently, a constructivist approach supports the shared arena of ‘explanatory power’ between the researcher and the participant (Mills et al 2006). A further component to the constructivist approach is keeping the data alive by using words in memos and text, as a method of keeping the participants’ presence in the research.

The epistemological position is that knowledge is co-created through the interface of the researcher and the participant, and refutes the ‘myth of silent authoring’ (Charmaz 2006), and to give a ‘voice’ to the participants (Breckenridge et al 2012). Norton (1990) goes further, suggesting that as this relationship exists, ontology and epistemology converge as the ‘knower is integral, to whatever is known’. Charmaz (2014) describes the researcher as stepping into the world of the participants, and viewing the data from the inside. In essence, it ‘reshapes the interaction between researcher and participants in the research process and in doing so brings to the fore the notion of the researcher as author’ (Mills et al 2006:6). Ghezeljeh and Emami (2009) state that the social reality and the researcher are indivisible as the researcher’s world becomes part of the reality. Therefore, researchers are part of
the research journey and their values must become transparent to the reader (Appleton & King 2002). A final theme is the use of a literary style of writing a constructivist grounded theory that is, using expressive creative writing to ‘communicate how participants construct their worlds’ (Mills et al 2006:32).

Differences between classic and constructivist grounded theory exist; for example a criticism of the traditional approach is that classic grounded theory is focused on the conceptual aspects of social behaviour, compared to a constructivist approach which is looking to interpretive understanding of participants’ meaning (Breckenridge et al 2012). In Table 1, the key differing attributes of classic grounded theory and constructivist grounded theory are illustrated. Charmaz (2006) suggests that the classic grounded theory approach does not recognise the relationship between the researcher and the data. A further difference between the classic grounded theory and constructivist approaches is that there is no search for a core category in the constructivist approach, which instead presents a ‘diffuse theoretical product’ (Martin 2006). I considered both grounded theory approaches but positioned myself in the constructivist approach, supported by my ontological positioning and epistemological view.

It is important to be transparent in recognising the researcher’s values and assumptions upfront as part of the process. The counter argument would be that this symbiotic relationship of the researcher and the participants is one of the cornerstones of a constructivist approach.
### Table 1. Key attributes of classic grounded theory compared to constructivist grounded theory (Charmaz 2006)

<table>
<thead>
<tr>
<th>Classic grounded theory (Glaser &amp; Strauss 1967)</th>
<th>Constructivist grounded theory (Charmaz 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective positioning</td>
<td>Constructivist assumes the position of relativist ontology – realities are socially constructed</td>
</tr>
<tr>
<td>Empty head – no preconceived ideas</td>
<td>‘Tabula rasa’ blank slate does not exist – the researcher comes to the research with values and beliefs</td>
</tr>
<tr>
<td>No preliminary literature search carried out</td>
<td>Preliminary literature review – to review what has been done before</td>
</tr>
<tr>
<td>Objective positioning from the data</td>
<td>Epistemology view, constructivist subjective interrelationship, ‘co-construction of meaning’ (Sexton &amp; Griffin 1997), ‘co-producer’ (Charmaz 2006)</td>
</tr>
<tr>
<td>One reality exists</td>
<td>World of multiple, processual realities exist (Mills et al 2006) or the reality arises from the interaction (Charmaz 2006)</td>
</tr>
<tr>
<td>No requirement for the researcher to set out their own values</td>
<td>Researchers in their humanness are part of the endeavour (Appleton &amp; King 1997) and values must be acknowledged – takes into account the positionality of the researcher</td>
</tr>
<tr>
<td>Raw data can be used</td>
<td>Raw data used in their theoretical memos – keeping voice present in the theoretical outcome, words remain intact</td>
</tr>
<tr>
<td>Silent authoring – distant expert</td>
<td>Searching for and questioning tacit meanings about values, beliefs and ideologies</td>
</tr>
<tr>
<td>No specific writing style required</td>
<td>Writing style needs to be evocative of the experiences of the participants (Charmaz 2006)</td>
</tr>
</tbody>
</table>

In positioning myself as the co-author in this research I adopted the Charmaz (2006) approach to constructivist grounded theory. Mills et al (2006:13) describes that in constructivist grounded theory “the researcher as the author of coconstruction of experience and meaning”. In support Charmaz (2014:174) claims that grounded theories do not have to write as disembodied technicians... rendering their experience through word choice, tone and rhythm”. The selection of a constructivist approach was congruent with my own ontological and epistemological positions. I
believe there are multiple realities and that my own values and beliefs form part of the co-construction of the research.

Mills et al (2006) outline the constructivist approach as the conscious repositioning of the author to re-tell the experience of the participants. This is one possible explanation as to why constructivist grounded theory is a popular method in nursing research, as researchers in their ‘humanness are part of the research endeavour’ (Appleton & King 1997). A ‘mutual shaping’ (Lincoln & Guba 1981:100) takes place which is influenced by both the researcher’s and respondents’ own value systems. Urquhart (2013:57) proposes that ‘the perception of reality and how knowledge is constructed in your discipline will hugely influence your research design’. Norton (1990:31) extends this view by proffering that the “links between ontology, epistemology, methodology and method are important in grounded theory in order to research rigour is maintained”.

I have selected this topic area because of my own professional interest in nursing leadership and caring practices. I also hold my own values related to high standards of patient care, and values related to the role of nurse leaders. My values as a nurse leader include the importance of leadership skills and nursing expertise. Literature related to values and caring practices were discussed in the preliminary literature review in chapter 2. I also have a professional interest in nursing as a profession, and the changes over the years that have occurred within the professional identity of nursing. I have friends and family who use the service of the NHS, and in doing so share their individual experiences and interpretations of good and poor caring practice. Finally, I am cognisant of the stories and reports pertaining to care failings and suffering experienced by patients and families that are portrayed through publications and the mass media. I am also aware that I find many of these stories
of suffering and neglect distressing and uncomfortable. Hence, my overall motivation for conducting this research was to understand and interpret these challenges to standards of care and understand more about the role of nurse leaders in relation to care-giving practices.

3.2.6 Consideration of other possible qualitative methodologies

A phenomenological approach to research is to describe a lived experience through the search for meaning and the crux of the experience (Holloway & Wheeler 1996). Phenomenology has its roots in philosophy and is based within a ‘humanistic design’ (Denscombe 2007). The founder of phenomenology was Edmond Husserl (1859–1938) and his approach was based on describing the ‘lived experience’. Central to this approach was the requirement for the researcher to ‘bracket their own ideas’, seeking knowledge from the participants which is not influenced by the researcher’s views. Some years later a split emerged when Martin Heidegger, a student of Husserl developing ‘hermeneutics’, offered a different standpoint which allowed for the researcher to bring their own experiences into the research rather than ‘suspending’ them (Holloway & Wheeler 1996). The phenomenological approach would not capture the experiences as it is descriptive in essence and does not seek to develop theory. The process of ‘bracketing’ views and values may have been more challenging as it does not support the researcher’s ontological and epistemological standpoint of co-constructing the data with the research participants.

An alternative approach to grounded theory would be an ethnographic approach. Ethnography originates from anthropology (Saunders et al 2012). The aim of ethnographic research is to observe and question what is going on within a specific group or culture (Hammersley & Atkinson 1995), by studying interactions and
behaviours, observing the interactions within the environments that they occur (Hammersley & Atkinson 1995). This approach often involved researchers living within communities and observing a culture’s shared beliefs, rituals and behaviours (Cutcliffe 2005). Whilst an ethnographic approach to this research could have focused on some interesting aspects of the observation of the culture and environments of Directors of Nursing, the research aim for the study was to gain an understanding of the perceptions of caring practices and therefore an ethnographic approach would not be the most appropriate method to adopt.

Charmaz (2006) states that constructivist grounded theory is firmly rooted in the interpretive paradigm, where both the “data and the analysis are created from shared experiences and relationships” (Charmaz 2006:130). Silverman (2004) observations of conversational analysis argue that the researcher needs to understand how meaning is constructed to inform how they behave. Charmaz (2006) also states that constructive grounded theorists must take a reflexive position in respect to the research process to be able to show how the meanings were co-constructed between the researcher and the participant.

A possible alternative interpretative approach to this study could have been to have adopted a discourse analysis approach by interpreting the language patterns of the Directors of Nursing in their professional worlds. Discourse analysis is described as a social constructivist approach which explores the relationships between ‘text, discourse, and context’ (Philips & Hardy 1992:8). Jørgensen & Phillips (2002:12) suggests that “our ways of talking do not neutrally reflect our world, identities and social relations but, rather, play an active role in creating and changing them”. It could be argued that in relation to this research there was an emergent discourse in the media following the failings of care at Mid Staffordshire NHS Hospital. A meso-
discourse analysis focusing on patterns in the discourse as described by Alvesson and Karreman (2000) may have been a suitable alternative approach to the constructivist grounded theory approach adopted in this research.

### 3.2.7 Possible disadvantages of the grounded theory approach

One possible disadvantage of the grounded theory approach is that some researchers are hesitant to be explicit and clear about their choice of grounded theory approach. This could be problematic, as discussed, because there are distinct differences in grounded theory approaches, and these should be explicitly laid down by the researcher (Cutcliffe 2005). Three related components to research – ontology, epistemology and methodology – guide a set of beliefs and values that support research studies. (Norton 1990) has stated that a relationship between these components needs to be maintained in grounded theory, to ensure research rigour has been achieved. Other potential criticisms of the grounded theory approach have focused on the risk of the researcher producing a descriptive narrative by ignoring abstract concepts and explanatory social contexts (Becker 1993). In support, Strauss and Corbin (1998) maintain that grounded theory research must be grounded in the data, hence the application of an analytical framework to support grounded theory research.

A grounded theory methodology was chosen for this research so as to facilitate an exploration of individuals’ experiences within their social worlds and lead to theory generation which could add to the body of knowledge (Strauss & Corbin 1998). A further rationale was that grounded theory is most appropriate when there is little known in the specified area (Benton 1996; Stern 1980). The constructivist grounded theory approach was chosen primarily because it is symbiotic with my own ontological and epistemological stances and it proffers the method of data co-
construction. The constructivist approach resonates with my constructivist philosophical stance and the view that the world is made of multiple realities and social construction. Importantly, Charmaz (2006) asserted that philosophical identification and clarification is important as it will influence the rationale for methods and methodology. I, as the researcher, am shaped by my professional experience and knowledge in this area of research, both as a qualified nurse with over twenty-five years’ experience. I do not share professional membership as an Executive Nurse Director although I have experience as a former non-Board nurse leader. As such, I acknowledge that I share part membership with the research participants, primarily as a nurse. (Please see section 3.3.6 Myself as the researcher)

In summary, when selecting the most appropriate approach to grounded theory, the researcher needs to consider the research question that is to be explored, and their own ontological and epistemological positioning as a researcher. Holloway and Wheeler (1996) have observed that grounded theory methods are popular in nursing research, and offer the rationale that the method is akin to the ordered and systematic processes found in nursing. A possible additional rationale could be that there are significant gaps in nursing knowledge which in part lend itself to a grounded theory methodology. Therefore, it could be argued that a constructivist approach was most appropriate for this research study.

3.3 Research Methods

In the first section of this chapter, the research aims and the rationale for choosing the constructivist grounded theory approach for this research were demonstrated. Next, the focus shifts to a critical discussion of the chosen research methods,
sampling, access and recruitment, data collection, ethical considerations and the constructivist data analysis framework.

3.3.1 Interviews

In keeping with a grounded theory approach, open-ended interviews were the method of data collection chosen for this research study (Interview guide, Appendix 3). Holloway and Wheeler (1996) proposed that a familiar method of data collection is interviewing, where the researcher frames the area of inquiry such as perceptions, feelings and experiences. In qualitative research the researcher hopes to gain an understanding of the meaning and experiences of the participants (Kvale 1996). Conversation is a vital part of the human interface and through this process an understanding is developed about the person’s belief system and aspirations (Kvale 1996). Cormack (1996) argued if participants are given freedom in the interview process they are more likely to discuss the issues that are most pertinent to them. However, interviews should not be seen in a solitary end product of the research process (Nunkoosing 2005). In agreement, Xu & Storr (2012:14) propose that researchers ‘becoming partners in creation of knowledge, meaning that qualitative researchers must develop as research instruments’. I agree with this position as see myself as co-creating the story with the participants. A further component in the interface is the art of listening and hearing the participants, being cognisant of cues and expression to give meaning and depth (Ruben & Ruben 2005). In agreement Nunkoosing (2005:698) argues that the ‘use of the self in relationship building... to communicate with people to create stores’. This view of the role and impact of the researcher, it could be argued are aligned to the co-constructive grounded theory approach.
An alternative method could have been focus groups as a potential suitable method of data collection. The potential opportunities and challenges of a focus group are sharing and disclosing experiences of caring practices to a peer group of Directors of Nursing. Holloway and Wheeler (1996) argue that focus groups may inhibit disclosure of personal experiences in a group setting.

I conducted a trial interview with my supervisor prior to the first pilot interview being conducted. This was primarily to ascertain if the sequence and the flow of the interview questions was appropriate. Next, I conducted two pilot interviews with Directors of Nursing in July 2013. The purpose of the pilot interviews was to ensure that the interview guide (Appendix 3) would assist in eliciting relevant high-quality data. Following the pilot interviews the ordering of the questions in the interview schedule was modified. This assisted in allowing participants more time to get comfortable with the interview before focusing on more complex areas such as caring practices. The re-ordering focused on posing questions about interpretations of caring practices later in the interview schedule when it was hoped the participants might be more at ease in answering. The impact of the re-ordering of the questions following the pilot was an improved sequence and fluidity of the questions, which also supported me to gain more relevant and higher quality data from the remaining interviews, based on the emerging themes.

I used a research diary as a contemporaneous record of my notes, memos, feelings and comments during data collection and throughout the research process. The value of a research diary can be demonstrated in supporting an awareness of the subject, reflexivity and the feelings of the researcher (Hutchinson 1993).
3.3.2 Sampling and theoretical saturation

In exploring the Directors of Nursing perceptions of caring practices in NHS acute Trusts, there was a potential sample size of 163 NHS acute Trusts in England at the time of data collection in England. This number was variable due to various Trust reconfigurations, Trust mergers and possible vacancies of Directors of Nursing in some NHS acute Trusts. However, when using a grounded theory approach and in-depth interviews, a purposive sample of ten to fifteen participants was anticipated. The rationale for choosing a purposive sample was that it allowed access to the participants most appropriate for the research topic or subject (Morse 1998). When the aim of the researcher is to develop a substantive theory to explain specific experiences, then a narrow sample is appropriate (Glaser & Strauss 1967; Strauss & Corbin 1998).

The first two Directors of Nursing who were interviewed formed the pilot phase of the research study. A further ten Directors of Nursing were interviewed for the main study. Theoretical saturation was reached after a total of twelve Directors of Nursing from NHS Acute Hospital Trusts in England had been interviewed. Charmaz (2006:113) states that theoretical saturation is the point ‘when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these theoretical categories’.

The inclusion criteria for the sample were:

- Directors of Nursing at NHS acute Trusts\(^1\) including the job titles of Chief Nurses, Executive Nurses and Nurse Directors;

\(^1\) The Directors of Nursing are defined ‘as those executive members of the Trust board with responsibility for professional nursing, and those who are registered with the NMC, and acknowledged as fulfilling the duty on Schedule 1 of the Health & Social Care Act 2003’. 
• NHS acute Trusts in England only.

The rationale for the inclusion criteria of Directors of Nursing in NHS acute Trusts is that there is a gap in the literature for an England-wide study of the perceptions of Nurse Directors. The rationale for choosing NHS acute Trusts is that at the time of the research the Health and Social Care Act 2012 (DH 2012a) to bring about significant structural reforms was under way in relation to commissioning arrangements. As a result the Board structures of the Clinical Commissioning Groups (CCGs) were not nationally and uniformly configured, hence there were not Executive Board nurses in all Clinical Commissioning Groups. A further aspect was that much of the literature pertaining to failing standards of care has focused on NHS acute Trusts. The exclusion criteria were therefore Directors of Nursing from non-NHS acute Trusts (private or voluntary sector), Mental Health Trusts, Community Trusts or Clinical Commissioning Groups.

3.3.3 Access and recruitment

The Chief Nursing Officer (CNO) for NHS England was approached by the researcher to ascertain if permission could be granted to publicise the study to NHS Trust Directors of Nursing through the CNO Bulletin (NHS England online newsletter). The agreed wording of the section to go into the bulletin (Appendix 4) was approved through the favourable ethical opinion from the University of Surrey Faculty of Health and Medical Sciences (FHMS). The study was first advertised in the CNO Bulletin in June 2013. It was advertised in three further editions of the CNO Bulletin over the summer of 2013. When the Directors of Nursing came forward via email or telephone to express an interest in taking part in the study, my primary aims were to establish whether the potential participants met the inclusion criteria and, if so, to share information relevant to the study. I also received two initial inquiries
from Directors of Nursing who did not meet the inclusion criteria, one from a Director of Nursing from a private sector hospital and one from a Mental Health NHS Trust. These two potential participants were thanked for making contact, and an explanation of the exclusion and inclusion criteria was offered.

Once the inclusion criterion was established with the remaining twelve Directors of Nursing the participant information sheet (PIS) (Appendix 5) was emailed to the participants, detailing information pertaining to the study. Following this, I contacted each individual respective Research and Development (R&D) department in the employing host NHS acute Trusts to seek R&D approval to permit the interview of the Director of Nursing for the study. The Trust-level R&D approval processes varied from Trust to Trust. All NHS Trusts R&D departments were provided with the necessary research documentation including the confirmation of favourable ethical opinion from the University of Surrey Faculty of Health and Medical Sciences (FHMS) (Appendix 6). All Trusts granted R&D approval for the study to proceed. Once individual R&D approval was granted, the participants were contacted again through their personal assistants (PAs), to ascertain if they still were in agreement to continue to interview and then to make arrangements to conduct the interviews. I found timely access at times challenging, to book interviews into the busy diaries of the Directors of Nursing, and on several occasions the interviews were postponed due to NHS hospital business priorities. I travelled across England to conduct the twelve face-to-face interviews.

The interviews with the participants were either conducted in a private office at the host Acute NHS Trusts where the Directors of Nursing were based, or a mutually convenient venue such as a conference room. In all cases interview rooms were
prearranged and booked to ensure privacy. The interviews varied in length from 45 minutes to 1½ hours but were usually 1 hour in duration.

Gaining access and permission to interview the participants was central to this research. There was an established mechanism for accessing all the Directors of Nursing in the NHS acute Trusts through one single information conduit, as opposed to contacting all Directors of Nursing in NHS acute Trust in England individually.

Initial recruitment was encouraging with five Directors of Nursing coming forward in four months, but recruitment slowed down during the latter part of the summer of 2013. I agreed with my research supervisors that additional methods of recruiting the sample would be required in addition to the CNO Bulletin. The research was still in the early stages of data collection and analysis, and saturation of data had not been reached at this point.

To this effect, an amendment to ethics (protocol v.10) (Appendix 7) was submitted to the University of Surrey Faculty Health and Medical Sciences (FHMS) Ethics Committee on 3 October 2013. The amendment focused on securing alternative methods of accessing potential participants. This included adding information about the research to the delegate packs at a forthcoming CNO business meeting. I was planning to attend the CNO business meeting which was open to all Directors of Nursing, and therefore potentially an excellent event to publicise the study. In addition the amendment to ethics also requested approval for direct email contact with the Directors of Nursing if required and to be able to use the social media site Twitter© to publicise the study. Favourable amendment to ethics was received on 8 October 2013 (Appendix 8).
This amendment was for additional access to the potential sample, and included publicity of the forthcoming CNO business meeting and the use of Twitter© to extend the access to recruitment as requested. All potential participants made direct contact with me as the researcher, either following the advertising in the *CNO Bulletin*, or following promotion of the study at the CNO business meeting in the autumn of 2013. At the CNO business meeting, the organisers distributed information cards onto the tables for the delegates. The cards contained the same information regarding the study as that contained in the *CNO Bulletin*, including my contact details. Also during the CNO business meeting, the organisers of the business meeting used social media Twitter© to publicise the study. Following the CNO business meeting a further four participants came forward to be included in the study which made a total of twelve participants overall.

3.3.4 Ethical considerations and consent process

A favourable ethical opinion was received from the University of Surrey Faculty of Health and Medical Sciences (FHMS) Ethics Committee on 30 April 2013. This level of ethical review was appropriate as the study involved interviewing NHS staff. This was verified by the National Researcher Ethics Service (NRES) who referred to the GafREC guidance which covers issues of interviewing NHS employed staff: ‘REC review is not normally required for research involving NHS or social care staff recruited as research participants by virtue of their professional role’

The principles of biomedical ethics, as outlined by Beauchamp and Childress (2001) underpinned this research. The principles are respect for *autonomy*, *non-*

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2 [http://www.hra.nhs.uk/news/2012/03/21/gafrec-and-nres-sops/]
maleficence, beneficence and justice. The principle of autonomy was respected as participants were given free choice as to whether to participate in the study. All potential participants directly contacted myself as the researcher, and were given verbal information pertaining to the study in conjunction with the written participant information sheet (PIS) (Appendix 5). All participants had an opportunity to withdraw from the study at any time. Autonomy was demonstrated by maintaining the participants’ confidentiality and anonymity, and through the safe storage of data and anonymising the transcripts. Before each interview the participant was given the opportunity to re-read the participant information sheet (PIS) and ask any questions about the study. The participants were then asked to read and complete the consent form if they wanted to proceed to interview. The PIS explicitly stated that if there were any disclosures suggesting a risk or significant harm, a reporting process was appropriate to safeguard patients and staff. Some of the participants discussed the potential issue of disclosure. Corbin and Morse (2003:336) have warned that a potential complication from interviewing could be that ‘there might be a break in confidentiality/anonymity, with possible consequences of a social, financial, legal, or political nature’. I offered reassurance during the consent process that their individual experiences would not be attributable to their employing organisation or to them as Directors of Nursing. I reflected during the data collection period if some of the Directors of Nursing may have been apprehensive to come forward to share their experiences for fear of losing their anonymity.

Due to the nature of the research there was a risk that participants could have highlighted specific examples of sensitive areas pertaining to standards of nursing care within the respective NHS Trusts. If this issue had arisen I would have discussed with the participant the processes available for escalation and support available both locally and nationally, if required by the participants.
Regarding *minimising harm*, participants’ anonymity was maintained by allocating sequential alphabetic labels to the transcripts and with the safe locked storage of the transcripts. The interview questions invited participants to reflect on caring practices within their organisations and there was potential for distress (Appendix 3). One participant became a little distressed, when reflecting on the pressure she was experiencing within her role as Director of Nursing. We took a break at that point in the interview and I asked whether the participant wished to stop the interview. The participant confirmed that she wished to complete the interview. At the time I was struck by the seeming enormity of the role and responsibility of the Director of Nursing that this participant was sharing with me. The participant seemed determined to do the right thing in her Executive role, but overwhelmed at the same time by the challenges facing her in her role. The emotional impact of the role of the Director of Nursing was not something that I had considered in depth, prior to this interview in particular.

‘The issue of reciprocity extends beyond being there with the participant, and that participants often need to unburden and there is no one else to whom they can turn to tell their story’ (Corbin and Morse 2003:343).

The principle of *beneficence* in this research was highlighted in the participant information sheet (PIS) (Appendix 5) which states that although the individual participants may not benefit themselves from taking part in the research, it was hoped that there would be a benefit by contributing to the wider knowledge of the role of Directors of Nursing in caring practices. Finally, the principle of *justice* is demonstrated as the research process was reasonable and objective throughout recruitment and the research process.
The participants were treated with dignity and respect throughout the process. Following the interviews all the participants were contacted the following day, and thanked for taking part in the study. They were also offered a summary of the findings when the research was completed. Many of the research participants asked for me to return to their host NHS organisation to present the findings of the research to staff. At the time I recall being surprised by the initial request and yet this was the same for most of the participants. I hadn’t considered that the research might be of interest to a wider group of nurses other than Nurse Leaders. Corbin and Morse (2003:335) have proposed ‘that when research is conducted with sensitivity and guided by ethics, it becomes a process with benefits to both participants and researchers’.

The researcher was also mindful of the elements of the ‘concordat to support research integrity’ which are: honesty, rigour, transparency and open communication and care and respect (Universities UK 2012:11).

3.3.5 Data collection

The demographic data collected was the approximate range of length of service that each Director of Nursing had worked at the employing NHS Trust. In order to protect the participants’ anonymity I selected range of length of service, rather than exact dates. In addition, the geographical location of each Trust by regional NHS England regions was noted. Contextual demographic data is presented in Table 2. Across the twelve interviews, six different NHS England regions were represented: London, East Midlands, South East, Yorkshire and Humber, North East and North West. Three participants were employed by NHS Foundation Trusts.
Table 2. Demographic data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Geographical location</th>
<th>Range of length of Board service at current Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>London</td>
<td>More than 5 years</td>
</tr>
<tr>
<td>B</td>
<td>East Midlands</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>C</td>
<td>South East</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>D</td>
<td>Yorkshire and Humber</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>E</td>
<td>North East</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>F</td>
<td>South East</td>
<td>More than 5 years</td>
</tr>
<tr>
<td>G</td>
<td>North West</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>H</td>
<td>South East</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>I</td>
<td>South East</td>
<td>More than 5 years</td>
</tr>
<tr>
<td>J</td>
<td>London</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>K</td>
<td>South East</td>
<td>Less than 5 years</td>
</tr>
<tr>
<td>L</td>
<td>South East</td>
<td>Less than 5 years</td>
</tr>
</tbody>
</table>

The main interviews were carried out between July 2013 and January 2014 with a total of ten participants. Two digital Dictaphones were used to record the interviews, which provided a back-up in case one device failed. This allowed me to listen back to the recordings while the other recording was sent to a transcriber for transcribing. All the tapes were transcribed by the same individual, an experienced secretary working in research, to provide continuity.

When I submitted by research proposal it did not immediately occur to me that it was a likelihood that I might interview any of the Directors of Nursing that I knew from my
previous role. Partly because the potential sample size was 163 Directors of Nursing and also as I was advertising the research through a national forum. On reflection I wonder also if this may have been because initially I saw my primary identity very much as a Doctoral research student for the purposes of the research rather than my occupational role. I also used my University email address for recruitment rather than my NHS email so this could not have influenced the sampling. Although I did recognise that I also shared professional identity and past professional experiences with the Directors of Nursing, although this was primarily as a nurse. I was also drawn to selecting a constructivist grounded theory, where the co-construction of data supports that I share some familiarity with the peer group. When it came to the interviews a few of the Directors of Nursing I had actually met opportunistically before in my former professional role as a Board Nurse Director. I recorded my feelings, beliefs and values regarding this in the research diary, but also importantly reflected on these throughout the data collection and analysis in conjunction with a reflection of my potential role as an instrument of the research. Chapter 4 will demonstrate the co-construction of the data leading to the theory of the perceptions of Directors of Nursing on caring practices.

One of the reflections I recorded was whether those Directors of Nursing who I had met before were more likely to be open and honest, or whether instead the role of unfamiliarity supported more candid exchanges. Platt (1981) suggested that an advantage in interviewing one’s peer group is that you remove the distance and anonymity and hence the participants are more likely to share their experiences. Conversely, Nunkoosing (2005) argues that the participant will only reveal the segments of their story that they wish to. On reflection I am not aware that interviewing Directors of Nursing caused any conflicting issues, and as I was
interviewing staff who may fall into my peer group this could not have been avoided out of a potential sample of 163 Directors of Nursing.

3.3.6 Myself as an interviewer, and as an instrument of the research

I have twenty-five years’ of clinical experience as a nurse, specialising in oncology and palliative care. I also have four years’ experience working as a Nurse Director without executive Board responsibilities. In addition to this experience, I have worked as a research fellow conducting research projects, interviewing patients and health professionals regarding healthcare provision and treatment. I acknowledge that I bring some of my own experiences to the research, both as a nurse and a researcher, and as such it has been acknowledged that I share a membership with the research participants as a nurse. I consider that I have several professional identities and belong to a two professional ‘tribes’ as a nurse and as a researcher, these tribes are different and I have different membership in each. My predominate membership is as a nurse through my chosen career and more closely aligned to my self-identity – I see myself as a nurse, but I am also working as a researcher.

Maykut & Morehouse (1994:123) argues “that the qualitative researcher’s perspective is perhaps a paradoxical one: it is be acutely tuned-in to the experiences and meaning system of others-indwell-and at the same time to be aware of how one’s own biases and preconceptions may be influencing what is trying to be understood”. A further facet to the relationship between the researcher and the participants may be an issue of power, in engagement for knowledge and what is known (Nunkoosing 2005). I was also aware of the differing levels of rapport that I was experiencing between myself and the participants, some were more open and candid from the start of the interview and all seemed very honest and open when the more challenging issue of the challenges facing Directors of Nursing were
revealed. ‘The interviewer has to wait, to negotiate, to build an enabling relationship’ (Nunkoosing 2005). I was not consciously aware that I was trying to establish a rapport with the participants, but more that I was consciously trying to put the participants at ease in the interview. I also felt very fortunate to have an opportunity to learn so much about their perceptions of caring practices.

Corbin Dwyer and Buckle (2009) propose that the issue of research membership as either as an insider or as an outsider of, membership is an omnipresent characteristic of the study. Adler and Alder (1987) described three distinct types of membership roles that the researcher may have, peripheral, active and complete members and the influence each membership may have on the research. In applying Adler and Adler’s descriptions I see myself as having a ‘complete membership’ as a nurse and as such I may influence the research by writing myself into the research, by reflecting on my own values and beliefs as a nurse. However, from the outset of the research I did not consider myself to have a shared membership with the participants as an Executive Director of Nursing. Faye (1996) argued that one of the advantages to not sharing membership with the research participants was the ability to stand back and interpret the experiences.

In selecting to undertake interviews for this research study it was important for me to consider my own potential and actual impact and influence on the production of knowledge and the co-construction of the data. It could be argued that in qualitative research both methods are symbiotic as they need to work together. In agreement, Nunkoosing (2005:701) proffers “the interviewer does not collect data as if picking daisies; he or she colludes with the interviewee to create, construct, stories”. I do not agree that co-construction is a ‘collusion; but instead as a process and journey of re-creating stories between the participants and the researcher. My viewpoint is
also that the data from the interview is co-created, modelled and shaped to re-create the stories. Nunkoosing (2005:704) describes ‘the continually changing ontological state for the creation-destruction of competing discourses and desires’. The co-construction of data by the experiences of the researcher and the participants is supported by adopting a constructivist grounded theory approach. A considered decision has been taken to write in the first person in this thesis, as a method of ‘writing myself’ into the research. The rationale for this is that the constructivist grounded theory approach is an interpretivist research approach and the process of co-construction is a cornerstone in this approach. Webb (1991) advocates the use of the first person, when the researcher is working in an interpretivist method.

3.3.7 Reflexivity

Reflexivity is important in understanding the co-creation of the meaning of the research. Charmaz (2014:344) described the important role of reflexivity as ‘the researcher’s scrutiny of the research experience, decisions and interpretations in ways that bring him or her into the processes. In support, Schwandt (1997) describes the process of reflexivity as considering your own biases and predispositions on the research process. Reflexivity in relation to the study will be demonstrated in chapter 4 (data analysis). Therefore it is asserted that reflexivity is synergistic with a constructivist approach in grounded theory where the researcher is a component in the interpretation of the data. The process of reflexivity alongside co-construction of the findings will be also be demonstrated in the findings chapter (chapter 4). This will demonstrate both my roles as a researcher and my impact on the research as instrument of the research to demonstrate methodological rigour.

A research diary was used to record notes and thoughts about the research process and to support reflexivity through the use of memos. Hutchinson (1993) agreed that
the use of a research diary can support the researcher to develop an awareness of
the subject and their own feelings, and thereby support a reflexive approach.
Gardner (2006) argues that the researcher’s skill to be reflexively is key to improving
theoretical sensitivity. My approach to reflexivity was to participate in supervision
with my supervisors, using a research log to record feelings and decisions along the
research journey. A further crucial element was the use of memos to ask critical
reflexive questions during the data analysis and the participant’s verbatim words
were used to demonstrate theory generation.

3.3.8 Data analysis
In this section the analytical processes will be described, guided by the constructivist
grounded theory approach. The grounded theory coding processes will be justified,
in addition to the use of memo-writing, theoretical sampling, saturation and sorting.

The twelve interviews were audio recorded and transcribed verbatim. In the first
instance I checked the transcripts against the audio-recordings to verify details
make any minor amendments and ensure accuracy. Holton (2007:275) states that it
is important that the researcher does their own coding in a grounded theory study as
it ‘continually stimulates conceptual ideas’. All the transcripts and the audio-
recordings were given a sequential alphabetic code to ensure the participants’
confidentiality and anonymity. Prior to initiating the coding, the audio-recordings of
the interviews were actively listened to, to allow a greater understanding of the
narratives. Each line or each transcript was numbered and referenced to provide an
audit trail.

The process of data analysis in grounded theory has been described as a fluid and
evolving process (Charmaz 2006). An advantage to this approach is the cyclical
process of theory creation and data analysis, facilitating a constant relationship to
co-exist between data and theory (Seale 1999). Figure 1 is a visual representation of the evolving, iterative, non-linear research levels in the grounded theory process adapted from (Charmaz 2006:11). This starts with the research question, initial coding leading to writing the first draft. The diagram represents the iterative and fluid stages weaving back and forwards through the data and memos until the grounded theory is constructed and created.

**Figure 1.** Research levels in the grounded theory method adapted from Charmaz (1990, 2006)
In keeping with the constructivist grounded theory method and supported by QSR NVivo 10, two initial coding processes were undertaken. The first phase was initial or line-by-line coding, followed by focused coding. Line-by-line or initial coding is the process of breaking down the data into fragments or segments and coding each line accordingly into a high-level dissolving of ‘incidents, ideas or events’. Initial coding requires no interpretation of the data or co-construction at this stage of the analysis. The coding process supported me to see the world from the participants’ viewpoint rather than imposing my own views. This is facilitated by immersing the researcher into the components of the narrative (Charmaz 2014). Thomas (1993) asserts that an advantage of initial coding is that it encourages the researcher to see the data through the participants’ eyes, rather than their own views. Urquhart (2013) agrees with the approach of line-by-line coding, by keeping the researcher close to their data. A further advantage is that line-by-line coding supports the interview focus as an evolving process by offering possible areas of enquiry (Charmaz 2006).

In this research, the initial coding was presented as ‘gerunds’ in keeping with a constructivist grounded theory approach of nouns acting as verbs. Creating action codes or verbs supports the process of constant comparison between data and categories (Glaser 1978). In addition, initially Glaser (1978) and more recently Charmaz (2006) proposed the use of ‘gerunds’ in the coding of data as a method of identifying practices inherent within the data.

In the second phase, focused coding took place encompassing the conceptual level of the most frequent codes, where decisions were made by me as to which codes have the most analytical meaning. An example of the most frequent codes is illustrated in appendix 11- ‘failing and damage’ which describes the feelings and impact on the Directors of Nursing when the quality of care is poor in their respective
Trusts. Next sifting, sorting and analysing of the codes are required, in part to determine the suitability of the codes when analysing the data. This phase is more ‘directed, selective and conceptual than the initial coding’ (Charmaz 2006:56). Charmaz (2006:59) outlined this as an evolving and fluid process where the researcher can move across and between ‘interviews, comparing people’s experiences, actions and interpretations’. The comparison of data against data supports the focused coding process.

Coding in grounded theory integrates the following questions:

- What larger analytical story do these codes suggest?
- What process do they indicate?
- When, how and with what consequences are the participants acting?

(Charmaz 2014:127)

During the coding phase, the QSR NVivo 10 computer package was used to assist with the data management. I recorded the initial codes as ‘free nodes’ using the QSR NVivo 10 package, followed by focused codes into ‘tree nodes’. Each line of the transcripts was segmented line-by-line and coded using the computer package. The package recorded the number of times that particular free nodes were identified, and supported the cross-review of the nodes in the different transcripts as they emerged. The rationale for choosing QSR NVivo10 was that there are synergies with the grounded theory approach to data analysis in inductive data analysis, focusing on coding and memoing. An advantage of using the NVivo 10 computer package to support the data management was that I was able to review large sections of transcripts and code line-by-line into ‘free nodes’ as I worked through the transcripts.
Some of the nodes were coded ‘in vivo’ whilst others were coded as verb ‘gerunds’. In vivo codes capture ‘verbatim’ words that are important as ‘characteristics of social worlds and organisational settings, they reflect assumptions, actions and imperatives that frame action’ (Charmaz 2006:56). There are three types of in vivo codes: generalist terms, participants’ individual meanings and organisational narrative codes. Charmaz (2014:134) describes these distinctive types of codes as being able to maintain the participants’ meaning or views by ‘serving as symbolic markers’ of participants’ speech and meaning. Mills et al (2006) highlighted that an integral part of constructivist grounded theory is that maintaining the words of the participants is integral in the research analysis. This is facilitated by conserving the in vivo codes and then weaving them throughout the text. Using QSR NVivo10 also enabled me to also review the frequency of the codes in each transcript and across the transcripts, and informed the interviews as an evolving process.

Each transcript was analysed applying the constant comparative approach, which is a cornerstone of grounded theory methods. Constant comparison is the unequivocal process of comparing occurrences of data in one category with other occurrences of data in that category, and ensuring that the data is compared against the whole picture as well (Urquhart 2013). Charmaz (2006) and Urquhart (2013:17) describe the constant comparison approach as ‘the rule of thumb process’: as researchers work with the data they enquire ‘to what category does this incident or property relate?’ Constant comparative analysis allows the data to be coded into emerging themes, and then to be concurrently re-examined and compared with previous data in the same and different groups (Hewitt-Taylor 1991). The process of data collection and data analysis are simultaneous in a cyclical process of ‘constant comparison’ to allow the data to guide further areas of discovery (Strauss & Corbin 1998). Constant comparison was used to ‘establish analytical distinctions and thus
make comparisons at each level of analytical work’ (Charmaz 2014:132). This facilitates the development of the theory derived from the analysis. Similarly, Seale (1999) proffers that using constant comparison promotes a constant symbiotic relationship between the data and the theory.

Following the focused coding supported by memo-writing, the third phase of coding, namely theoretical coding, was implemented. Theoretical coding is used to develop possible emerging relationships between categories. Glaser (1978:72) defined the process for theoretical coding as ‘weaving the story back together’. Charmaz (2006) and Evans (2013) have described the process of developing sub-categories from categories as the process of the theoretical coding. This method can be used as an alternative approach to axial coding where a framework is not required by the researcher (Charmaz 2006). Charmaz (2014) warns that an inherent risk of axial coding is that it can limit the researcher’s ability to let the data unfold, with potential disadvantages in the procedural application, rather than the sub-categorising process which is described as emergent. Therefore, a logical explanatory storyline emerges from the data when using theoretical coding.

Memo-writing is a fundamental core part of grounded theory and has been posited as the transitional step between data collection and writing drafts of findings (Charmaz 2006). Glaser (1978) asserted that memos are intended to increase the level of abstraction. Memos are used to capture and analyse the thoughts of the researcher when analysing their data, and as such are an important part of demonstrating co-construction and reflexivity in the research process. Charmaz (2006:72) states that ‘memos catch your thoughts, capture the comparisons and connections you make, and crystallise questions and directions for you to pursue’. Memos were used throughout this research to support the construction of the
grounded theory. Charmaz (2012:9) has described the possible questions that can arise from your memos: *who’s involved? how? why? when? what do they do?* and what are the consequences of their actions? In figures 2a-c are examples of the memos which I constructed, they are used to demonstrate the process of co-constructing the data between myself and the participants by using interpretative questioning framework ‘*who’s involved? how? why? when? what do they do?*’ and what are the consequences of their actions. This illustrates how the codes and ideas developed allowing me to compare data and direct further areas to be gathered.

In Memo 2a the participant describes her anxiety about the consequences of failing care in her Trust. I identify with her notion of accountability as a nurse leader and that in trying to secure the quality of care she reverts to her bedside nursing role which is in her control. My interpretation of this memo is that the participant fearing she may lose her job. Mills et al (2006:13) describes the constructivist approach as having ‘an emphasis on keeping the researcher close to the participants through keeping their words intact in the process of analysis’.
Figure 2a. Memo. Demonstrating the process of co-construction of the researcher’s thoughts and questions alongside the emerging data- ‘fearing the worst’.

In Memo 2b the participant describes the tension between regulators becoming overwhelming. My interpretation of this narrative is that the participant is feeling the pressure of needing to provide assurance to the NHS system in regard to standards of care in the organisation. This finding resonates with the findings of the Mid Staffordshire NHS Trust which outlined the ‘drift’ to providing external assurance and the impact on quality standards within the organisation.
**Figure 2b.** Memo. Demonstrating the process of co-construction of the researcher’s thoughts and questions alongside the emerging data- ‘getting sucked in’.

Finally, Memo 2c depicts the vision of good care and the participant as being part of the vision in delivering the care. I identify with the vision and also feel part of it, as it is described as being person-centred care; this resonates with my own values and beliefs about nursing care. As a visual descriptor which provides my own memories of visualising care of my own patients.
Figure 2c. Memo. Demonstrating the process of co-construction of the researcher’s thoughts and questions alongside the emerging data- ‘describing my picture of good care’.

The three examples of memos which were pivotal to the co-construction of the data were ‘fearing the worst’, ‘getting sucked in’ and ‘describing my picture of good care’.

In the next chapter, namely findings there will be further demonstration of the process of co-construction and illustration of how the research findings were derived through inductive analysis and how these memos are integral to the shared co-construction of data and analysis. In developing theoretical sensitivity, memos and gerunds are used to focus the researcher on the actions within the data (Charmaz 2006).
Theoretical sampling, saturation and sorting has been described by Charmaz (2006) as ‘the robust process of seeking data to support emerging themes and to refine categories, until no new categories emerge’. It is used for conceptual and theoretical developments. Therefore, I continued to sample until the no new properties emerge. Emergent theoretical sampling is used:

- To delineate the properties of the category;
- To check hunches about categories;
- To saturate the properties of a category;
- To distinguish between categories;
- To clarify relationships between emerging categories;
- To identify variation in a process. (Charmaz 2006)

There are some inherent risks of not carrying out theoretical sampling to a high level, such as not continuing to explore a category to its full potential. Theoretical sampling was implemented in this study to explore properties of the emerging categories.

Finally, the constructivist approach is interpretative and places ‘priority on the phenomenon on the study and sees both data and analysis as created from shared experiences and relationships with the participants’ (Charmaz 2006:130). Of importance in the constructivist approach to grounded theory is the interpretative aspects of not only how participants view their own worlds, but also how the researcher interprets the co-construction of the worlds. Therefore, Charmaz (2006:131) suggests that the analysis was ‘contextually located to place, culture, time and situation’. This research was contextually oriented to the Directors of
Nursing in NHS acute Trusts, following the failings of care at Mid-Staffordshire NHS Foundation Trust.

**3.3.9 Constructing grounded theory**

Strauss and Corbin (1998) described the two main classifications of grounded theory as substantive theory and formal or grand theory. Formal theories are less contextually specific, by studying the phenomenon under a variation of situations. Charmaz (2006) suggested that many grounded theories are substantive theories, describing a specific contextual phenomenon. Constructivist grounded theory aims to develop a comprehensive understanding of the underlying social and psychological processes within a certain context (Gardner et al 2012). Charmaz (2006:30) has argued that ‘neither data nor theories are discovered, rather, we are part of the world we study and the data we collect’. Therefore, grounded theory is posited to co-construct theories about the phenomena we are exploring.

The overall aim of this research was to use the constructivist grounded theory method to study the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices. Due to the specific phenomena and contextual situation of this research, it was anticipated that a substantive grounded theory would be constructed.

**3.4 Summary**

The aim of this chapter was to provide a justification of the methodological and theoretical underpinning of this research. The evolution of grounded theory has been outlined from the symbolic interactionist school to grounded theory discovery in 1967 (Glaser & Strauss 1967) and, more recently the divergence of the
constructivist approach in grounded theory (Charmaz 2006). Furthermore, there has been a justification of the choice of the constructivist grounded theory approach as the most appropriate methodology. The aim of a constructivist approach is to construct a story about the world under investigation.
Chapter 4: Findings

4.1 Introduction

In chapter 3, the research methodology and theoretical underpinning were justified in relation to this research. In addition, there was an exploration of the chosen research method and the data analysis framework shaped by a constructivist grounded theory approach. The findings were analysed by means of initial, focused and theoretical coding, and supported by a process of constant comparison.

Congruent with the constructivist grounded theory, excerpts from the transcripts and memos will demonstrate how the analysis is grounded in the data. The findings are illustrated using codes, memos, diagrams and extracts from the transcripts. Data extracted from transcripts are denoted in speech marks and italics, with an anonymised alphabetic letter.

The purpose of this chapter is to present the research findings co-constructed through inductive analysis, in accordance with constructivist grounded theory (Charmaz 2006). Charmaz (2006:131) further states that in constructivist grounded theory a ‘researchers and research participants interpret meanings and actions’. In addition, this chapter will establish the constructivist grounded theory applied in exploring the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices. Constructivist grounded theory aims to co-construct theory from the data, by exploring how the participants construct their worlds or reality (Charmaz 1990).

The findings are presented to establish the co-construction of the substantive grounded theory ‘Directors of Nursing Perceptions of caring: Post-Francis paradoxes’. The grounded theory has three categories: ‘Trusting my senses’, ‘Avoiding becoming collateral damage’ and ‘Being in a different place’. There are
also associated sub-categories and codes which are illustrated in Figure 3. The categories and sub-categories will be presented to demonstrate a transparent audit trail of the co-constructed grounded theory, which offers an interpretation of the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

In the next section, using the constructivist grounded theory approach; the data analysis process to co-construct the theory is described and illustrated. Figure 3 illustrates the theory, related categories and the associated sub-categories. The theory ‘Directors of Nursing Perceptions of Caring: Post-Francis Paradoxes’ is constructed from the three categories, associated sub-categories and codes. The three categories are described as ‘Trusting my senses’, ‘Avoiding becoming collateral damage’ and ‘Being in a different place’. In this context the meaning of ‘different’ is that the participants are working in a contrasting environment, and as such a different professional world following the findings of the Mid Staffordshire NHS Foundation Trust Report (Francis 2013).
4.2 Trusting my Senses

This first category of ‘trusting my senses’ was defined as the participants’ stories of caring practices that are interpreted to be centred on the human senses. This category has three sub-categories: *articulating my vision of caring*, *recognising failing care* and *showing a continuum of kindness*. Within these three sub-categories there were codes identified during the analysis and represented in Figure 4.

‘Trusting my senses’ described the participants sharing stories of caring practices that are centred on the human senses, and the trust they placed in these senses to give assurance. There are five traditionally recognised human senses: sight,
hearing, taste, smell and touch. A further sense, sometimes referred to as ‘a sixth sense’, also came through the data, that is, the sense which comes through from the mind or intuition. The three sub-categories are all theoretically constructed to the category of ‘trusting my senses’: articulating my vision of caring, recognising failing care and showing a continuum of kindness.

4.2.1 Articulating my vision of caring

The participants articulated their own personal vision and values of caring practices within their own organisations. The participants used phrases describing the ‘vision’ of caring, for example, ‘that’s the picture’ and ‘that’s a real image for me’. They were describing the visual human sense of ‘sight’ in the narrative. The visions of actively seeing care and caring practices, focused on seeing kindness, dignity, courtesy, respect, compassion and safe patient care. I was initially slightly surprised that the participant’s visual descriptions of caring practices resonated so closely with my own perceptions of caring and compassionate nursing care. I reflected afterwards that this surprise may have been centred on my interpretation of the simplicity and seeming clarity of the concept of ‘caring practices’ as opposed to a more complex and shrouded description. I was aware that the perceptions of caring practices I shared were through my professional membership with the participants as a nurse. My ideals and values of caring practices remain unaltered since entering into the nursing profession.

It is not apparent whether the participants’ vision of caring practice is overtly conveyed and articulated to their teams of nursing staff; or whether instead the Directors of Nursing’s individual visions of good care remain exclusively a ‘conceptual’ powerful sense. The interpretation of this is that the participants are describing their ideal picture of caring practices.
When describing the picture of caring, one of the participants focused on the values and behaviours displayed during the micro-level nurse–patient interaction. She used the phrase ‘it’s easier for me to visualise it’ as a visual ‘anchor’. I considered whether the participant used the visual anchor as an emphasis, in that she wanted me to appreciate and understand her role in supporting and promoting caring practices. She went on to explain that she found it easy to visualise good care because she can ‘feel it’ and ‘see it’, again underpinned to the human senses:

‘That’s the picture for me, of kind of a caring, understanding, teaching, taking time to teach people about what’s happened, what they might need to do differently, so not only dealing with the moment but dealing with what will happen, it’s easier for me to visualise what it does look like, I’ve just told you really clearly, I can see it and I feel part of that picture.’ (Participant J)

A memo (Fig 2c page 85) was raised in relation to the code of describing my picture of good care. This code was constructed and I interpreted this to mean that the Director of Nursing sees herself in the image of caring by reflecting the mirror image of good caring practices. This was theoretically linked to the category of ‘articulating my vision of caring’.

Another participant provided powerful imagery of the caring interaction between the dying patient and the nurse providing comfort. She combined the sense of ‘touch’ as well as sight, in her description of good caring practices. The role of person-centred care and anticipatory care comes into focus in the description as she proffers the concept of looking beyond the immediate needs of the patients:
‘I could see that person sitting holding the hand of somebody who’s dying, and that’s a real image for me, you have to look past what that person requires…’ (Participant C)

The visual description of the dying patient resonated with me as having prior experience as a palliative care nurse; it was powerful narrative and allowed me to personally recall several patients that I had cared for in their final moments of life. I could see myself as a nurse sitting and holding hands with the patients in the most privileged of positions, again reminding me of the shared nursing membership with the participants. The imagery of the dying patient was being co-constructed between the participant and me, they described a person sitting with a dying patient and I wove myself into the imagery as I identified with good caring practices.

Participant L depicts her visits to the ward and the value of the sense of sight. She uses this sense to gauge whether good care is being delivered on the ward or not. In particular, she is looking to see the visibility of the nurses interacting with patients. She acknowledges that she does not always see this happening, but on the wards where there is good patient and staff interaction, she defines this as a ‘good ward’. She also outlines the relationship in her vision of seeing a well-managed ward, with good standards of care:

‘My key thing is when I walk round a ward is to see the staff in bays with patients and you know, that’s not something I universally see, but that is something I feel I should see and on good wards that is what I see. I want to see that there is someone in charge who knows exactly what’s happening, not that someone’s gonna say to me “oh I don’t know about this, it’s not my patient”. I want to see, you know.’ (Participant L)
The notion of the ‘good ward’ also resonated for me as I recalled personal experience when I had also not seen nurses interacting with staff, particularly during my formative years as a student nurse and also the best examples of nursing staffing interacting with patients. I also considered what her response might be to the less ‘good wards’ in her role as Director of Nursing. Observing staff interactions such as communication and interactions between members of staff and patients was seen as an indicator of good standards of care. This was also reinforced by another participant in the following narrative when she discusses staff engagement with patients. She goes further to elaborate on the visual sense of both a tidy environment and whether the patient looks cared for:

‘I see the interactions between patients; I will witness the interactions between staff because that gives me a really good feeling. Then you’ll see it, you’ll see the way, you know, is the bed space tidy? Is the patient, do they look cared for? Are people in the areas interacting with people? Are they sitting at a desk?’ (Participant H)

The contrasting perspectives of seeing the visual of care is described by participant C, who identifies the positive experience in her role as Director of Nursing of seeing good care on the wards which were synonymous with her own perceptions, as ‘beautiful moments’ against the opposite, when care has not be delivered in the good standards, she asks herself a rhetorical question on poor standards of care:

‘…and you do see beautiful moments of staff doing that and you see moments of thinking “deary me, how did we get into this?”’ (Participant C)
In summary, ‘articulating my vision of caring’ describes that the participants held a strong sense of what good care should visually look like. They were clear in their own vision of good caring practices and were able to identify good caring practices on the wards by sharing scenario based examples of caring. In particular this was focused on the individual caring interactions between the nurse and the patient. I was aware that I shared these perceptions of caring practices and I easily identified with them maybe as a member inside as a nurse. This category links to the code of ‘trusting my senses’ which describes the participants sharing stories that placed reliance on the human senses which are cues to caring practices.

4.2.2 Recognising failing care

The second sub-category was concerned with the Directors of Nursing recognising and experiencing failing patient care in their organisations. All of the participants shared their experiences of failing patient care, and their perceptions of failing care. These experiences were on the opposite continuum of ‘my vision of caring’. The contrast and opposing side to caring practices was revealed as recognising failing care.

Recognising failing care was a sub-category and was linked to the category of ‘trusting my senses’ and the five human senses: sight, hearing, taste, smell and touch. The senses were used in the same way as cues to recognise failing care, as they were in articulating good caring practices. Participants shared examples of recognising failing care that included seeing, hearing and touch. In addition, emergent was the phenomenon of the ‘sixth sense’ which describes the sense when things do not intuitively feel right. Intuition in this context is interpreted to mean the
Directors of Nursing instinctively knowing when care is of a good or poor standard on the wards.

The first examples are related to the sense of hearing and sound being used as a cue to poor failing care. The participants reported that examples where they sensed or felt that the atmosphere on the ward affected patient care. In this example, the topic of noise and calmness was raised, and how this was an unpopular atmosphere to feel when the participant was visiting the ward. The issue of hearing the buzzers may also have been indicative of patients calling for assistance and that call not being responded to quickly enough. I found myself feeling slightly anxious and my listening became more intense as the serious nature of the descriptions of poor caring practices were unfolding, seemingly relayed with a sense of inevitably and frustration. My anxiety I felt stemmed both from my intolerance of poor caring practices and also repeating the themes from the failings of care described in the Mid Staffordshire NHS Trust enquiry. This area of interviewing brought me back to re-affirm my original motivation for undertaking this research study, to explore ‘how could nurses be anything other than caring and kind when faced with patients’ suffering and distress?’

In this extract the participant uses the words ‘want’ and ‘don’t want’ as a way of trying to use her control, authority and power to confirm her expectations as a nurse leader of the behaviours of the ward staff:

‘I don’t want to hear the buzzers going, I want to, you know, I want it to be looking clean and calm.’ (Participant L)

I interpreted this as the participant was struggling between trying to improve care but
acknowledging that there were wards where the care was of a poor standard in her organisation. Another participant concurred with the notion of calmness, and providing a sense that this was an issue related to how the ward staff were disengaged with caring practices by seemingly ignoring the ‘buzzers’ and ignoring her arrival on the ward. She described the effect of her staff being disengaged and as a warning that there may be issues of poor care or poor staff behaviours:

‘...the alarm mat goes off and all the staff around the nursing station no one bats an eyelid, there’s doctors there, physios there, nursing staff there, no one even raised their head to actually see where that alarm’s coming from.’ (Participant K)

‘so when you go to an area and they don’t turn, even acknowledge that you’re there, I have a real issue with’ (Participant K)

The perceived lack of attention and disengagement to requests for help from the staff was seen as a signal for potential failings in care.

The sense of smell was also offered as an indicator of possible failing care, and was used to describe first impressions of quality of care on a ward area, maybe as an indicator of general ward cleanliness:

‘Immediately I’m walking through the doors into a ward or department,
I’m immediately looking at “What does it smell like?”’ (Participant D)

The descriptions of smell on the wards I found to be powerful in my own recollections of experiences on the wards and other clinical areas. Although I had
not considered this to necessarily be a signal of failing care more of unwell patients needing care and support. I could however see how in the examples shared that this was a cue for failing care.

There also seemed to be the powerful sense of trusting intuition by the participants, particularly with reference to the wards which were perceived to be more difficult to correctly assess for caring practices. Participant L expresses that although superficially and visually the patients are well cared for, ‘clean as a pin’; she has a concern that on one of the wards the care was being carried out in a mechanistic and process-orientated manner. This illustrated a disconnect with person-centred care which was a cause for concern:

‘Which is a ward of concern for me, but when you go on that ward all those patients are sat out of bed and their beds are made and they look clean as a new pin, but I know no one’s thought beyond that.’

(Participant L)

Participant H also described the values she placed on her intuitive skills in her role as quality assurer, and refers back to the notion of the ‘visual’ picture of caring. She recalls how even if the environment and clinical performance metrics are good, her intuition tells her that all is not as it seems in terms of clinical care on the ward. This seems to be an unsettling experience for the participant and she trusts her instinct that things are not as they should be. Many of the participants seemed to place great reliance and trust on their sense of intuition over the other senses, suggested a hierarchy of senses:

‘Often the ones where something doesn’t feel right and you can’t put
your finger on it, and sometimes they're the wards which are doing well on the indicators but you just can't work out what's going on. It's not just what you see, it's what you feel. So it looks organised, it looks tidy.’

(Participant H)

I identified with the sense of trusting your instincts through experiences in my own nursing career in the clinical areas, although I had not considered that the Directors of Nursing might rely on their instincts, I had assumed there would be a higher reliance on quantifiable data with the most senior nurse. The Director of Nursing in the following extract described the lack of ward engagement in the collation of the quantifiable, quality assurance ward data, collated as a component of the ward clinical metrics system. She again relied on her sense of intuition to alert her that the care standards needed looking into in more depth:

‘We’ve got one ward over the other side that we had concerns about, so we had a failure, we have a minimum set of data standards, KPIs, that they produce, and they were failing on them, and it was a bit of mañana and “oh yes, we just didn’t get it right” and you know, there was just something in my mind saying to me “this ain’t right, this is, we’ve got to look at this”.’ (Participant G)

However, the reliance on intuition as a guiding decision-making tool was called into question in this extract when the participant reveals a challenge from her Chief Executive. He was challenging her for factual quantifiable evidence to support a Board presentation:
‘I think probably the Chief Exec is very good at pushing back and saying “don’t know what you’re talking about, you need to bring that argument back”, but not in an aggressive, so for example, with maternity we’ve just single sited as a temporary measure high risk maternity services, and that came about probably through my initial “there’s something wrong here”, and he’ll say to me “yeah, OK, that’s great *C, but you’ve got to quantify it”, you know, that nursing intuition of, and I don’t know when we learn it, of “actually this doesn’t feel right” doesn’t wash at Board.’ (Participant C).

There seemed to be an inherent tension here where the reliance on intuition was not necessarily valued by other Board members. She went on to disclose how she believes that her role is linked more to the emotive issues at the Board, such as patient care, perhaps more than other portfolios at the Board, and uses a style of language and shares patient stories to get her message across at the Board, along with her intuitive approach to care. These are very different styles to her Chief Executive’s:

‘We’re probably very lucky as nurses at a Board level because the subject we have is emotive, and because I am able to articulate what I’m thinking, or what I want to get across, usually in a patient story or evidence it in actual fact, it makes it easier. I’m very plain speaking, I don’t use long words, I try to use language that people will understand and it’s interesting.’ (Participant C)

I started my research with an assumption that the Directors of Nursing would broadly hold equal power and position on the Trusts Executive Board alongside other Board members. So I was surprised to hear that a hierarchy within the Executive Board was experienced by many of the participants, and in differing roles with the Director of Finance, Medical Director and Chief Operating Officer.
In sharing examples of failing care participant B, described how failing to provide standards of care was based on human interactions and values of respect and compassion, rather than the technically challenging aspects of caring. She uses the sense of sight again to describe caring practices and questions the rationale for failing care. She also challenges her own inherent values of nursing in her rhetorical statement:

‘It’s not the high tech things we fail on, it’s actually the smile, it’s the “Hello”, treating people with respect, holding of the hand, cold flannel for the forehead, you know, just things that somehow is inherent in you as a nurse, or so I thought.’ (Participant B)

Reflecting on a participant’s discussion with a patient’s relative, this participant described how she challenged herself to correct the failings of care with an individual patient:

‘People will say a relative of mine received really poor care and I thought “I can do better than that”.’ (Participant C)

Managing and controlling failing care was a recurring theme disclosed by the participants. The conflicting positions of which team member to attribute failing care to; from the individual nurse to the nurse leader of the ward area. Further tension arose in the approaches to performance-managing failing care and the strong message this participant was giving her teams about performance managing care:
‘It was really difficult and there was some, people took things very personally and then people would say, well I’m going to bring the matron next time and he’d say no, you’re failing, you’re the leader and you know, some really hard messages that it was a really hard time, it took about six months for us to understand we are performance-managing care, not you as an individual, although actually if non-delivery of you to lead your ward sisters to deliver this standard is an issue then it will be you but we had to go through quite a big cycle of you now need to issue a performance notice to that ward sister.’ (Participant G)

In the sub-category of recognising failing care, the in vivo code of ‘the grit in the oyster’ emerged. The Director of Nursing’s description conjectures that it is the nurse’s role and responsibility to improve poor standards of care, by being the grit from the oyster shell. Therefore, the nurses need to recognise when patient care is not of a good standard, and the nurses should challenge poor practice to improve the standards of patient care:

‘I think for me it’s about nurses being accountable, taking on responsibility, being confident, in a way be the grit in the oyster, to say what’s good quality patient care.’ (Participant B)

One participant described how she had managed poor performance of a member of nursing staff who made errors, by asking her to leave the organisation; this was the participant’s approach to trying to prevent failing care and maintain the standards of care. This approach is in response to driving up standards of care. An underlying paradox was evident as the
participant refuted the member of staff’s rationale for poor standards not being picked up elsewhere. The participant was concerned:

‘So we’ve had a nurse leave because she kept getting called up because she made drug errors and kept failing her drugs assessment, and we went “Well then you can’t do”, you know. She went “But this wouldn’t have been picked up anywhere else”, I said “Well I don’t care, it’s picked up here and we’ve spotted it, so let’s sort it out. Just because somewhere else wouldn’t have noticed doesn’t mean it’s acceptable.” So there’s something about not tolerating poor standards and being very clear, and I do sometimes feel that I’m very nit-picky.’ (Participant I)

Experiencing failing care was discussed by the participants, and their individual responses and perceptions to these incidents. I interpreted that they believed that the responsibility lays with the individuals for failing care, rather than the participant’s own leadership skills was a belief shared by one participant. Perceiving that individual behaviours were to blame for poor caring practices and that the individual was in control of their own behaviours, as opposed to possible meso (cultural and organisational) and macro (political) influences, the Director of Nursing tried to distance herself from the potential failings in care:

‘I can sleep at night and if someone chooses, if there is a failing in care and I know it won’t be down to my lack of leadership and it will be down to someone who’s chosen not to do what they should have done.’ (Participant A)
This position was different to the other participants as I interpreted that this participant seemingly assured herself by distanced herself from the failings of care within her organisation. I considered whether this might be a coping mechanism or strong belief about the correct ownership for failings of care. I was not able to draw a conclusion to this view and it left me with some unanswered questions. In summary, the participants placed significant personal trust and reliance on the human senses when recognising both failing and good patient care. The role of the senses and in particular the reliance on ‘gut instinct’ of intuition was important to support the other senses, as illustrated in this extract:

‘It’s not just what you see, it’s what you feel.’ (Participant H)

4.2.3 Showing a continuum of kindness

The third sub-category of ‘Trusting my senses’ is described as showing ‘a continuum of kindness’. The co-construction centres on the emerging continuum, participants describe the nursing staff showing kindness to each other, and extending to kindness being displayed to the patients, this was interpreted and co-constructed to be a continuum of kindness. The role-modelling of kindness in shared behaviours and values was believed by the Directors of Nursing to have a direct affirmative association with kindness shown to patients and in turn high standards of patient care. I believe that I may have held a bias through a prior assumption that the participants might use ‘compassion’ to describe good caring practices, I consider that this assumption comes from my own beliefs and perceptions of caring practices as a nurse. It came as a surprise therefore when the participants described caring most closely associated with kindness and a continuum of kindness rather than compassion.
Observing and perceiving kindness in human interactions between staff members connotes a continuum of standards of caring behaviours with patients. The relationship of kindness is illustrated by the participants in observing staff behaviours and interactions on the wards:

‘Before I see the interactions between patients I will witness the interactions between staff because that gives me a really good indication about how people, um, how people, how kind people are to each other. If they’re not kind to each other they’re not kind to patients.’ (Participant H)

‘Because if we can’t be kind to each other and show good care to each other then we can’t instil that within the rest of the organisation.’ (Participant A)

Therefore, an absence or lack of kindness between staff and then patients is contrasted on the continuum, and is defined by staff displaying unkind behaviours to each other and patients:

‘...but it's not just about being kind and caring to patients, and this is where we've had this issue with staff of late, they haven't been kind and caring to staff.’ (Participant I)

This participant described the effects on caring practices of staff disengaging with patients. The effect of the disengagement is an absence of genuine and authentic caring practices. An explanation of this disengagement is offered as stress or distress of the nursing staff:
'Actually being able to see when people are disengaged from there, and that nurses, quite often when they're stressed or distressed will disengage and you can see that, you can see in the way they behave towards people that they're not actually actively engaged with the person, they're almost carrying the caring tasks out but in a way that's not authentic.' (Participant F)

This description in particular resonated with my reflections and reading during the preliminary literature review of this research, and in particular the work of Joan Tronto (1993) who defined ‘practice’ as having inherent integrated ‘thoughts’ and ‘actions’ aimed at achieving an outcome of care. The concept of authenticity in caring resonated with my own thoughts and beliefs as a nurse and I could understand how a lack of connection in caring could feel unkind to a patient.

In this following example, the organisational-level buy-in to kindness as a concept, and the value of kindness, is acknowledged in cultural change programmes. This participant perceives that kindness as a tool for bringing about organisational improvement has not been sufficiently recognised:

‘I think kindness. And I think people underrate, it was really interesting I’ve been talking about kindness for a few years around the cultural change programmes I’ve been involved in to say that people think it isn’t something that carries a lot of weight, and I’ve seen kindness be one of the most effective management and leadership tools ever.’ (Participant H)
In summary, the participants all described the phenomenon of showing kindness between each other as staff and then to patients in their care. The continuum of kindness was co-constructed and described as existing if kind behaviours were shown between staff and then on towards patients.

4.2.4 Summary of trusting my senses

The first category of trusting my senses described the participants’ personal vision and values of caring practices within their own organisations. It was not evident whether the individual visions of good care remain exclusively a conceptual vision or an operational vision shared with and upheld by their nursing teams. This category is constructed through the role of trusting the human senses in recognising and sensing good and failing caring practices, on the ward areas. Of importance was the foremost value that the participants placed on the ‘sixth sense’ of intuition in assessing good or failing caring practices. The three sub-categories are all integrated: articulating my vision of caring, recognising failing care and showing a continuum of kindness. The participants described their sense of caring practices and, contrariwise, how they identified and responded to poor caring practices. The final sub-category of showing a continuum of kindness offered an interpretation of how good and poor caring practices could be influenced by the attributes of staff showing kindness towards each other.

4.3 Avoiding Becoming Collateral Damage

Avoiding becoming collateral damage co-constructed and interpreted from the data, it is concerned with the participants’ feeling of being at risk of peril, when there were care failings within their organisations. Therefore, their appointments as Directors of Nursing within the Trusts were perceived to be at risk and vulnerable. The
participants felt that they had little control over this situation as they would inevitably become accountable for the care failings within the organisation. As such they perceived that they would become collateral damage of the failing care. The Directors of Nursing feared that they would be expelled from their posts by virtue of their accountability and role association to the quality agenda. Their perceptions of becoming collateral damage centred on the belief that they held singular responsibility for quality and standards of care within the organisation. The context of avoiding collateral damage seemed to be more acutely expressed following a time of recent exposés of care failings in the media.

I was touched by the participants accounts of struggle and isolation in their roles. I had not anticipated that these sorts of personal issues would be disclosed to me during the research. It occurred to me that there was a potential for a dichotomy within their roles. My belief is that the Executive Nurse Director role may be viewed as the professional goal and pinnacle in the career for many nurses, I share this view. However, for some the reality was seemingly tainted by powerlessness, struggle and acute short-termism. This was in contrast with my own beliefs that professional success is not necessarily tainted with professional sacrifice. I considered why the participants chose to share their stories of professional and personal struggle with me. I reflected whether the participants found it easier to share their concerns about the security of their roles as I was an outsider of their Executive group. I was unable to be sure if this was the case but I was struck their honesty and candour.

The two sub-categories of avoiding collateral damage are ‘balancing the cost of caring’ and an in vivo code sub-category ‘anticipating the Sword of Damocles’. The
associated category, sub-category and codes are illustrated and represented in Figure 5.

**Figure 5. Avoiding becoming collateral damage**

**4.3.1 Balancing the cost of caring**

At the centre of the participants’ perceptions and feelings of peril and vulnerability were their individual interpretations of the organisations’ inevitable responses to failing standards or quality of patient care. Their perceptions of the ramifications of failing care standards were linked to feelings of peril and vulnerability. A response to this feeling of peril was to aim to successfully increase nursing staffing numbers on the wards, secured through additional Trust Board investment. My interpretation of this phenomenon was that the participants believed that direct investment in nursing staffing numbers would promote caring standards with little disclosure of other potential contributing factors. I was a little surprised by the possible unilateral view of protecting and promoting care on the wards that was shared with me, but wondered on reflection is this was articulated as the participants felt they had some
individual power at the Board over influencing this outcome. The staffing investment was seen as a way to balance the competing priorities of quality and investment, and potentially secure the participant in their Board role, by reducing the risks of poor standards of care within the organisation by increasing staffing establishments. The concept of increasing staffing numbers as a method of securing quality assurance was linked to their interpretation of the staffing recommendations within the Francis Report.

On the issue of increasing nursing staffing investment, this participant describes her perceptions of her own role and that of the Medical Director, as being at most risk of losing their positions over poor care failings. Ultimately it is the participant who perceives that she has sole responsibility to balance correct staffing ratios on the wards and investment, and therefore is more vulnerable in her position. The participant describes the tension between meeting standards of care if there is no additional investment available to recruit additional staff to the clinical areas. I interpret this tension as her desire to keep some control over potential to failings in care by being able to close beds if there is not sufficient staff on the wards. Her final standpoint, if required, would be to take control over standards of care before they risk care failings, by insisting that beds are closed to safeguard quality of care:

‘I still feel that in the firing line for that will be the Director of Nursing and Medical Directors first, but actually if they’re presenting case after case, or they’re starting from a baseline of staffing for example in terms I do staffing, which is, you know, nowhere near what is going to be required to meet the fundamental standards of care, but there’s no money in the system, what on earth do you do? Well I know what I would do, I’d shut
the beds, so I’d shut the wards, so if you can’t staff them I’d shut ‘em.’

(Participant A)

In response to staffing issues, the following participant describes how she came into post at the Trust, after a period of savings were made on the staffing levels on the wards. Now, however, she is addressing the Trust efficiency programme by balancing the correct staffing ratios to preserve quality of care. She is hoping to mitigate against the risk of the impact on staffing or savings targets. She perceives the cost savings to have had an impact on quality of care:

‘I think there are a lot of conversations again about staffing investment, pressure to save, be more efficient, so when I came into post I was really concerned about some principles of staffing. So what we have is we have two high length of stays so we’ve got too many wards open and the workforce has been thinly spread under those wards. There’s been an extensive savings programme over the last however many years that has done everything. Some of that I’ve already stopped and changed, so I’ve changed the skill mix, increased the RN to healthcare support worker [ratio].’ (Participant H)

In the following extract the cost of caring and the concern of costs due to patient harm were discussed. The tension between balancing the increase to staffing costs, against the cost to the longer-term costs to the organisation and the patient when a patient suffers harm, such as a fall, was disclosed. My interpretation is that this tension seems to be at the core of the issue of avoiding becoming collateral damage, balancing investment against potential care failings:
‘...but I strongly do believe that if you get quality right money does follow, a practical example of that, if you prevent patients from falling and fracturing their hips and then needing surgery you know, as well as doing the right thing for the patient, how much more does it cost us to take them to theatre, how much you know, a pressure sore is a real issue for me you know.’ (Participant K)

A further example of staffing numbers and the direct link to and impact of patient falls is rhetorically questioned by this participant:

‘So, you’ve got a large number of falls on here, what was your staffing like?’ (Participant C)

There was a strong sense that there was a current timely opportunity to successfully use the Board to make the case for additional investments in nursing staffing. This followed the recommendations from the Mid Staffordshire NHS Foundation Trust Report. The opportunity was seen as a direct result of the impact, legacy and staffing recommendations following recent high-profile exposés of care failings. These were seen in the dynamics at Trust Boards with balancing the quality agenda with the finance agenda:

‘If we don’t get this right at this moment in time we’ll never get it right and we’ll never have an opportunity like we’ve got now, both with Francis, Keogh and the thrust to get quality at the forefront of everything because no longer does finance drive the Board where nursing staffing establishments are concerned. Because Mid Staffs has completely
changed all of that and if we don't seize the opportunity now than we'll never get this opportunity again.' (Participant D)

In co-constructing, I interpreted this to mean that the opportunities had come from the major failings reported in the Mid Staffordshire NHS Trust recommendations; particularly staffing investment and that this was believed the window of opportunity to improve standards of care in hospitals. A further facet in the Board was the professional relationship between the participants and the Directors of Finance and the differing perceptions of priorities. In the following it is played out in when the participant challenges the differing perceived importance between her work portfolio as Director for Quality and Standards of Care, and the Director of Finance’s portfolio:

‘I said to the Finance Director “it’s just numbers, you know, I’ve got people, I’ve got people” that’s what matters.’ (Participant C)

The complexities of the two Board relationship are further elaborated when the tension at the Board in managing infection control in cases of Clostridium difficile was disclosed. The Director of Nursing is concerned that the ‘intangible’ elements of her role may contribute to the perception that she is not performing by not managing the quality aspects of her role, even though in this example the infections were contracted by patients out of hospital, and beyond her direct clinical control. She was concerned whether this aspect of her role is well understood by non-clinical Board members such as the Director of Finance:

‘You know, the Finance Director’s managing to do his job and he’s managing to come and bring us in on budget and yet we’re sort of
saying “oh well, you know, I'm not sure there’s a lot we can do about this”, and it must feel quite frustrating sometimes I think for the people who aren't clinical to say “well, why aren’t you doing something about it, surely it must be easy to manage this?” and it just isn't and it's trying to get across sometimes the intangibles like quality.’ (Participant L)

I interpreted this to mean that the participant viewed that the Director of Finance had a more manageable and achievable portfolio of work which was in contrast to the experiences of her own role. I was cognisant that the participants were disclosing their experiences of Board tensions to me and I wondered what effect I might have been having as a researcher during this part of the interview.

In balancing the cost of caring and quality, securing financial investment from the Board was seen as crucial to protect and improve the quality of care by increasing nursing staff numbers. Having the correct staffing numbers on the ward was perceived and assumed to improve the quality of care and reduce patient harm such as from falls. It followed that, as a consequence of having safer staffing numbers on the wards, higher standards of care would thereby reduce the peril and vulnerability of the participants to becoming collateral damage in their organisations. The primary motivation of the participants was to ensure the patients had high-quality, safe care during their admission.

4.3.2 Anticipating the ‘Sword of Damocles’

The in vivo code of the ‘Sword of Damocles’ depicts the phenomenon of imminent and ever-present peril faced by the participants who are in positions of power. In this case the participants believed that they were in peril or vulnerable within their organisations, if there were failings of care during their tenure at the Trusts. This
sub-category supports the category of avoiding becoming collateral damage, and the risk of losing their positions due to perceived care failings.

This participant described the anxiety and pressure as feeling like she was anticipating the ‘Sword of Damocles’. She felt she was in a precarious and vulnerable position, and her position as Director of Nursing in the Trust might become untenable if a significant failing occurs in standards of care, hence the ‘sword’ would fall and seal her fate. This perception of vulnerability seems to be heightened following the more recent high-profile exposés of care failings including Mid Staffordshire NHS Foundation Trust. Her own professional tenure was under threat if the quality of care within the organisation failed, and as a result of the pressure she had considered her own position as to whether she could continue on in her role:

‘It feels like the Sword of Damocles at the minute hanging over me because of the pressure that we’re under and there’s been a couple of times I’ve thought they’ve had enough…’ (Participant D)

On hearing this I recall being cognisant about what the particular reference to the ‘couple of times ‘meant what might be the point of no return for the participant. And then considered in turn what would my own point of ‘no return be’? I thought about the interplay with the relationships at the Board and how this might also affect the level of pressure. I found the selection of the poignant language used of the ‘Sword of Damocles and the ‘Sacrificial Lamb’, which gave a level of gravity to the perceptions described by the participants. I interpreted this to mean that the participants felt they were not secure in their roles. A memo was raised in relation to
the code of fearing the worst. The memo demonstrates the interpretation and construction of the perception that stress in her role is linked to the level of quality assurance that she has in her role. This code was constructed during the analysis of the data, and was linked to the sub-category of anticipating the ‘Sword of Damocles’.

This following participant suggests that, within the Trust, it is the Director of Nursing who is most a risk of losing their post. Again she is sharing and confirming her views in relation to the vulnerability of the role of Director of Nursing, following the reported failings of care at Mid Staffordshire NHS Foundation Trust. She compares the security of the role with that of the role of the Medical Director, who she perceives to be safer, possibly due to retaining a strong occupational identity, their clinical workload and being seen to be more aligned to a stronger Union voice:

‘Hold on here, they cannot be the “sacrificial lamb”, because it’s really interesting, in every problematic hospital the Director of Nursing is the first one to go. I think they’re easy to get rid of because we don’t… you know, the RCN isn’t like the BMA. I think because they always hang on to some of their clinical workload it makes them safer, whereas a nurse seems to give up all clinical work just to take on management, so it makes them more vulnerable, and I think they go quieter.’ (Participant B)

She powerfully illustrates this risk by elaborating that she has friends who have lost their positions towards the end of their careers, and how she feels that she is in a ‘privileged’ position as she has retained her post:
‘I feel really, really fortunate and very lucky, because a lot of my colleagues get destroyed in the last few years of their career and that’s wrong when you’ve done such a good job, so I do feel very, very privileged.’ (Participant B)

My interpretation of this scenario was that the participant was describing a relationship between privilege and power between herself as employee and her employer. I was quite shocked to hear that she viewed keeping her job as associated with privilege in some way, in particular because this was not associated with not delivering in their jobs, more that they were seen as dispensable without regard. I reflected on my own feelings of injustice that was being described and wondered how difficult it would be to function in that context.

Another participant described her own vulnerability and suggests that feelings of being dispensable in her role may be linked to this anxiety, supporting the anticipatory nature of the perception of the ‘Sword of Damocles’. The emotional impact of this is outlined as ‘feeling like a sitting target’ which manifested a feeling of loneliness and worry:

‘I think the Director of Nursing role is a role, there are a lot of nurses around, they can usually fill them, not always but they can usually fill them, we’re not protected by all sorts of legal bits and legislation, and I just think it’s easier, it’s a sitting, you know, you do feel a sitting target at times very lon….ely., it is very lonely, it’s very isolating, I do worry, you know, personally, just around what the impact is on me as an individual, and then on my career. I don’t want to really end my career right this moment in time.’ (Participant C)
The impact of failing is described by Participant J when she relates the extent of the emotional impact of failure and the damage to individuals, the organisation and also the nursing profession. In both examples I interpret this to suggest that the Director of Nursing is passive in the process and that failure in their roles will happen as an inevitability, as supported by the in vivo code of ‘the Sword of Damocles’:

‘We’re setting people up to fail, or we might set people up to fail. And that’s horrid, that’s deeply distressing actually for everybody, it doesn’t serve nursing as a profession, it doesn’t serve the organisation and it damages individuals, it absolutely damages individuals. Hmm, yes.’ (Participant J)

The effect of the Sword of Damocles and responses to managing feelings of peril and vulnerability were for the participants to increase their vigilance of caring practices in their respective Trusts. They described seeking out reassurances of good standards of care from their nursing teams. They became more visible in the clinical environments, trying to reassure themselves of the standards of care on the wards. However, the reality was that they also sensed and found examples of poor care within their own organisations.

One participant was seeking assurance by monitoring standards of care on a ward. She was using a Trust-wide remote ‘real-time’ patient monitoring system from her office, when she intervened by phoning the ward from her office and directing the staff to go and attend to a patient on the ward whose metrics revealed they were deteriorating. She disclosed that she was cognisant of the potential risk of being perceived as ‘Big Brother’ by her nursing staff; she balances this risk against a potential failure of care on the ward by taking control directly:
'I mean it’s a bit of a Big Brother thing, I have rung wards up before and said “the patient in bed 6 looks like they’re bleeding, will you go and look?”.’ (Participant L)

As a response to the threat of the ‘Sword of Damocles’, another participant described how she desires to be more consistently visible to her nursing staff, and therefore increases her own vigilance in monitoring care standards. This works as opposed to only seeing the nursing staff when care has failed on the wards, after the event when there would be little that she could do to prevent failings in care. To support this vigilance she divides her work plan out and nominates Thursday as her clinical day:

‘Be present for staff, so staff need to know who I am before things go wrong and not just see me when it’s all horribly wrong. So I’m visible on a Thursday.’ (Participant H)

My interpretation of the concept of vigilance and being visible on the ward was the participants wanting to see the ward in its normal daily operation, rather than through a pre-prepared visit. This strategy to reduce her feelings of peril in her role was constructed by setting out to gain a greater level of reassurance and trust from the staff through unannounced visiting:

‘If you walk round your clinical areas and it’s like a royal visit every time you go then you’re not gonna see the stuff that you need to see and then you’re not gonna have the rapport with them that you need to see...’

(Participant A)
Participant G described how she had met with a bereaved relative following a failure of care within the Trust. She described that the observation system of recording fluid balance had failed or had not been used correctly, causing harm to the patient and distress to the family. The participant made a personal promise to the relative that by investing her own personal vigilance this mistake could be avoided in the future:

‘On this particular occasion when this lady’s husband had lost ten litres from his ascites\(^3\) and it wasn’t documented on a fluid balance chart and I promised her that I would sort it out and I really felt responsible and I’d thought in the current way that we work, unless I put something really robust in, when she, you know, she works here, she’s on my shoulder now and how can I face her if we don’t make improvements?’ (Participant G)

4.3.3 Summary of avoiding becoming collateral damage

The second category of avoiding becoming collateral damage described the participants feeling peril, when there were failings of care within the organisations. The penalties for the care failings were felt to be the risk and vulnerability of their own positions. Therefore, they perceived that they would become the collateral damage of the failing care within their organisations. The two interconnected sub-categories of avoiding collateral damage are ‘balancing the cost of caring’ and an in vivo code sub-category ‘anticipating the Sword of Damocles’. The participants described the experiences and feelings of anticipating the Sword of Damocles as living with the fear of losing their positions. Securing additional Trust Board investment for increasing nursing staffing on the wards and adopting an increased

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\(^3\) Ascites is described as the accumulation of fluid in the peritoneal cavity, causing abdominal swelling. (Oxford Dictionary Online)
surveillance of their ward areas supported mitigation against this risk. I wondered why the participants had chosen to disclose their feelings of powerlessness and vulnerability during this part of the interviews. I considered if during the course of the duration of the interviews whether the participants were feeling more comfortable with me as an interviewer as a rapport may have been developing through waiting, negotiating and building the relationship. I also questioned whether the sequencing of the interview guide may have also played, although the disclosures of this nature came in the middle sections of the interviews, sometimes maybe 10-15 minutes into the interview. I felt more likely that there was a significance of disclosure and my role as the researcher; I had not considered that there may be a therapeutic aspect to my research having only experienced this previously when interviewing patients and carers. I considered if my gender identity was a factor interviewing female participants disclosing their feelings of insecurity, or whether the security of anonymity ascribed by the research concordat was in fact giving a safe space and sanctuary to the participants. Much of the data co-constructed in this category was ‘in-vivo’ in nature, but was also influenced by the nature of disclosure and the relationship between myself and the participants.

4.4 Being in a Different Place

This section describes the disparate and different professional and occupational worlds within which the participants operate, having shifted to a different position following the responses to recent exposés of care failings and in particular the Mid Staffordshire NHS Foundation Trust inquiry. This shift has impacted on their roles, positions, relationships, values and behaviours as Directors of Nursing. There are three sub-categories within the code of ‘Being in a different place’: ‘navigating the Board’, ‘restoring nursing’s professional identity’, and the in vivo code of ‘feeding the beast’ (Figure 6).
4.4.1 Navigating the Board

One key area of change following the responses to care failings and exposés has been the relationships between the participants and other Trust Board members. The participants perceived that they were uniquely and solely responsible and accountable for the quality of care within their organisations. This led to a sense of isolation and feelings of powerlessness within these roles at the Board. In response to these feelings the participants’ actions were to seek out support from other Board members to become ‘allies to their cause and work’.

Having support at the Board was perceived by the participants to have the potential for a more successful outcome and impact at the Board. The key ‘allies’ or partnerships were most frequently with either with the Medical Director of the Director of Finance. Both posts were seen as ‘strategic allies’ in supporting the
Director of Nursing at the Board, so as to secure a voice on ‘quality’ issues or financial investment. ‘Navigating the Board’ describes the complexities of the relationships with the Board as the participants seek out support in relationships. One participant described how she used a certain language at the Board to get her message across by avoiding long words; perhaps this was a more comfortable approach in communicating with the Board.

In navigating the Board, participant B outlines her aspiration to be viewed as totally symbiotic and aligned with the Medical Director. The reason for this partnership was deemed as possibly securing a more successful outcome at the Board. The outcome could be security in her post or agreement on key clinical issues which could be powerful at the Board:

‘I'm very clear and I've said it since I started here that the Medical Director and the Nurse Director has to be joined at the hip.’ (Participant B)

Participant J concurs with the phenomenon of navigating the Board, and is keen that she is seen by the Board to be strategically aligned with allies, either the Medical Director or the Director of Operations. My interpretation is that this was seen as one possible strategic move by the participant to mitigate against potential isolation and reinforces the need for allies and hence guard against failure in their Executive roles:
‘So the way I work with the Medical Director and the Director of Ops is really important and the way I’m seen to work with them as well’.

(Participant J)

Potential tensions within the relationship with the Director of Finance were disclosed. In contrast, on the continuum of navigating the Board, this participant does not seek an ‘ally’ in the Director of Finance, and indeed is questioning of others’ motivations who do seek allies, and the possible consequences behind this partnership:

‘I’ve seen it over the years, once they’ve sort of become a Director of Nursing they then want to be on the Board, so their mates become the Board. Well that’s not what they’re there for. You know, being best friends with the Finance Director isn’t what we’re paid to do.’ (Participant B)

In interpreting these examples there seems to be a disparate view as to the relationship and proximity particularly between the Director of Nursing and the Director of Finance. Sharing the discourse of quality and finance at the Board between the Director of Nursing and the Director of Finance was expressed by this participant:

‘I expect the Director of Finance to be able to talk about compassion and care and making a difference…, and I also obviously expect him to you know, be the expert around financial management, but I would expect him to be able to talk about that in the context of what great care is.’

(Participant F)
Participant H describes the anxiety when she has concerns about care in the organisation before a Care Quality Commission (CQC) inspection, and how she tries to navigate and reassure the Board, but also make them aware that there are current challenges. In this extract she seems to take on the sole responsibility for this quality agenda but seeks reassurance by looking for Board ‘allies’:

‘Medical director was great, chief exec was great, and it was interesting because everyone’s going “are you okay?” I said “no I am okay but I need to tell you this is how I’m feeling because this is driving a lot of my conversations at the moment and, you know, there’s nothing you can do, we just need to wait now, I’m keeping everyone else calm, this isn’t going outside this room but you just need to know, I want you to know that I’m finding this quite difficult at the moment”.’ (Participant H)

In co-construction of this data I interpreted this to be that this participant perceived that she had a dual role in keeping the Board calm during the regulatory visit. It was curious to me that she adopted the role of calming the Board and I reflected that I had not considered that the Executive Nurse Director might adopt this in the Board hierarchy structures.

In summary, navigating the Board by looking for support or in some cases distance from key roles through building alliances, this was one of the responses and actions to the category of ‘being in a different place’. The relationships with other Board members, in particular the Director of Finance and the Medical Director, were seen as crucial for gaining support in the quality agenda.
4.4.2 Restoring nursing’s professional identity

In response to care failings and the mandate to drive up the quality of care following the Francis recommendations, the participants’ roles were increasingly spilt between their Executive Board roles and their operational role as nurses within the organisations. In response the participants seemed to veer towards increasing their visibility and presence on the wards as a mechanism to gain greater assurance about the quality of care in their respective organisations. In doing so and in the context of ‘Being in a different place’, this was co-constructed as an increasingly shift towards attempting to restore nursing’s professional identity.

Participant J describes how she increasingly sees her role to share the external message that nurses are doing a good job as a method of managing poor external reputations. She uses her occupational identity as a nurse to convey this message, as opposed to her role as an Executive Board nurse:

‘I believe that nurses and midwives still, the vast majority of them want to deliver great care to people, and that is what I see most days – great care, and it’s beholden to me and other people in my position to make sure that people hear this, no-one wants the profession to have a bad reputation, saying that I also know we don’t get it right all of the time.’

(Participant J)

In my own professional identity as a nurse I conferred with this description, belief and value which were shared by the participant, in that nurses are motivated to do the right thing for their patients. I also identified with the position of the professional responsibility of preserving and re-negotiating the nursing professional values. I
was very aware that my identity as a nurse was paramount when listening to this extract; it was both valued by me and resonated with me.

Managing and restoring nursing’s reputation and the impact of the media were disclosed by several participants, along with the impact of the care failing at Mid Staffordshire NHS Foundation Trust on nursing’s reputation:

‘And the media’s not helping because actually... I mean, Mid Staffs was terrible, don’t get me wrong, but there’s a lot of good going on, and I really do genuinely believe that no nurse gets up in the mornings and says “How could I make some patient’s life even more difficult?”’, you know, we actually come to do a good job.’ (Participant A)

‘The patient’s expectations are getting higher and higher and some of it is fuelled you know, by the media of course but you know, the British public have very, very high expectations, and some would argue well that’s right and why shouldn’t they, but that puts a huge amount of pressure on resources and expectations from our staff.’ (Participant K)

In the following extract, the participant describes the conflicting parts of her role, by needing to be focused on nursing as well as the strategic Trust issues:

‘I think that you have to bring very strong focus on nursing but you also have to have an understanding of the business, and you can’t do one without the other.’ (Participant E)
In summary, the participants’ response to ‘being in a different place’ focused on restoring nursing’s professional identity. This included supporting the reputation of nursing and articulating good caring practices and the ‘good’ in nurses.

4.4.3 Feeding the beast

A further sub-category to the category of ‘Being in a different place’, was the requisite to ‘feed the beast’. Feeding the beast was an in vivo code. It depicts the participants in their executive roles as being required to produce and submit an insatiable level of increased documentary evidence pertaining to the quality standards of care within their organisations. This complex and detailed documentary evidence was required by numerous parties including the Trust internal Boards and external agencies including the Care Quality Commission, the Trust Development Authority and the Clinical Commissioning Groups.

This evidence was frequently and repeatedly requested, with the purpose of providing reassurance to the extensive range of external regulations about the quality of the care standards within their organisations. I interpreted this impact as the increased burden of work, along with the seemingly insatiable appetite required by regulatory systems to give this level of quality assurance, caused some tension for the participants in balancing competing priorities. It was described as an in vivo code feeding the beast:

‘I think we have to challenge that and that’s quite a growing thing we have to do because of the way that things are and how things post-Francis have been really.’ (Participant F)
The effects of this feeling of pressure to provide numerous versions of documentary evidence were also felt in reaction to external regulation:

‘I think the biggest challenges must be CQC and the way they’re sort of… because they’ve changed, haven’t they, so it’s what their new monitoring regime will be and how that will impact.’ (Participant B)

The intense feelings of pressure and scrutiny were denoted by participant C, as she described feeling ‘sucked in’ as she ‘feeds the beast’:

‘The demands are really high to respond, you know feeding the beast, you’re under scrutiny and with all the scrutiny on care at the moment so whether it’s Monitor, CQC, commissioners or patients groups.’

(Participant C)

A memo was raised in relation to the code of getting sucked in (see Chapter 3). The interpretation of this ‘sucking in’ is that a loss of control occurs within the roles as the insatiable appetite of the ‘beast’ is fed, centring on the perception of the increased regulation post-Francis recommendations. This code was co-constructed from my interpretation of the participants stories that increased regulation on health care providers was creating anxiety about the level of evidence required, this was linked to the sub-category of the ‘feeding the beast’

Referring to Mid Staffordshire NHS Foundation Trust, this following participant perceived some anxiety within the regulatory system as to the close geographical proximity to an identified failing NHS Trust, to give assurance that their Trust was not in the same situation:
‘We also share the same commissioners as Mid-Staffs so I think around the time that Mid-Staffs was rumbling, not so much in the public eye but very much locally there was a real drive for us to reduce the variability in the care that we were delivering.’ (Participant G)

In response to these feelings of regulation and ‘feeding the beast’, participant G hoped that over time, if the system became less anxious regarding potential care failings, then self-regulation of quality and governance would be the preferred route of assurance and hence would reduce the need to feed the beast.

‘But over time with the national agenda around care it’s been really key to educate the Board I think around what questions they should be asking so that we can self-regulate ourselves a lot better and also working with the commissioners. So it’s been about relationships, openness and trust so that we can, you know, progress care together.’ (Participant G)

4.4.4 Summary of being in a different place

The third category has been interpreted as ‘Being in a different place’. It outlines the changes to the professional and occupational worlds within which the participants describe and operate within. These experiences are co-constructed to be dissimilar from the time before the failures at Mid Staffordshire NHS Foundation Trust, which had shifted and altered following the responses to recent exposés of care failings. This shift has impacted on their Board roles and relationships, and their values and behaviours as Directors of Nursing. The participants tried to restore nursing’s identity as a way of redressing the disparate nature of their worlds. However, they
had to contend with feeding the beast to provide assurance and evidence of the quality of care in the system. The three sub-categories within the code of being in a different place are: 'navigating the Board', 'restoring nursing’s professional identity' and the in vivo code of 'feeding the beast'.

4.5 Co-constructing a Substantive Grounded Theory

The overall aim of this research was to use the constructivist grounded theory method to explore the perceptions and experiences of Directors of Nursing in NHS acute Trusts, on caring practices. The co-construction and interpretation of the narratives between myself and the participants was an iterative evolving journey which created a story and a theory of the perceptions of Directors of Nursing in NHS acute Trusts. The interview seeks to “primarily construct stories and versions of events that can have the possibility of generating theories” (Nunkoosing 20015:702).

A grounded theory of ‘Directors of Nursing perceptions on caring: Post-Francis paradoxes’ was co-constructed from the findings and conveys that several paradoxes have arisen from the recommendations of the Francis Report into care failings at the Mid Staffordshire NHS Foundation Trust (Francis 2013). A paradox is described as a contradictory or unhelpful consequence of an unintended outcome (Oxford Dictionaries Online 2014). In this thesis, the paradoxes which are those which might inhibit as opposed to improving standards of caring practices. The recommendations from the report into care failings at the Mid Staffordshire NHS Foundation Trust (Francis 2013) centre on the ambition for NHS acute Trusts to improve the quality of care by improving systems and processes to reduce and prevent failings of care. The participants described some positive outcomes from the recommendations such as increased staffing on some wards. However, one of the
paradoxes and contradictions that have occurred is that more statutory monitoring, a
newer framework of regulation and increased scrutiny are perceived to be
hampering, inhibiting and over-burdening the system. This has led to an insatiable
requirement to monitor and produce statutory evidence of improving standards of
care. The paradoxical problem has two facets; the need to produce reliable high-
quality assurance in the system about standards of care, whilst not detracting and
impacting on those nurse leaders’ roles that are essential to raising standards away
from internal assurances processes.

There is a political backdrop to the paradox and a legacy from the Mid Staffordshire
NHS Foundation Trust findings that external monitoring standards may not be
congruent or valid in capturing the ‘real’ warning signals of failing care within an
organisation. This tension was at the core of the failings at Mid Staffordshire NHS
Foundation Trust, when the metrics and numbers were juxtaposed to the reality of
standards of patient care. Additional pressures were being experienced by the
participants as they try to balance the competing priorities of their Executive roles,
statutory monitoring, external regulation, as well as leading the internal
improvements of quality standards of caring practices.

Charmaz (2006) has acknowledged that constructivist grounded theories are
contextually orientated, to a defined culture, time, place and situation. It is proposed
that in applying this contextual vision of Charmaz’s constructivist grounded theory,
the ‘Directors of Nursing perceptions of caring: post-Francis paradoxes’ is
contextually orientated in the post-Francis era, to a defined culture of Directors of
Nursing in NHS acute Trusts, and the situation of the response to exposés of care
failures.
A participant described the pressure and impact of many agencies and the regulator requesting differing evidence of improving patient outcome and patient safety:

‘…but it feels like we’re being performance-managed within an inch of our lives, and by externally, by either the CQC or by the CCG or by the TDA, all wanting something slightly different, and you could very quickly get sucked in, and that’s my issue.’ (Participant C)

The following Director of Nursing described the impact within the NHS system to monitor standards of care post the Francis inquiry into Mid Staffordshire NHS Foundation Trust, and the perception that all organisations are being viewed as potentially failing in care standards from a position of negativity:

‘Post Francis… I think now I think we’re working in an environment where everybody’s watching their backs and it’s, it’s, it was hard enough before, it’s even harder now, and there’s certainly zero tolerance completely for failings of which I don’t disagree with whatsoever, but it does feel like we’re all being tarnished with the same brush. But it does feel a much more toxic environment.’ (Participant A)

The impact on the participant specifically in relation to an NHS acute Trust was outlined, as she tried to balance the additional bureaucracy, regulation and scrutiny against supporting improvements to caring practices in her own organisation:

‘I also think the acute Trust sometimes hasn’t been able to see the wood for the trees so that’s a chaotic system, a lot of bureaucracy, and the more you fail to give confidence the more bureaucracy and the less control you seem to
be able to harness. It's really challenging here, so trying to kick back and stay focused on the things that are really going to improve outcomes for patients.'

(Participant H)

The participants shared their perceptions and personal visions of identifying good nursing care as discussed in section 4.3; however, some clinical metrics and other outcome measures were often seen as unreliable and unnecessary, not ‘true’ reflections of good caring practices. The participants placed a higher value on ‘softer’ metrics and reliance on the ‘sixth sense’ of intuition, when seeking assurances of the quality of care. Thereby this described a further paradox whereby the ‘positivist scientific’ approach to regulation, monitoring and outcomes can be positioned in opposition to the ‘interpretative intuitive’ approach also relied on by the Directors of Nursing to give assurances of care. They relied on their intuitive skills to identify and manage poor caring practices and described how they used these as warning systems to identify failing care to the Board. This participant described the impact of the scrutiny as having to work harder to produce the evidence, which conflicted with keeping the Board assured of the more sensitive indicators of standards of care. It was a finding from the Mid Staffordshire NHS Foundation Trust public inquiry that the existing governance system had failed to identify that care was sub-standard at the hospital, so the warnings were not identified. This is defined as anticipating any problems with standards of care as opposed to ‘comforting’ the Board with clinical metrics which may not give a true reflection of quality of care:

‘You know, so we’re constantly stretching ourselves to... And I think when you are a Trust under scrutiny you do tend to push yourselves harder because you’re under such scrutiny and when you’re under scrutiny your regulators and you know. Also getting that fine line between, you know, I produce a four-page
Board report, that’s all I produce around harm, workforce, patient experience and metrics and that gives enough assurance around care, but it’s the very sensitive smoke alarms that I should be alerting the Board when things have gone wrong.’ (Participant G)

The impact of being in the role of Director of Nursing in an NHS acute Trust during the post-Francis Report era was described as feeling fearful and being aware that they might lose their positions if standards of care failed in the Trust. The Directors of Nursing perceived themselves to be in a precarious predicament and felt insecure:

‘I think that it feels a bit draconian at the moment, you know, because increasingly we’ve seen Directors of Nursing being the sacrificial lamb where it’s failed, there’s got to be a better way, we can’t afford to lose everybody, and who’s going to do the jobs?’ (Participant B)

The participants described working in a different environment influenced by the legacy of the past failings of care at Mid Staffordshire NHS Foundation Trust and the impact on their roles with little support mechanisms:

‘I think it’s post Francis, you know we’ve now got the consultation out, that came out on Monday about “the fit and proper tests for Directors”,⁴ we’ve got the CQC new potential regulatory review, and I don’t disagree

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⁴ Strengthening corporate accountability in health and social care, setting out proposals for all directors of providers registered with the Care Quality Commission (CQC) to meet a new ‘Fit and Proper Person Test’. These proposals were to enable CQC to insist on the removal of directors that fail this fit and proper person requirement (FPPR).
with any of it, but there isn’t enough in the system to support Directors of Nursing.’ (Participant A)

‘Post-Francis paradoxes’ explained the interpretations and perceptions of the participants as feeling that additional monitoring, regulation and scrutiny of standards of care had inhibited and conflicted to a certain degree by detracting the participants’ workload from driving up standards of care, and this was the opposite of what was intended through the recommendations of the Mid Staffordshire NHS Foundation Trust Report. In addition to the paradox of reliance on intuition to give assurances of caring practices rather than the positivist approach mandated through regulatory processes.

There are three categories which support this theory of ‘Post-Francis paradoxes’ – ‘trusting my senses’, ‘avoiding becoming collateral damage’ and ‘being in a different place’:

‘I think the whole landscapes changed since the Francis Report really, it’s moved us into a whole different arena now.’ (Participant K)

4.6 Summary
This chapter has presented the findings from the research and the substantive grounded theory ‘Directors of Nursing perceptions of caring practices: post-Francis paradoxes’. The three categories are ‘Trusting my senses’, ‘Avoiding becoming collateral damage’ and ‘Being in a different place’. In keeping with a constructivist grounded theory, memos, diagrams and codes have been an integral component and used to determine the co-construction of the theory from the data, alongside an
exploration of the influence and impact of my own role both as a researcher and nurse in this process.

In chapter 5, there will be a discussion of the findings, with the main themes that have emerged from the data analysis. These will be explored, applying the three different levels of micro, meso and macro, alongside existing empirical and theoretical literature. An in-depth literature review was conducted during the analysis, building on the earlier literature review, and will be expanded upon in the discussion chapter to illustrate how the grounded theory builds on and develops current knowledge.
Chapter 5: Discussion

This research study is an interpretation of the perceptions of Directors of Nursing in NHS acute Trusts regarding caring practices. In chapter 4, there was a presentation of both the findings and the co-construction of a substantive grounded theory ‘Directors of Nursing perceptions on caring: Post-Francis paradoxes’. This grounded theory had three categories: ‘Trusting my senses’, ‘Avoiding becoming collateral damage’ and ‘Being in a different place’.

In keeping with the grounded theory approach a secondary literature review was undertaken as an integral part of the data collection and data analysis, and this literature, supported by the preliminary literature, will be interwoven throughout this discussion chapter. In this chapter there will be a critical analysis and discussion of the findings from this research. Caring practices will be described in the context of three levels; micro, meso and macro levels. There is a lack of consensus regarding a definition of context although Bate (2014) argues that “Context is everything... nothing exists, and therefore can be understood, in isolation from its context, for it is context that gives meaning to what we think and do” (Bate 2014:3).

Micro level context relates to the individual behaviours and responsibility for caring practices; meso-level context relates to the organisational and cultural impact; and thirdly the macro-level context describes the regulatory and political impact on caring practices (Baillie et al 2008).
5.1 Introduction

The overarching literature related to the context of the micro, meso and macro levels is mainly situated in organisational behaviours and quality improvement literature (Cappelli & Sherer 1991 & Robert & Fulop 2014). Although, Coleman (1986) proffers that macro–level explanads are underpinned by sociological theory and micro-level by psychological theory. It is argued that the meso-level is centred on organisational behaviour and culture, and as such is the ‘bridge’ between macro external level and the individual micro-level (Cappelli & Sherer 1991). It is suggested that “the middle step in the macro-micro relationship: is the environment that shapes organisational characteristics and phenomenon, which in turn shape individual behaviour and attitude” (Cappelli & Sherer 1991:89). Furthermore, perspectives of the differing levels in the system such as the micro, meso and macro levels, and the relationship between the levels is important in viewing the broader context of situations (1& Sherer 1995).

A further consideration is argued by Cappelli & Sherer (1991) who state that often micro-level individual behaviours are often seen in isolation to the external macro-level explanation. They argue that individual behaviours are created by the macro ‘context’. Hence, the three levels are interdependent and sensitive to the influence of each other’s impact. The external political context impacts on the organisational level cultures and in turn on the individual’s attitudes and behaviours and visas a versa.

An alternative perspective in the context literature to the three levels of macro, meso and micro, is outlined by Pettigrew et al (1992) who described the inner context (micro experience) and the outer context (macro experience). Pettigrew et al’s (1992) contribution identifies the interplay between the organisational behaviours
and cultures and the external social and political environment. Pettigrew et al’s argument is that the inner context is more likely to be managed and controlled compared to the outer context (Pettigrew et al 1992).

It is important to acknowledge that the three main levels of micro, meso and macro as described in this chapter are overlapping with each other; they are interrelated and should therefore be seen as the complex and interwoven perspectives of the Directors of Nursing on caring practices (figure 7). It is contested that the micro-level of individual behaviours such as kindness are influenced by the meso organisational, and macro regulatory influences, and vis a vis regulatory influences impact on individual behaviours such as kindness.

In the first section there will be a critical examination of the micro-level, exploring the Directors of Nursing’s perspectives of caring and poor practices at the individual level, focusing on the micro-level of emotional impact, moral distress, intuition and tacit knowledge. There will also be a critical analysis of the micro-level categories of ‘Trusting my Senses’ and ‘Showing a Continuum of kindness’. The second category considers the meso-level organisational and cultural impact on the role of Directors of Nursing, and in particular the perceptions of becoming ‘Avoiding becoming Collateral Damage’ and the ‘Sword of Damocles’. The third section focuses on the final category of the macro-level challenges facing Directors of Nursing and in particular the perceptions of ‘Being in a different place now’ and ‘Feeding the Beast’ centring on external regulation and the political context of the NHS system post-Francis (Francis 2013).
Figure 7. Macro, meso & micro levels as related to the Perceptions of Directors of Nursing on caring practices
5.2 Micro-level perceptions on caring practices

5.2.1 Introduction
In this section, the Directors of Nursing’s perceptions of the micro-level of caring practices will be critically analysed alongside ‘Trusting my Senses’ and ‘Showing a Continuum of Kindness’. The main findings were that participants trusted and placed reliance on their ‘senses’ in identifying individual level good and poor caring practices, and applied their intuitive skills and tacit knowledge to understand further about good and uncaring practices on the wards. It is therefore suggested that this reliance on their ‘senses’ supported their individual contributions in identifying standards of caring practices. Therefore, by identifying and understanding their own perceptions of caring practices as nurse leaders, they would be able to strive to improve standards of caring practices and reduce uncaring practices within their respective organisations.

5.2.2 Caring practices
A conjecture is offered that nursing staff are typically intrinsically and altruistically motivated to provide good care and enter into the nursing profession to support and help people. Corbin (2008) proposes that nurses are naturally caring and this may be the rationale for entering into the nursing profession. Stockdale and Warelow (2000:1261) agree that ‘it is beyond dispute that nurses should care and be caring’. However, as outlined in the literature review there are examples of care failings since the seventeenth century, which suggest that caring is more complex and cannot be explained by intrinsic motivation and altruism alone. The meso-level of organisational cultural behaviours and ineffective leadership can have a catastrophic impact on caring standards (Francis 2013; Hammond 2013; Walshe 2010).
The descriptions by participants of the caring practices of their nursing staff in the findings seem to be comparable and aligned with Tronto’s (1993:104) description of care as ‘both a practice and a disposition’. Where nurses are carrying out a particular interaction in a way that shows concern for the patient, patient-centred care would be one example of caring in this way, as the individual patient becomes the focus rather than the individual task. The ideals and values shared by the participants were important in setting the goals for standards of care in their organisations. In support, ideals, rather than being viewed as unobtainable ‘represent the values and aspirations of professional nurses’ (Maben et al. 2007:99).

‘Care can characterise a single activity, in this regard caring is not simply a cerebral concern, or character trait, but concerns the living, active humans engaged in the processes of everyday living’ (Tronto 1993:103). A similar interpretation of caring is found in Boykin and Schoenhofer’s (2001) description of ‘nursing as caring’ which defines the behavioural qualities of caring: honesty, being connected, entering into the patient’s world and being in the moment. These qualities were also evident in the participants’ accounts.

However, both Tronto’s (1993) model of caring and Boykin and Schoenhofer’s (2001) description of ‘nursing as caring’ focus more on behavioural qualities and character traits of the nurse in caring, whilst recognising the two-way relationship between the nurse and the patient. Corbin (2008) has suggested that the emotional aspects of caring must be supported by technical expertise to be most effective. Roach’s seminal work on caring, ‘the human mode of being’, also supports the view that the meaning of caring encompasses aptitude, practices and technical effectiveness (Roach & Maykut 2010). However, it could also be argued that these models of caring do not explore the possible meso-organisational cultural impact
and the macro external regulatory impact and environmental on nurses’ caring behaviours. The findings from this research indicate that there are occasions when the clinical metrics collected on the ward are incongruent with the ‘cues’ picked up during the Director of Nursing’s visit to the wards.

The literature reviewed in chapter 2 supports the view that there were different definitions of caring practices (Jasmine 2009; Law Harrison 1990; Leininger 1981; Phillips 2012). Corbin (2008:164) agreed that there is inherent difficulty in defining caring but disputed the position that caring is a lost art and stated that ‘caring is not lost, but an art at odds with many of the conditions under which nurses are working today’.

5.2.3 Poor caring practices

All the participants shared examples of micro-level poor caring practices that they had identified on the wards. They identified that their contribution to caring practices was to identify these practices and to support and develop staff to improve the quality of care. The participants shared examples of where the directly performance-managed staff fell short of the standards of care expected within the respective organisations.

One explanation of uncaring and unethical practices with a micro-level is offered by Jones (2010) who suggested that examples of poor caring practices may occasionally come from the unkind behaviours of individuals, and as such offers a differing view of the system impact of poor care, suggesting instead that individuals should take responsibility for their own actions. Conversely, Tronto (1993:133) argued for a ‘flexible interpretation of responsibility’ for care, as it is more complex
and often defined by gender and cultural roles. However, there are other explanations offered regarding uncaring and unethical practice. One of these macro-level external political conditions may be attributed to the changes in the nurse skill mix that have taken place, with a greater proportion of healthcare assistants at the patient’s bedside, whilst qualified nurses have taken on more leadership roles, undertaking managerial and operational responsibilities (Corbin 2008). A possible reason for this shift in roles and responsibilities may be argued as a move towards the professionalisation of nursing where, it has been argued, and there has been a devaluing of the basic essential nursing tasks such as washing and feeding (Corbin 2008). Bridges et al (2012) stated that organisations may also not value those caring activities which are more complex to measure, due to emerging quantitative patient outcome metrics in place. In addition, a policy shift has also occurred and was described by Iles and Vaughan Smith (2009:20) ‘as a shift away from “relational models” of care to “transactional models” of care where the patient is cared for rather than cared about’. There was also a change to health policy at this time with the discourse moving towards system efficiencies and productivity, coupled with a clinical grading exercise for nursing structures (Traynor 1999). This would suggest that this period was a time of change for nursing as a profession.

5.2.4 Emotional impact and moral distress

In examining the Directors of Nursing contribution to caring practices, it is important to consider the possible areas of impact on their nursing workforce’s role which may influence the sustainment, improvement and promotion of caring practices within their workforce. At the micro-level the emotional impact on nursing staff from caring can be significant and is linked to stress, burnout and withdrawal (Hopkinson et al 2003). ‘If nurses are able to care for patients that match their personal aspirations,
and are seen to be best for that patient, they experience feelings of gratification, personal enrichment and privilege’ (Bridges et al 2012:765). Smith et al’s (2009) study reported the importance of leaders recognising ‘emotional labour’ in their workforce as a method of identifying patient and staff safety. This research suggests that leaders have an important role in identifying the support required for their workforce to develop and sustain good quality and safe care (Smith et al 2009).

A different perspective on emotions at work was described by Jameton (1984) who defined moral distress as a phenomenon where a person is prevented or hindered from taking the right action that they wish to carry out. This could have an effect of emotional distress as the nurse may not be able to care for somebody as they would hope to, and this may cause staff stress and burnout. The effects of moral distress on the behaviours of healthcare staff have been well documented. McCarthy (2013:5) offered that ‘moral distress is a contested concept…, which acknowledges the role that emotions play in having a moral life and being a moral agent’. Corley (2002) described an incompatibility between the aspirations of the nurse and the external organisational pressure which can impact on the ability to deliver good care. The possible reasons for disconnect could be the system pressures, such as professional and organisational pressures as illustrated in Maben et al’s (2006) research findings. Schulter et al (2008) warned that the effects on staff of experiencing moral distress can impact on the mental well-being of staff. This could possibly manifest itself in staff exhibiting unkind and uncaring behaviours.

It could be argued that the Directors of Nursing may need to be cognisant of other possible factors impinging on caring behaviours and practices in the clinical areas. Providing ward to Board assurances for the standards of care within their organisations is a key element within their roles. Schein (2010) stated that culture
and leadership are intertwined. In support, therefore, governance is endorsed through leadership.

Uncaring and unethical practices may also be linked to moral distress, which may be associated with clinical areas of higher patient acuity on the wards, staffing shortages, and specific patient groups such as those patients with more complex needs. Additional explanations can be associated with a lack of resources or working in an environment which could undermine caring practices. One possible response to moral distress is for the nurse to withdraw from caring practices and implement what Mackintosh (2007:986) described as the ‘plastic shield’ used as a way of self-preservation by adopting a different persona. The protective ‘plastic shield’ may manifest in disengaged caring practices and withdrawal as the nurse tries to emotionally protect herself from the difficulties in the clinical area by disengaging from patients. Another important justification for understanding the impact of staff well-being is the established link to the micro-impact of caring practices and their effect on patients' experience of care. The Boorman Report on staff well-being and patient experience stated that 'we made clear links between staff health and well-being and the three dimensions of service quality: patient safety, patient experience, the effectiveness of patient care' (Boorman 2009:8). In support, Maben et al’s (2012) research which explored whether NHS staff well-being affected patients’ experience of care concluded that

‘there is a relationship between staff wellbeing and staff-reported patient care performance and patient-reported patient experience, hence seeking to systematically enhance staff well-being is, therefore, not only important in its own right but can also improve the quality of patient experience.’ (National Nursing Research Unit 2013)
In applying these findings to the current study it could be argued that there is an important role for the participants within their own organisations to support and lead initiatives that promote staff well-being so as to contribute to and support the micro-level improvements to caring practices.

The link is established between staff well-being, good patient experience and good outcomes and hence the importance of this approach. ‘Caring about the people who work in healthcare is the key to developing a caring and compassionate health service’ (Point of Care Foundation 2014:5). Clinical leadership at all levels and including Directors of Nursing can play a crucial role in nurturing and developing staff and in turn influencing standards of patient care. ‘The local climate is critical for staff wellbeing and high quality patient care delivery; team leaders have a critical role in setting expectations of values, behaviours and attitudes to support the delivery of patient-centred care’ (Maben et al 2012).

In summary, in this research study the Directors of Nursing shared examples of micro-level individual poor caring practices that they had observed on the wards. Their perception and interpretation centred on the nurses disengaging from their patients. The examples that were given included reduced eye contact, lack of good communication, and only engaging in the nursing task in hand rather than a holistic patient-centred approach to care. My argument here is that the identification of good and uncaring practices is an important contribution that the Directors of Nursing can make in providing ward to Board assurances. My reasoning is that the identification and management of poor caring behaviours will help to support a reduction in uncaring and unethical care, with the appropriate support and leadership.
In the next section, there will be an exploration of the micro-level individual reliance that the Directors of Nursing placed on their own ‘senses’ when assessing good and poor caring practices.

5.2.5 ‘Trusting my Senses’

At the micro-level of caring practices, the participants described how they trusted their own senses of sight, sound and smell, when seeking assurances of caring standards on the wards, but they also placed a high reliance on and valued their skills of intuition. Some of the participants found it more difficult to articulate what good caring looked like on the ward, but instead framed caring practices through the application of their senses and their ‘gut instinct’ and intuitive skills to support their descriptions of caring practices.

The process of nurse decision-making has been outlined as either systematic-positivist models or intuitive-humanist models (Thompson 1999). One of the positivist approaches is known as the ‘information processes model’ which proffers that the two areas of short- and long-term memory can be divided as based on ‘factual and experimental knowledge’ (Carnevali 1984; Thompson 1999). Criticism of the systematic-positivist model is that decision-making is not always seen as linear in practice (Thompson 1999).

Conversely, an example of an intuitive-humanist model is outlined in Benner’s (1985) novice to expert model. It is based on acquiring skills, and was originally established by Dreyfus and Dreyfus (1980) who described the preparation of helicopter pilots by using a combination of past experiences and a holistic perspective of situations (Meerabeau 1992). The model of novice to expert describes a progressive and incremental skills and expertise advancement which is
associated with length of experience in nursing and development of expertise (English 1993). It is argued that the expert nurse uses intuitive skills based on elucidation and perceptions of clinical scenarios and cues, and these skills are different from those used by novice nurses (English 1993). Novice nurses in contrast may use rules and systematic processes to support their early decision-making (Meerabeau 1992). Nursing knowledge is also influenced by direct perception ‘in that direct contact, awareness is increased through opportunities to select from a wide range of available auditory, visual and tactile information’ (Effken 2007:196).

Benner and Tanner (1987) concur with the view that intuitive skills are more usually used by experienced nurses in combining cognitive understanding, skills and experience. In support, Thompson (1999:1244) argues that the expert nurse no longer relies solely on ‘analytical principles to connect their understanding of the situation’. McCutcheon and Pincombe (2001:343) argue that the inherent difficulty in describing intuitive thinking has led some to consider that intuitive practice is somehow ‘unreliable and unscientific’.

The argument here is that the findings indicate that at the micro-level, the Directors of Nursing as experienced nurses are reporting that they use their intuitive skills when observing, interpreting and understanding standards of caring practices on the ward. Analysis of the data showed that the Directors of Nursing describe their perceptions of caring practices by using intuitive cues as a method of self-confirmation regarding the level of quality assurance on the wards. This is in contrast to the explanation of how a novice nurse uses knowledge, and might explain why there is a dissonance in what is observed on the wards, with the Directors of Nursing responding to sensory cues that are seemingly not picked up by the more inexperienced nurses. The participants were very experienced nurses so this explanation of using intuition would support why the participants placed reliance
and high value on intuitive knowing and trusting. The view that expert nurses use their perceptive intuitive skills is supported by the literature (Benner 1985; Benner & Tanner 1987; English 1993). A further facet to the role of intuition is how clinical leaders apply intuitive practice. Bacon (2013) has suggested that leaders can use intuitive intelligence to understand more about complex confusing situations and when a crisis is occurring. This can offer an insight into the findings of this research: if the Directors of Nursing are receiving many ambiguous cues on the wards about the standards of caring practices, they rely more heavily on their intuitive skills to make sense of the clinical situation they are observing.

An alternate view of how clinical situations are interpreted is described as a ‘feature-detection model’ whereby an experienced nurse through exposure to numerous typical sequential clinical events builds up a pattern anticipation and recognition (English 1993). Goodman (1980) described this as recognition of ‘atypical’ sequences of events. Thereby the experienced nurse who notices a change in expected clinical patterns will respond to these cues. The debate about evidence-based practice is at the heart of the debate on whether nursing is positioned as a scientific or artistic based profession. Criticisms of over-reliance on intuitive approaches to care centre on the view that intuition is less credible and is a less scientific nursing skill, largely because intuitive skills are difficult to quantify and measure and are juxtaposed against evidenced-based care (Truman 2003). English (1993) has stated that if nursing is to be seen as a scientific research-based profession it must place equal reliance of the evidence base, as well as intuition. Evidence-based practice provides a platform for ‘safer higher quality care’ (Sandström et al 2011:212). A literature review was conducted by Sandström et al (2011) and the findings revealed that there are three influencing factors on the implementation of evidence-based practice: leadership, organisation and culture In
summary, ‘evidence-based practice (EBP) requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care’ (Dawes et al 2005:1). McCutcheon and Pincombe (2001) urged nurses to be more explicit and transparent when using their intuitive skills and urged experienced nurses to express their use of intuition as a method of role-modelling with less experienced nursing staff. The participants in this study identified that they used their human senses and intuitive skills when assessing caring practices on the wards.

In the next section there will be further analysis building on intuition to explore the participants’ use of tacit knowledge.

5.2.6 Tacit knowledge

In exploring the research question pertaining to the Directors of Nursing’s understanding of caring practices, the participants were hesitant in defining caring practices per se. The observation that the participants had some initial hesitancy in defining caring practices may be explained by the view that some caring practices are seen as ‘tacit’ knowledge. Polanyi (1958) cited in Meerabeau (1992) described this entrenched knowledge as ‘tacit knowledge’. Tacit knowledge is outlined by Meerabeau (1992) in that the experienced practitioner cannot articulate these skills or distil them down into component parts. This view would concur with the findings from the research that the Directors of Nursing found it inherently difficult to describe caring practices; they did not try to reduce caring practices into fragments, but instead described how they applied their intuitive skills in assessing what good and uncaring practices looked like on the wards.
Although the Directors of Nursing found it difficult to articulate caring practices, they were able to offer examples of micro-impact caring practices by sharing vignettes of their nursing staff demonstrating patient-centred care. This included the use of therapeutic touch, being 'in the moment', communicating, delivering compassionate care and being kind to patients. Their perceptions of the values and ideals of micro-impact caring practices were focused on holistic, patient-centred, compassionate anticipatory care. They identified positive values and behaviours of the nursing staff in caring practices. A strong theme emerged specific to the value and trust placed by the participants in their intuitive skills in clinical practice. It could be argued that qualities of intuition and tacit knowledge can be important skills and attributes in nursing care. Directors of Nursing described caring practices in a way that was often 'tacit' and at an 'intuitive' level. They perceived that the nurses were demonstrating good caring practices if they were both anticipating and meeting the needs of the patient. Notably, rather than just attending to the immediate needs of the patient, they were working within a holistic framework, as outlined by Benner's work (Benner & Tanner 1987), which would suggest that they were recognising and valuing their own nursing staff who demonstrated the application of expert knowledge.

The participants found it easier to identify examples of poor caring practices on the wards. These poor practices included examples of staff disengagement, patients being ignored when calling for assistance, a non-anticipatory patient-centred caring approach, a lack of eye contact and poor one-to-one communication with the patient. These examples were in contrast to their ideal of good caring practices. The participants were able to categorise these as poor caring practices, and hence a dissonance occurred between their expected standards of care and the uncaring practices that they observed in the ward environment. The participants again placed
significant reliance on their skills of intuition and tacit knowledge to identify poor practices in the same way that they had with good caring practices.

In summary, the Directors of Nursing’s understanding of caring practices centred on relying on and applying intuitive skills to recognise and understand caring practices. Intuition and tacit knowledge were linked to the findings of the category ‘Trusting my senses’. The participants stated that they had a personal wish for patients to be treated with care and dignity, and that patients should also be safe from avoidable harm during their stay in hospital, and as such identified quality and safety as interlinked. The findings of this research are supported by the literature regarding the application of intuition and tacit knowledge in the most experienced expert nurses such as the Directors of Nursing in this research.

In the next section there will be a discussion about the identification of kindness in staff and how this was seen as a likely indicator of kind behaviours in caring practices.

5.2.7 Showing a Continuum of Kindness

The Directors of Nursing described how when they identified staff exhibiting kind behaviours to each other then there was perception that there was a likely continuum of kindness shown to patients. Therefore, they perceived kindness in staff as a barometer for caring practice. At the micro-level of caring practices, the findings revealed that a continuum of kindness was a recurring strong theme that was frequently shared by the participants. Valuing kindness and seeing kind behaviours were viewed as having a positive effect on caring practices on the wards. The participants identified that if the nurses showed kindness towards each other, they were seen as more likely to demonstrate a continuum of kindness and
compassionate care to patients and families. Hence, the continuum of kindness was seen to transverse from staff to patients alike. Kindness was closely aligned to caring practices, and frequently used by the participants in describing caring practices. The NMC (2015:4) code of professional conduct sets out the expectation in terms of behaviours of nursing staff, ‘Treat people with kindness, respect and compassion’. These values are also underpinned by the NHS constitution: ‘We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person’s pain’ (DH 2013:5).

‘Kindness has been described as ‘being sympathetic,…helpful or forbearing nature…and indicates what we are, who we are, and that we are linked together’ (Ballatt & Campling 2013:9). This definition gives the sense of responsibility towards one other through a connection. This view is supported by the findings of this research, in that staff that were identified or perceived to be kind and caring were seen as more likely to be kind to patients. Notably, the Directors of Nursing acknowledged kind behaviours between staff were more likely to act as a continuum towards patients, rather than the opposing way. It could be argued that this aspect of the findings makes a contribution to the body of research.

The overriding descriptor in recounting caring practices by the Directors of Nursing was kindness; however, it is not clear how the participants differentiated kindness from caring or compassion, or whether this was a unique attribute or one that was embedded within caring, compassion or other qualities. It could be suggested that it is the kinship element of kindness that sets it apart from the other qualities and maybe this is what the participants were describing. However, Ballatt and Campling (2013) observed that kinship is not developed between NHS staff. This view is of a society lacking in kindness, influenced by consumerism, selfishness and self-regard:
‘By the end of the Victorian period, kindness had been largely feminized, ghetto-ized into a womanly sphere of feeling and behaviour where it has remained’ (Phillips & Taylor 2009:41).

The findings illustrate that the participants highly valued the view of a continuum of kindness between nursing staff and subsequently patients. Their interpretation of kindness and the link to good caring practices was strongly appreciated, and kindness in staff as a barometer for caring practice. It is argued that in this research the continuum of kindness transcends from the micro-individual level to the meso-organisational level. Being kind to staff was symbolic as an indicator of likely kindness to patients which transcends to organisational culture. Ballatt and Campling (2013) have suggested that kindness should not be viewed as an easy-going and low-value quality, but rather as a ‘binding, creative, problem-solving force that inspires and focuses the imagination and goodwill’...."It inspires and directs the attention and efforts of people and organisations towards building relationships with patients, recognising their needs and treating them well' (Ballatt & Campling 2013:16). In applying MacIntyre’s (1984) description of practice in relation to this research study, it could be argued that internal goods were of importance in caring practices.

The continuum of kindness shown to the patient may be established through the notion of connectedness in care-giving. Tronto’s model has emphasised the separate aspects of caring phases whilst recognising the interconnectedness of the phases (Tronto 1993):

- *Caring about* – recognising a need for care;
- *Caring for* – taking responsibility to meet the need;
- *Care-giving* – providing care; and
•  Care receiving – evaluating the care.

In more recent years, there has been an emerging discourse in care and leadership, defined as intelligent kindness and a shift to including a focus on values-based recruitment. ‘Intelligent’ kindness is defined as having knowledge and skills in directing kindness (Ballant & Campling 2013). Notably, showing kindness was a theme that emerged from the participants’ perception of micro-level caring practices.

However, it could be argued that kindness as a concept may also transverse the meso and macro levels of caring practices. This may be seen through the values and behaviours of the Trust Board and organisational culture and the impact of regulation policy.

'What's needed is a change in culture in the NHS to ensure that everyone is treated with dignity and respect. This cannot be achieved by political fiat. Every hospital must create a climate in which staff are encouraged to treat patients as well as they can.' (Ham 2013:1)

In support, Jones (2010:2) argued that ‘every one of us has it in our own hands to act kindly towards our patients and each other’. This quote identifies the link between staff kindness and patient kindness as described by the participants in this research study. In summary, the Directors of Nursing perceived that staff that were kind to each other were more likely to demonstrate a continuum of kindness to patients and their families. This was seen as an important indicator in understanding and identifying caring practices. The ‘continuum of kindness’ was a sub-category of the category ‘Trusting my senses’
In this section the micro-level of the Directors of Nursing’s perspectives of caring and poor practices at the individual level were examined, focusing on the micro-level emotional impact, moral distress, intuition and tacit knowledge.

In the next section, there will be a discussion of the perception of the meso-level of organisational and cultural challenges perceived by the Directors of Nursing on caring practices.

5.3 Meso-level perceptions on caring practices

5.3.1 Introduction
This section provides a critical analysis of the perceptions of the Directors of Nursing of the meso-level of organisational and cultural challenges, focusing on the impact of the category of ‘Avoiding becoming collateral Damage’ and specifically the sub-category of the ‘Sword of Damocles’. The meso-level is defined as the organisational and cultural impact in relation to caring practices. The meso-level of organisational culture on caring practices is also interwoven with the macro-level of the regulatory and political agenda which is examined later in the chapter in section 5.3. The meso-level of the organisational culture on the Directors of Nursing was described as working in an precarious and unsecure environment where the perception is that your post is at risk if standards of patient care failed, this was highlighted by many participants as being challenging and difficult. The vivo code of experiencing ‘The Sword of Damocles’ describes the experience of waiting for their impending ‘career fate’ to be sealed. This section of the discussion will also focus also on the sub-category of ‘Navigating the Board’ adopted as a strategic approach of mitigating the meso-level of the impending anxiety associated with the ‘the Sword of Damocles’.
5.3.2 ‘The Sword of Damocles’

The Directors of Nursing perceived that they were designated by the Board and the NHS system to be individually responsible and accountable for the standards and quality of care within their organisations. The findings of this research supported this perception, which appears to have intensified following the changes to the external regulatory monitoring in the aftermath of the Mid Staffordshire NHS Foundation Trust inquiry.\(^5\)

At the meso-level of organisational culture there was a perception that their posts were at risk if standards of care are poor, this was described by many participants as being challenging and difficult. One of the challenges described by the participants was that if the standards of care were poor or failing within the organisation, then the likely consequence might be that they themselves could be at risk of losing their positions in the Trust. This perception and the associated feelings seemed to place the participants in a position of imminent vulnerability. The associated feelings that their positions were at potential risk may have contributed to feelings of insecurity about the sustainability of their personal career within the

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\(^{5}\) Much of the approach of CQC as a regulator has been informed by the events at Mid Staffordshire NHS Foundation Trust and other instances of poor health and social care. So the key features of our approach to the new registration system reflect our learning from those experiences and are…set out below:

- There should be a swift response to issues raised;
- The views of frontline staff, carers and above all people using services should be at the heart of our regulatory activity;
- A central regulatory activity should be (generally unannounced) inspection that focus on direct observation of care – talking to people using services, carers and frontline staff;
- We should seek to put information about services, including any concerns, into the public domain as soon as possible;
- We set out to be on the side of people using services – to inform and empower them; and
- Our regulatory model should be based on outcomes for people using services – not processes and policies.’ (CQC 2010)
Trusts. Most of the participants sought additional nursing workforce through the Trust Board as a method of trying to control the concerns about quality of care.

The participants expressed feelings of fear and peril that they might lose their executive nurse leadership roles. These feelings were associated with their perceptions and interpretations of the findings from the Mid Staffordshire NHS Foundation Trust inquiry. These findings are supported by Hayter (2013) who stated that the Mid Staffordshire NHS Foundation Trust inquiry put standards of nursing care and ‘nursing’ centrally into focus. It was not clear whether the participants’ perceptions of the peril and risk were based on assumptions, or whether they held tangible examples that led them to interpret this situation in the way they had. In response to these feelings of anxiety the Directors of Nursing seemed to gravitate towards the wards in order to seek greater assurances about the quality of care.

My argument here is that the feelings and experiences of the Directors of Nursing seemed to have the effect of creating worry and anxiety about the potential for uncaring practices within their organisations. My reasoning for this is that there was a perceived link between good standards of caring practices and the perception of the security of the role of Director of Nursing. The perceptions of peril were only expressed in relation to poor standards of care versus perceptions of doing a good job by maintaining standards of care, translated into being equipped to provide greater assurance to the Board and thereby aim to provide greater security for their roles as Directors of Nursing.

At the meso-level it is not clear from the participants whether there were overt expectations from the Board in their respective Trusts, regarding their roles.
However, it was clear that many of the participants felt great anxiety about the security of their posts if they were not able to safeguard the quality of care in their organisations. The impact of clinicians on Trust Boards was most noticeable in terms of clinical quality improvements with a doctor on the Board; however, the same was not found when nurses or allied health professionals were on the Board (Veronesi et al 2013).

However, Thorlby et al's (2014) study of NHS acute Trusts one year after the publication of the Francis Report concluded that many Boards and Executive teams were taking their responsibilities more seriously in terms of assurances of quality of care, including ‘walking the floor’. One possible explanation of why the Directors of Nursing described feeling anxiety is that of ‘displacement theory’, where external regulatory pressures may result in Board behaviours which transfer the anxiety to the participants as a method of trying to seek control of the quality standards in the Trusts (Ballatt & Campling 2013). This may be seen more often in a ‘command and control’ centralised model of external management. This has led to a fast-paced and time-pressured NHS environment, immersed in a culture of performance measurement, which may paradoxically be opposed to enabling compassionate patient care at all times (Mannion 2014).

The meso-level of the organisational culture of working in an environment where the perception is that your post is at risk if standards of care are poor, was described by many participants as being challenging and difficult. Many of the participants also expressed that the one area of quality on the wards that was most intensely associated with the feelings of anxiety and peril centred on securing the additional investment required to support the safer nursing staff ratios within their organisations. Improved staffing ratios were seen as a way to ‘safeguard’ standards
of nursing care and an area that the participants could take control of by leading this change and influencing the outcome. Securing additional investment required the participants to successfully submit business cases to the Trust Board. The uncertainty about outcomes of support for the business cases seemed to heighten the feelings of anxiety. Illingworth (2014) stated that since the Francis Report was published, the Foundation Trust Network had reported £1.2 billion worth of investment in care improvements, with staffing establishments accounting for 90% of this expenditure.

A study by Aiken et al (2002b) on the impact of registered nurses on patient mortality rates concluded that investing in additional qualified staff can reduce patient mortality and reduce staff burnout. Human factors are another area that can influence patient outcomes. Smith et al’s (2009) research cited recognition of staff emotions as extrinsically linked to patient and staff safety. In addition, Armstrong and Laschinger’s (2005) research on patient safety concluded that structural empowerment and positive cultures have a positive impact on patient safety.

The inquiry into the Mid Staffordshire NHS Foundation Trust revealed specific cases of failings in nursing care at Mid Staffordshire Hospital. These cases may have left a legacy of perceived heightened nursing responsibility in the participants’ role. In supporting this argument, there are other examples of role association and accountability for standards of care: the target of blame as a nurse executive was brought sharply into focus by the Healthcare Commission’s investigation into the outbreak of Clostridium difficile at Stoke Mandeville Hospital (Machell et al 2009). The findings from the research revealed that the participants were worried about whether their own roles or their peers’ roles would be safe, if standards of care failed or were of a poor standard.
Further at a union of the micro and meso-levels, the link between quality of care and security of the Board was disclosed by Machell et al. (2009:1): ‘failure to deliver the fundamentals of care can bring down an NHS Board faster than failures of either finances or performances’. However, the findings from the Mid Staffordshire NHS Foundation Trust inquiry concluded that a ‘shame and blame culture’ stifled innovation (Francis 2013). A conflict may occur in the nurse executive’s role, whereby they are equipped to provide Board assurance on the quality of care in the organisation, yet they are often blamed for quality standards and poor care (Machell et al. 2009). ‘Nurses can and should play a role in developing and monitoring those systems, where they are deficient, raise the alarm’ (Hayter 2013). The systems and levers to drive up quality of care based on an ‘incentive model’, whilst having a positive effect on improving measurable standards of care, may have some unintended outcomes. The unintended consequences are described as not achieving the desired outcome (Francis 2010). It is argued that one of the unintended consequences, as described by the participants in this research study, is the fear and anxiety surrounding potentially being unable to take time to lead and influence the quality of care to measurable outcomes, with the Board becoming nervous of the speed in improvements. Another example of unintended consequences is the impact of performance management ‘command and control’ which may raise fear of failure amongst individuals or teams, which has the reverse effect by ‘making staff more defensive and less emotionally available’ (Ballatt & Campling 2013:59). Buggins (2011:2) agreed that the ‘culture of the NHS is one in which an undercurrent of anxiety is endemic’. This view is supported by Gerada (2014) who stated that the current NHS culture is juxtaposed with the ethos of kindness and compassion, citing low staff morale, bullying and whistleblowing as indicators of poor organisational culture. These examples of the cultural challenges
in the NHS may signify that the Director of Nursing role is experiencing similar challenges to other roles in the NHS.

In summary, the participants described their perceptions of the meso-level challenges facing Directors of Nursing as the fear and anxiety associated with potentially losing their posts if standards of care failed within the Trust. There is a limited amount of literature specifically associated with the role of Director of Nursing. However, there have been two high-profile inquiries, where the Director of Nursing’s position has come under scrutiny following significant care failings, which support the experiences described by the participants. Machell et al’s (2009) study supported the findings in this research study, which highlights the participants’ anxiety and feelings of peril experienced in the Director of Nursing’s role, due to the potential for care failings. The fear of failure and the participants’ anxiety specific to the role of the Director of Nursing does not appear to be described elsewhere in the nursing literature, and therefore it can be argued that this is an area in which this research offers a contribution to the body of knowledge.

The next section focuses on the responses by the Directors of Nursing to this perception of role insecurity which was to look the Trust Board to try and secure investment into additional staffing in the organisation.

5.3.3 Navigating the Board

Most participants found some aspects of Board relationships challenging. Some of the participants strove to have strong alliances at the Trust Board; specific alliances focused on the Medical Director or the Director of Finance. There was a perception from some of the participants that the Medical Director role was most closely aligned to theirs as clinical leaders, so for some participants there was a desire to share the
quality and safety agenda with the Medical Director. As such they shared a ‘professional language’ on the quality and safety agenda. There was notable divergence in the participants’ perceptions regarding a potential alliance with the Finance Director. Some Directors of Nursing saw this alliance as crucial in gaining support for increased investment in staffing numbers and therefore key in supporting their aim to maintain standards of care within the Trust. Other participants perceived the roles of Executive Nurse and Director of Finance as having the most diverse and potentially incongruent portfolios, that of numbers and finance versus patients and quality.

It could be argued that a Trust Board has an inherent hierarchy and power structure with the differing Trust Board roles and responsibilities. One example of differing perceptions of roles and responsibility of the Nurse Executive on the Trust Board is described by Machell et al (2009), where the Nurse Executives were viewed as being the ‘guardians of quality’ at the Executive Board, rather than quality being seen as the responsibility of the ‘collective’ Board. Young (2000) described the Board authority and influence shifting within a hierarchal structure. The medical hierarchy within the organisation may be prevailing and requires a negotiating and resourceful leadership style to work alongside the hierarchy. Buse et al (2010) argued that variances in power within professional groups exist and doctors are often seen as having high status with access to finance and ability to successfully influence the organisation. Within each organisation it is argued that there are sub-cultures of groups and hierarchies that share similar cultural traits. It is also suggested by Davies et al (2000), using the medical professions as an example, that the prevailing culture can be influenced by external professional cultural issues as well as the cultural impact from inside the organisation.
Davies (2004) observed that nurses are still positioned as performing duties assigned by others, rather than showing complete autonomy. Positive patient outcomes rely on positive organisational cultures (Curran & Totten 2010). The King’s Fund (2012) demonstrated the benefits of effective leadership and positive engagement, as improved patient experience, reducing errors, lowering infection and mortality rates, a more viable financial balance sheet, improved staff morale and fewer staff.

There is divergence pertaining to the meaning of the term ‘culture’, centring on two main views as to the origins of culture. Firstly, a positivist view is that the concept of culture is the study of groups and originates from anthropology (Scott et al 2003; Smircich 1983). Garratt (2010) concurred that common practices within cultures are often preserved in rituals, customs and folk tales. Or, an alternative view is that culture is seen as a metaphor and co-exists alongside sub-cultures (Scott et al 2003). The culture of the NHS is made up of ‘basic values, shared beliefs, deep-seated assumptions and working practices that underpin how its staff behave’ (King’s Fund 2013:17). Historically, it has been argued that the prevalent culture within NHS organisations has been dominated by the medical profession; however, since the 1980s this has shifted to a managerially led model of NHS organisation. The 1980s saw an abundance of management literature on ‘organisational culture’ transcending many industry settings including healthcare (Davies et al 2000). Schneider (1994) defined four basic culture types: cultivation culture, control culture, collaboration culture and competence culture. In applying this model to the findings, it could be argued that when the participants were describing the anxiety about the security of their roles and that of their colleagues, they were more likely to be experiencing a control culture based on the perceptions of the power at the Board.
Schneider (1994) described this culture as hierarchal and focused on rewards and punishment approaches to Board control and power.

In summary, this section has presented a critical analysis of the meso-level perceptions of the Directors of Nursing on caring practices. The focus of which was the Directors of Nursing experience of living with fear of ‘The Sword of Damocles’ and the process of ‘Navigating the Board’ to secure additional funding to try and mitigate the risk of poor standards of care by aiming to secure additional nursing staffing resources in the clinical areas. However, the literature revealed that safer staffing and quality of care were multi-faceted, complex and interwoven with cultures and behaviours.

In the final section, there will be a critical analysis of the macro-level of the perceptions of the Directors of Nursing on caring practices, focusing on the regulatory and political environment in the post Francis era.

5.4 Macro-level perceptions on caring practices

5.4.1 Introduction

The next section focuses on the macro-level main challenges facing Directors of Nursing which they perceive to be impacting on caring practices. Macro-level is defined as the role of government policy and in particular healthcare regulation, in relation to the impact on Directors of Nursing in sustaining and promoting caring practices.
5.4.2 Regulation

All the participants described the macro-impact challenges that the organisational regulatory bodies were having on their roles as Directors of Nursing, within their respective Trusts. The impact of regulation on the role of the participants was a strong theme that emerged from this study and was supported by the sub-category of *feeding the beast* (an in vivo code) and the category of *being in a different place*. The three main groups that fulfilled the participants’ definition of ‘regulators’ were organisational regulators, professional regulators and Clinical Commissioning Groups (CCGs). It is of interest that three of the participants were employed by NHS Foundation Trusts. The changes to regulation following the Francis (2013) recommendations is that all NHS Trusts, including NHS Foundation Trusts, are assessed for quality through a single process of the Care Quality Commission (CQC) inspection regime. The participants described the impact of the ‘bewildering’ bureaucratic system on their roles in trying to manage the assurance processes.

The participants are describing a two-fold fundamental problem with the regulation process from their perspectives, an increased bureaucratic system which is causing an additional time burden on their roles, and a fundamental shift required to buy-in to the regulatory model as an assurance framework.

The individual regulatory bodies that were referred to by the participants included the CQC, the Trust Development Authority (TDA), Monitor and the local CCGs. Most of the participants surmised that the increased level of regulation was an inevitable legacy following the recommendations from the Mid Staffordshire NHS Foundation Trust inquiry. There was also a perception held by the participants that the Director of Nursing holds the remit for quality within the organisation and it follows thereby that they would be at the forefront of the relationship with the regulator. This view is supported by Thorlby et al/s (2013:6) research conducted with one NHS acute Trust.
one year following the publication of the Mid Staffordshire NHS Foundation Trust inquiry, which concluded that the Trust reported ‘greater pressure from external bodies seeking quality assurance in the wake of the Francis report’.

A few participants also described their perceptions of fear and worry about being referred to the professional nursing regulatory body, the Nursing and Midwifery Council (NMC), under the ‘fitness to practise’ agenda. They described how they were fearful that they could lose their jobs or livelihoods if they were held accountable to the nursing profession’s regulator. Thorlby et al’s (2013:6) research supports this perception that the external monitoring could feel ‘punitive at times’. One possible reason for an increased level of regulation could be the post Mid Staffordshire environment, where the system could be described as nervous of another systemic failure in the NHS which would further erode public confidence. Around and since the publication of the Mid Staffordshire NHS Foundation Trust Report (Francis 2013), there have been reports of continuing egregious care failings, including at Winterbourne View Hospital in 2012 (DH 2012b) and the independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital (Andrews & Butler 2014). In discussing the impact of regulation on the role of the Director of Nursing it is important to set the context within the political landscape.

Since the establishment of the NHS in 1948, health service funding has come almost entirely from government taxation. As a state-funded service there is an intense amount of political pressure about the way the NHS is managed and how care is both delivered and provided. Following the exposure of above-average death rates in children’s heart surgery at the Bristol Royal Infirmary (public inquiry report: Kennedy 2001), the Labour Government legislated in 1999 to set up the
Commission for Health Improvement (CHI) with a mandate to offer support to NHS Trusts on clinical governance (Gillam & Siriwardena 2014). The Care Quality Commission (CQC) superseded the CHI and other smaller regulators in 2009, driven by the mandate to reduce the number of regulators. The introduction of regulators was seen to be monitoring standards of care although it could be argued whether this aspiration has been consistently and successfully met:

‘A commitment to delivering high-quality safe healthcare has been a policy goal of governments worldwide for more than a decade, but progress in delivering on these aspirations has been modest.’ (Dixon-Woods et al 2014:106)

In November 2012 a political reaction to the Mid Staffordshire NHS Foundation Trust failings of care was pronounced by the Rt. Hon. Jeremy Hunt as a ‘crisis in standards of care that exist in parts of the health and social care system’ (DH 2012c:1). An independent review was declared to explore new methods of assuring the quality of care including an Ofsted-style star rating for providers of care. The remit was that any proposed new ratings system should have:

- no increase in bureaucracy;
- clear, simple results that patients and the public can understand – driving organisations to excel rather than just cover the basics; and
- greater certainty that poor care is identified early. (DH 2012c:1)

The political clamour around standards of care following Mid Staffordshire NHS Foundation Trust inquiry was significant in addition to politicians’ assertions about solutions to care failings. There was heavy scrutiny of the standards of nursing care, with vivid accounts disclosed of patients being neglected, or treated with cruelty and
lack of care and compassion (Francis 2013). There was also a strong patients’ voice through the Patients Association (PA) that emerged at the time of the inquiry and created a ‘watershed’ moment in the NHS (Owen & Meikle 2013). The campaigning ‘cause groups’ and the patients’ voice were a crucial element in the uncovering of failings at the Mid Staffordshire NHS Foundation Trust, led by Julie Bailey, a bereaved relative of a patient who died at Mid Staffordshire NHS Foundation Trust. Hayter (2013:1) argued that the failings at Mid Staffordshire NHS Foundation Trust Hospital ‘put the quality of nursing care in the spotlight’.

The government responded to the failings by ordering two inquiries into care failings led by Robert Francis QC. Following the publication of the findings from the Mid Staffordshire NHS Foundation Trust inquiry, a contradiction and tension occurred between the government’s ambitions to keep bureaucracy at a minimum, whilst proceeding to introduce an additional patient assurance framework as a requirement for all NHS provider Trusts. This monitoring included an overhaul of the Care Quality Commission inspection model and outcomes framework, and the introduction of the ‘friends and family test’, which was designed to put the patients’ voice centrally within the quality assurance process. Both of these changes were in response to the rhetoric surrounding failing patient care.

Regulation has historically been linked to managing the economy; however, more recently it has also been ‘applied to social arenas including health and safety, environmental and consumer protection’ (Quick 2011:4). Regulation is regarded as a method of governing by managing ‘market failures’, using a ‘rules and rewards model’ supported by penalties and sanctions imposed by the government (James 2000). Salter (1999:149) categorises regulatory tasks into ‘standard setting, monitoring, evaluating and intervention’. It is widely accepted that regulation is a
form of mechanism to modify behaviours (Ogus 1994). Governance systems are designed to “support regularized control—whether by legitimate hierarchy or by non-legitimate coercive means” (Scott et al. 2000:21). Further, it has been argued that the proliferation of regulatory bodies ‘reflect[s] a public interest view seeing it as a means to mitigate government failures and improve public welfare’ (James 2000:328). However, Berwick (2013) warned that the ‘current NHS regulatory system is bewildering in its complexities and prone to overlaps of remit and gaps between different agencies’. In support, Trubek et al. (2008) have suggested that the proliferation of regulators has created some duplication and confusion in responsibility with the remit to monitor and encourage behavioural changes. Bilton and Cayton (2013) have stated that although the role and methodology of the regulators are similar, they differ in their scope and remit, with ‘no consistent application of risk in determining which occupations are subject which level of assurance’ (Bilton & Cayton 2013:5). Despite the proliferation of regulation practices the participants did not express a belief that assurance frameworks implemented by the regulators would improve the quality of care within their organisations. Dewar et al. (2013:1743) stated that there is a ‘potential misconception that focusing energy and attention on additional audit and inspection activities will eliminate care lacking in compassion’. This view would seem to support the perceptions described by the participants.

Bilton and Cayton (2013) argue that the regulation of products is more straightforward than regulating professional behaviours, where there is little evidence of a positive association of improving professional behaviours solely through regulation. Quick (2011) reviewed many studies on the effects of health professional regulation on those health professionals and concluded that regulation is only one component of improving outcomes. In contrast, Meleyal’s (2011)
research involving social workers concluded that regulation can have the opposite effect, with undesired results. However, the overall aim of regulation is to provide:

‘[a] sustained and focused attempt to alter the behaviour of others according to defined standards or purposes with the intention of producing a broadly identified outcome or outcomes, which may involve mechanisms of standard-setting, information gathering and behaviour modification.’ (Black 2002:20)

A paradox has emerged however from the narratives of the participants, which throws doubt on the potential positive benefits of improving quality of care by regulating the system in this way. The perceptions of pressure and further scrutiny, impacting on their roles by additional reporting to the regulatory body, became a distraction from the other elements of their roles. They perceived that they had an increased multiplicity of work providing evidence and outcomes, which then reduced their ability to strategically drive forward quality improvements within the Trust. Managing the impact on their roles from the additional regulation was causing difficulty and tension and some of the participants saw this as adding bureaucratic burden on their roles. At the centre of the participants’ perceptions of regulation was the paradox that additional regulation might not be the panacea to improve quality of care.

A perspective as to the possible origins of a disconnect between the benefits of regulation versus the burden in providing regulatory evidence may be found in the narrative and interpretation from the Mid Staffordshire NHS Foundation Trust inquiry findings. Hayter (2013) pointed out that the findings revealed a culture at Mid Staffordshire where quantitative data on quality was accepted whilst the soft intelligence pertaining to quality such as patients’ feedback and staff concerns was ignored. A participant spoke about the tension between getting the balance right
between providing the assurance and audit and leading quality improvements within the Trust. The findings from the Mid Staffordshire inquiry warned of ‘standards and methods of measuring compliance which did not focus on the effect of a service on patients’ (Francis 2013:4). This interpretation of the potential perils of loss of confidence in meaningful elements of the quality assurance mechanisms for feedback seems to be supported by the participants’ views, the inherent risk being that processes and outputs would take precedence over the ‘softer’ metrics of quality, safety and patient experience.

An additional complexity to the system came through the recommendations of the Mid Staffordshire NHS Foundation Trust report, as commissioners were criticised for not responding to reports of failing standards of care at Mid Staffordshire Hospital. It could be argued that this was an example of regulatory failure. The subsequent abolition of Primary Care Trusts (PCTs) in favour of Clinical Commissioning Groups (CCGs) also created some instability in the system, with newer relationships needing to be established between providers and commissioners. Some of the participants expressed the view that they felt their relationships with the CCGs were difficult in that there was an additional level of local assurance which is a more recent requirement. The participants described most anxiety and frustration at the process of perceived bureaucratic monitoring, one participant highlighting that this feels like ‘we’re feeding the beast’ and ‘we’ve got the CCG crawling all over us’. The reference to insatiability in feeding the beast was described as feeling that no matter how much evidence was supplied to the regulators as quality assurance, the system would not be assured. There was a continuous requirement for more evidence to another regulator in the system, as a perpetual cycle. Power (1997) has outlined the expansion of monitoring through regulation since the 1990s and coined the phrase ‘audit explosion’ in response to government policy. This description would seemingly
support the participants’ perceptions in this study, although they perceive that the ‘explosion’ of monitoring has come about since 2013 and the publication of the Mid Staffordshire NHS Foundation Trust inquiry.

Benson et al’s (2006) research used a stratified random sample of thirty NHS Trusts, looking at the outputs from clinical governance reviews conducted by the Commission for Health Improvement (CHI). The aim of the research was to examine documents to ascertain if Trusts were expected to implement the changes recommended by CHI. The findings revealed evidence that there had been a positive outcome to the CHI process, although the research was unable to conclude that these outcomes had been transformed into improving patient care. Wakefield et al’s (2010) research in Australia explored the factors that predisposed to patient safety orientated behaviours by allied health professionals, nurses and doctors. The findings revealed two overriding influencing factors for improving patient safety: firstly, ‘professional peer behaviours’ observed through role modelling in the clinical environment and secondly, ‘preventive action belief’, a confidence in the safety outcomes from the behaviours. Wakefield et al’s (2010) research resonated on one level with this research study by valuing the role of credible clinical leaders in supporting and developing staff. In summary, few studies have explored the direct relationship between regulation and improved patient outcomes, and ‘reflects the difficulties involved in seeking behaviours out, given the myriad of other sources of influence’ (Quick 2011:3).

An alternative perspective into regulation is offered as the deterrent theory. Quick (2011) stated that in tort law the threat of litigation is viewed as a deterrent, for example, the fear of the consequences of underperformance drives up standards. Conversely, ‘fear is toxic to both safety and improvement…incorrect priorities do
damage: other goals are important, but the central focus must always be on the patients’ (Berwick 2013:4). Furthermore, behaviours related to deterrence may manifest as defensive practices or behaviours appealing to the rational actors who in trying to avoid litigation will implement protective behavioural strategies (Quick 2011). The concept of defensive practice is seen as a by-product of the impact of regulation on healthcare professionals by favouring practices centred on ‘meeting the target, but missing the point’. This then can lead to modified practices to avoid penalties and consequences. Alternatively, imposing financial penalties may drive a system to improve. Some of the participants outlined the impact of the deterrent on the individual through the professional regulatory bodies, with the fear of losing their professional registration and facing possible corporate manslaughter charges in the extreme as repercussions of failing care in their organisations. The findings from McGivern and Fischer’s (2010) research into perceptions of regulators, using a purposive sample, concluded that the ‘blame business’ was inevitable in regulating patient care. Quick (2011) argued that whilst there are several limitations in this research study including the sample size, it does however offer an insight into the concept of ‘defensive medicine’ where clinical practice is modified to reduce the likelihood of disciplinary redress. Quick (2011) also argued that deterrence is a risk to individual autonomy, and fails to accept the role of individual choice, and suggested that deterreents may be seen as more successful when applied to systems and organisations, rather than individuals.

In summary, the impact of regulation on the role of the Directors of Nursing at the macro-level was a strong theme that emerged from this study and was supported by the sub-category of Feeding the Beast’ (an in vivo code) and the category of Being in a Different Place’.
The findings of the report on the failings of care at Mid Staffordshire NHS Foundation Trust propelled standards of nursing care to the forefront. An emerging incongruence as to the perceived value and confidence of the mechanisms of regulation to improve quality of care has combined with the burden to continually provide data to an insatiable regulatory audience. Notably, the participants’ executive range of responsibility and accountability regarding quality outcomes of caring practices had increased in recent years. The rationale for this was viewed as a paradox following the Mid Staffordshire NHS Foundation Trust findings. The paradox centred on a government policy to reduce bureaucracy at Trust level, when instead the perception was that the converse had occurred and this impacted at a local level on the participants’ role in providing local assurances. The overriding tension was the participants’ belief that although there was an inevitability to additional regulation, this was impacting on the time for the participants to successfully develop as clinical leaders and drive up standards of caring practices within the Trust. My argument is that the experiences of the participants were related to the perception of additional pressure and the strain of external monitoring. My reasoning is that this manifested itself in the feeling that each different regulator had differing requirements for data and submission which caused an additional burden to their roles. The argument is supported by the literature which agrees with the participants’ perception that there has been an increase in the amount of regulation and monitoring of the NHS system for providers (Berwick 2013).

In this section, the macro-level of the regulatory and monitoring bodies in relation to caring practices and the role of the Directors of Nursing were critically explored.
5.5 Conclusion

In this chapter, the impact on Directors of Nursing perceptions on caring practices have been critically explored using the micro, meso and macro-levels. It has been identified that the three levels of are not mutually exclusive of each other as they transverse through the different levels through a relationship of interconnectivity.

The aim of the research was to develop a theory to gain a deeper understanding of the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices. The discussion suggests that the Directors of Nursing as senior, expert nurses placed great trust and reliance on their own intuitive skills and tacit knowledge to understand caring practices, and to provide quality assurances at the micro-level regarding caring practices. If the Directors of Nursing observed micro-level caring practices on the wards that were incongruent in some way, a hierarchy of overall trust was placed in intuition over other senses or clinical metrics. These findings support the earlier work on intuition and the expert practitioner by Benner (1985), Benner and Tanner (1987) and English (1993). The participants also valued a continuum of kindness in staff, those who showed kindness to each other being perceived to be more likely to be kind to patients.

At the meso-organisational level the participants experienced anxiety as to the security of their posts, this appeared to be linked to the findings following the care failings in Mid Staffordshire NHS Foundation Trust (Francis 2013). One of the findings most pertinent to the Directors of Nursing role was related to safer staffing numbers. Seeking additional Trust funding to increase the nursing establishment was seen as a way of safeguarding the quality of care on the wards. However, the literature did not support the view that increasing staffing establishments would by itself improve caring practices. This specific aspect, related to the anxieties
experienced by the Directors of Nursing, is an area in which this research offers a contribution to the existing body of knowledge.

Finally, at a macro-level of regulation a paradox emerged centring on the impact of regulatory processes on the ability of Directors of Nursing to function at a local operational level. The paradoxical effect occurred in that driving up quality at a local level impacted on the participants' roles, fuelled by the requirement to feed the ‘insatiable’ appetite of regulators. This finding is supported by Bilton and Cayton's (2013) view of the impact of the ‘bewildering bureaucratic system’. The impact was felt on their roles in trying to manage the assurance processes. The overriding tension was the participants’ belief that although there was an inevitability to additional regulation, this was impacting on the time available for the participants to successfully develop as clinical leaders and drive up standards of caring practices within the Trust. The Directors of Nursing described how they perceived their roles to include trying to restore the nursing profession’s identity following the exposés of care failings. This focused on the belief that nursing was a trustworthy and credible profession, in contrast to the backdrop of exposés of neglect and cruelty that are left as a legacy within the public sphere.

This study captures a challenge, as perceived by Directors of Nursing, regarding how macro-level external regulatory demands can be accommodated alongside the meso-level internal organisational requirements, to lead the micro-level improvement agenda of patient care standards.

In the next chapter, there will be the conclusion and recommendations from this research, along with an exploration of the contribution of this research and the limitations of the research.
Chapter 6: Conclusion and Recommendations

In this chapter there will be a summary of the key findings from this research, and a presentation of the distinct contribution to the current knowledge that this study offers. There will also be an exploration of the strengths and limitations of the study, a critique of the grounded theory approach and recommendations for further research, education and clinical practice.

Through a process of reading and critiquing the literature on caring practices, and through undertaking this research focusing on interpreting the perceptions of the Directors of Nursing in NHS acute Trusts, this research journey has been both fascinating and challenging. Reflexivity has been an important component of this journey, as I have reflected in depth about my own feelings, values and assumptions about both caring and uncaring practices. I now have a greater understanding and appreciation of some of the complex interdependencies impacting on caring practices. These interdependencies include the macro level regulatory system, the meso level organisational and cultural, and the micro level impact on caring practices at the ward level. Gaining a broader insight into the differing perspectives and the complexity of caring practices has also highlighted the essential role and association that nurse leaders have in supporting and sustaining caring practices.

6.1 Summary of the Key Findings

Constructivist grounded theory aims to explore and interpret how and why participants construct meanings of their worlds (Charmaz 2014). It is acknowledged that this interpretative approach to grounded theory does not facilitate the researcher to stand aside from the phenomenon; rather that it is symbiotic with the researcher’s interpretation of the participants’ world (Charmaz 2014). This study
offers a grounded theory of Directors of Nursing in NHS acute Trusts, perceptions on caring: post-Francis paradoxes. This interpretation from the findings conveys that several paradoxes have arisen since the publication of the recommendations from the Francis Report into care failings at the Mid Staffordshire NHS Foundation Trust (Francis 2013). The paradoxes centre on describing a contradictory consequence of an unintended outcome; in this, a paradox which inhibits as opposed to improving standards of caring practices. A contradiction has occurred with more statutory monitoring, a newer framework of regulation and increased scrutiny seemingly hampering, inhibiting and over-burdening the system. This has led to an insatiable requirement to monitor and produce statutory evidence of improving standards of care which is diametrically opposed to the Directors of Nursing’s reliance on intuitive practices as opposed to positivist regulation. The paradoxical problem has two facets: the need to produce reliable high-quality assurance in the system about standards of care, whilst not detracting and impacting on those nurse leaders’ roles that are essential to raising standards away from internal assurance processes.

Underpinning the theory are the three categories of ‘trusting my senses’, ‘avoiding becoming collateral damage’ and ‘being in a different place’. Trusting my senses described how the participants placed more trust and reliance on the ‘softer’ metrics of caring practices and in the ‘sixth sense’ of intuition. They also used their intuitive skills to identify and manage poor caring practices and described how they used their senses as warning systems to identify failing care to the Board. Avoiding becoming collateral damage described the fear and anxiety of the participants that their posts would not be secure unless standards of care were maintained within the hospital. This anxiety was linked to a perception that securing an increase to staffing establishment would safeguard against potential failings as reported at Mid Staffordshire NHS Foundation Trust. The final category of being in a different place
was interpreted from the narratives that described how things have changed for the Directors of Nursing following the Mid Staffordshire NHS Foundation Trust Inquiry. Additional pressures were experienced by the participants as they tried to balance the competing priorities of their Executive roles, statutory monitoring, external regulation, as well as leading the internal improvements to quality standards of caring practices.

6.2 What is the Contribution of this Research Study?

The study confirms that experienced senior nurses such as Directors of Nursing relied on their skills of intuition when assessing the quality and standards of caring practices on the ward. However, this research would suggest that there is also a reliance on intuition when seeking reassurance about caring practices more broadly on the wards. This was particularly so when the Directors of Nursing attended and observed the nursing staff on the wards to seek assurances about the standards of nursing care, by observing staff’s interactions with patients. Senses were relied upon as well as intuitive feelings and instincts about good or uncaring practices. Notably, there appeared to be more reliance on instincts than on measurable ward clinical metrics. In a hierarchy of ranges of information about standards of care on the wards, ‘intuition’ was seemingly the default position adopted by the Directors of Nursing.

It is suggested that there are several distinct contributions that this research offers. Firstly, it notes the creation of paradoxes in the post-Francis era, because of the contradictory impact of additional regulation and monitoring on the role of Directors of Nursing, whereby the intention is through regulation to create and safeguard the quality of care and try and prevent future failing. The contradiction has arisen in that
there was an increased insatiable requirement for documentary evidence to be presented to the numerous regulatory parties. This is contested as having the effect of over-burdening the role of Directors of Nursing, which has impacted on their operational and strategic roles of leading improvements to patient care. This positivist approach to monitoring and regulating care is opposed to the interpretative approach of intuition applied by the Directors of Nursing.

A second contribution is the Directors of Nursing’s identification of a continuum of kindness in their staff, which is perceived as an indicator of staff more likely to be kind to the patients. This is important in understanding more about what influence the Directors of Nursing can have on caring practices at the ward level if kindness is nurtured and supported to flourish. Equally, they can make an impact by putting in support mechanisms and monitoring staff that are perceived to be demonstrating less kind behaviours, to help prevent uncaring behaviours from developing.

Finally, this research proposes that the Directors of Nursing experience feelings of anxiety about the security of their own roles, in anticipation that caring practices might fall below standards in the organisation. The research also suggests that the Directors of Nursing use their skills and relationships at the Trust Board to try and mitigate against this perilous situation by securing additional investment in the nursing workforce.

6.3 Limitations of the Study

One possible limitation of the study is the sample size of 12 participants, out of a possible 160 Directors of Nursing in NHS acute Trusts in England. However, in this
grounded theory study, data saturation was achieved with the sample size of 12 participants. Saturation was achieved when there were no new properties coming from the data which gave further insights into the theory. It could also be argued that a second limitation is that those Directors of Nursing who wished to share their own experiences of caring practices were possibly more likely to have come forward to be included in the study, compared to those who did not wish to share their experiences. Therefore, it is possible that these perceptions may not be representative of all Directors of Nursing in NHS acute Trusts in England. It is also possible that the views of the equivalent Director of Nursing roles in large acute Trusts in Wales, Ireland and Scotland might be similar or indeed different to their England counterparts. Another limitation of the study was that although the inclusion criterion was for NHS acute Trusts, it would have been interesting to extend this research to other NHS providers such as community Trusts and mental health Trusts, and also the private sector. This could be a basis for further research into this area.

The rationale for selecting a constructivist grounded theory approach was that a core tenet of the constructivist approach is that concepts are *constructed* as opposed to *discovered* as with classic grounded theory (Evans 2013). This approach allowed for my own interpretations of the perceptions that were shared with me by the Directors of Nursing. In researching some sensitive areas relating to caring practices, one should not under-estimate the courage and trust that participants placed in me when sharing their own experiences and perceptions.

On reflection it is possible that I was more sympathetic as a nurse in listening to the stories that were shared with me; or as a previous Nurse Director I was more or less ‘in tune’ with the experiences that were shared. On a few occasions during the
interviews the participants reached towards my role as a nurse ‘you know how it is’ or ‘you know when you do…’ I perceived that this may have been a way of reaching out for affirmation of their stories and experiences, especially when sharing more sensitive themes. I kept a detailed reflective journal and research diary which I used to support my reflexive stance. On reflection the co-construction approach facilitated the co-construction of data and my position as a researcher in the process.

In the next section, there will be a critique of the grounded theory approach for this research study, followed by a presentation of the recommendations for further research, education and clinical practice.

6.4 Critique of Grounded Theory

The overall aim of this research was to adopt the constructivist grounded theory method to study the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

Constructivist grounded theory aims to develop a comprehensive understanding of the underlying social and psychological processes within a certain context (Gardner et al 2012).

A substantive grounded theory was established, namely, ‘Directors of Nursing perceptions on caring: post-Francis paradoxes’. The three sub-categories linked to the theory were ‘trusting my senses’, ‘avoiding becoming collateral damage’ and ‘being in a different place’. In keeping with a constructivist grounded theory, memos, diagrams and codes were an integral component and used to determine the co-construction of the theory from the data.
The rationale for selecting grounded theory was the limited amount of published literature pertaining to this area of interest. The constructivist grounded theory method was used as it takes into account the researcher’s position and that of the participant. On reflection I feel that this approach was a particular strength of the research method in facilitating co-construction as I have previous experience as a Nurse Director. It is argued that an alternative approach of adopting objective positioning and an ‘empty head’ with no preconceived ideas from the classic grounded theory (Glaser & Strauss 1967) would not have been symbiotic with my ontological and epistemological positioning.

In evaluating grounded theory, Charmaz (2006:181) described that by evaluating research ‘we look back into our journey and forward to imagining how our endpoint appears to our readers and viewers’. In table 3, an abridged version of Charmaz’s criteria for evaluation (2006:182) is applied in evaluating this research study to demonstrate evaluation of the research.
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Justification to this research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility</td>
<td>'Has your research achieved intimate familiarity with the setting or topic?' Through in-depth semi-structured interviews. Through systematic coding, sub-categories and categories leading to the theory. Familiarisation with the current literature.</td>
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<tr>
<td></td>
<td>'Have you made systematic comparisons between observations and categories?' Through coding processes – creation of categories and co-construction of theory. Use of memos throughout to show thinking and interpretation.</td>
</tr>
<tr>
<td>Originality</td>
<td>'Are your categories fresh?' New insights into Board relationships and feelings of anxiety experienced by Directors of Nursing regarding standards of care.</td>
</tr>
<tr>
<td></td>
<td>'Do they offer new insights?' Insights into the use and application of intuition in assessing good and unethical caring practices.</td>
</tr>
<tr>
<td>Resonance</td>
<td>'Do the categories portray the fullness of the studied experience?' The perceptions are described at a micro, meso and macro level.</td>
</tr>
<tr>
<td></td>
<td>'Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?' The main emerging categories of my research have been shared informally with some Directors of Nursing. I believe that deeper insights into the worlds of Directors of Nursing will be gained through disseminating this research.</td>
</tr>
<tr>
<td>Usefulness</td>
<td>'Can the analysis spark further research into other substantive areas?' The experiences of Board members following severe egregious failings, e.g. industry such as aviation, or oil disasters. More research into the application of intuition to support decision-making by senior staff.</td>
</tr>
<tr>
<td></td>
<td>'How does your work contribute to knowledge? How does it contribute to making a better world?' It contributes to a greater understanding of the impact on Directors of Nursing working in an era post failings at Mid Staffordshire NHS Foundation Trust. It also contributes by offering an enhanced understanding about how Directors of Nursing use their skills in the clinical areas to assess good and uncaring caring practice. Enhancing the understanding of the continued reliance on intuition could support other members of the clinical team to assess good and uncaring practice.</td>
</tr>
</tbody>
</table>

Table 3. An abridged version of Charmaz’s criteria for evaluation (2006:182)
6.5 Recommendations for Further Research

1. Further research could consider a longitudinal study of Directors of Nursing in NHS acute Trusts’ perceptions of caring, to explore the longer-term issues and impact on these roles. This could include an exploration of whether the perceptions of ‘being in a different place’ continue over time, and if there are any other possible long-term implications following the Francis Report for the role of Directors of Nursing. This could consider if the perceptions of ‘feeding the beast’ and the impact of regulation on the role of the Director of Nursing diminishes over time, or remains heightened and linked to fears over the security of their roles.

2. Additional research to explore whether confidence remains high in the Directors of Nursing over time that additional staffing investment has brought about the clinical assurance they were seeking from the Francis recommendations. Building on existing nursing ethics research could explore in greater detail the perceptions of Directors of Nursing regarding ethical leadership, moral distress and ethical climate, and could consider other possible variables such as staff competency, training, ward skill-mixing, organisational culture and burnout.

3. An in-depth observational study of Directors of Nursing exploring the possible relationship between the increased use of and reliance on intuitive skills following failings in care. Exploring how the whole spectrum of evidence can work better alongside each other, focusing on the relationship between clinical metrics and ‘soft intelligence’ or ‘smoke signals’ on the wards. The study could explore whether there is a shift over time to the quantifiable metrics of care as anxiety pertaining to potential care failings reduces.

4. Further research could be conducted to explore and gain a deeper understanding of the perception of the ‘continuum of kindness’ with staff and vis-a-vis patients. Interviewing or observing staff on the wards interacting with each other and also with
patients to explore whether the continuum exists, or is purely a perception of the Directors of Nursing.

6.6 Recommendations for Education

1. It is crucial that NHS organisations prepare and develop Directors of Nursing in their ward to Board responsibilities and accountabilities. Alongside existing NHS Leadership Academy and King’s Fund executive leadership programmes, there could be the commissioning of a bespoke development programme for Directors of Nursing. Such a bespoke programme could focus on developing the role of intuition as a leader and ‘intuitive intelligence’. This could also encompass working alongside regulators and developing knowledge and reliance in the application of clinical metrics. This is more pertinent following the findings into Mid Staffordshire NHS Foundation Trust where it is argued that warning signs, both clinical metrics and soft intelligence, were not heard by the Trust Board.

2. Developing formal networks of Directors of Nursing across England supported with education learning sets to provide peer support. This model could particularly support and address the potential feelings of insecurity about their roles, developing intuitive skills alongside clinical metrics and the impact of regulation on their roles. The network would bring peer support for experienced Directors of Nursing and newly appointed Directors of Nursing to share best practice and provide peer-to-peer support. This network could be aligned to the Royal College of Nursing Executive Nurses Network.

3. There is a great opportunity for Directors of Nursing to work more closely with Higher Education Institutions to collaborate on developing an education programme such as the Cultivating Compassion Project and the Schwartz Centre Rounds®. This could support and influence caring practices with student nurses during their training and other healthcare professionals. In particular, talking about values and behaviours of
kindness in caring, and the learning from Mid Staffordshire NHS Foundation Trust recommendations.

6.7 Recommendations for Clinical Practice

1. Directors of Nursing could lead and develop innovative first-hand clinical ‘feedback’ sessions describing and affirming good caring practices in clinical areas and translate this into Trust Board feedback. Describing where they themselves have used their skills to ascertain good caring practices and also uncaring caring practices.

2. Directors of Nursing should share their perceptions and examples of kindness with their clinical teams and the Trust Board, to influence positive patient care and staff experience. In addition, developing an innovative reward and recognition system of acknowledging gestures of kindness in teams and individuals. There is an established link between patient outcomes, patient experience and staff morale. Improving staff morale by supporting staff may be an important area of development in promoting and sustaining caring practices.

3. Directors of Nursing are well positioned to influence the development of the current regulatory system as all NHS organisations are inspected through the Care Quality Commission inspection regime. They could use this platform to describe the impact on their roles and support the development of the programme going forward.

6.8 Dissemination of the Research

This thesis presents evidence from a systematic research study, culminating in the research project and the collection of the summative assignments. As a component of this work an article will be prepared for publication in a peer-reviewed academic nursing journal, to disseminate the findings from this research. Further dissemination of this research will be by using internet platforms, presenting at national and international conferences. This may
include presenting at the Chief Nursing Officer’s annual conference in England. Several NHS acute Trusts and the Royal College of Nursing Executive Nurse Network have also approached me to present the findings from this research.

6.9 Conclusion

It could be argued that regulation of the NHS and performance-related activity targets are going to continue to prevail in the NHS system, particularly in a fiscal climate where resources are scarcer and therefore tangible measurable outcomes will be mandated. Alongside the need to balance public assurance of standards of patient care and experience, there will also be a continued level of media interest and public scrutiny following the egregious failings of care as reported in Mid Staffordshire NHS Foundation Trust inquiry. Therefore, this study presents a challenge, as perceived by Directors of Nursing, regarding how external regulatory demands can be accommodated alongside the internal organisational requirements to lead the improvement agenda of patient care standards. Directors of Nursing need then to balance the competing priorities in their roles whilst supporting and leading a nursing workforce to deliver ethical caring practices. The role of the Director of Nursing is important in both leading a nursing workforce to deliver high quality caring practices, and to provide the Board with assurances of quality of care within the organisation. The impact of regulation on the culture of organisations is an important issue, alongside developing a compassionate workforce to deliver high quality care.

‘Importantly, too much threat in the system will fatally undermine the capacity for kindness. A compassionate healthcare culture depends on having the courage to trust the goodwill and skills of the majority, and the imagination to understand what they need to help them do their jobs well. Imagination is also required to understand the likely effects on staff and patients of any way of regulating and managing.’ (Ballatt & Campling 2013:179).
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Appendix 1: Literature Search Strategy
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<td>Appendix 1: Preliminary literature search method and results</td>
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Appendix 2: Summaries of Findings and Key Recommendations from some of the Significant Major Care Failings in England and Wales from the Seventeenth Century to 2013
<table>
<thead>
<tr>
<th>Reported scandal</th>
<th>Dates</th>
<th>Findings</th>
<th>Key recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bethlem Hospital ‘Bedlam’</td>
<td>17th /18th Century</td>
<td>Fear was used to manage uncooperative patients Force feeding widespread Restraints, straight waistcoat and blindfolding (adapted from McMillan 1997)</td>
<td>Government inquiries instigated reforms in the 1700s and 1800s 1815 moved site to improve patient conditions</td>
</tr>
<tr>
<td>Sans Everything (Robb 1967)</td>
<td>1967</td>
<td>Cruelty to and neglect of elderly patients Complaints were not believed and discredited Whistle-blowers victimised</td>
<td>Staff training in modern geriatric care Policies to be put in place</td>
</tr>
<tr>
<td>Ely Hospital, Cardiff</td>
<td>1969</td>
<td>First modern Inquiry Patients with learning disabilities were treated cruelly and inhumanely Old-fashioned standards of care Serious overcrowding</td>
<td>Hospital Advisory Service established to inspect hospitals for people with learning disabilities and mental health problems (Ham 2013)</td>
</tr>
<tr>
<td>South Ockenden, Farleigh, Napsbury and Normansfield</td>
<td>1970s-1980s</td>
<td>Long-term care Leadership qualities of kindness, empathy must come from the senior staff in role-modelling behaviours (Smith 2011)</td>
<td>Led the impetus to support closure of the Victorian asylums and the introduction of care in the community (Timmins 2013)</td>
</tr>
<tr>
<td>Alder Hey, Ashworth (Blum Cooper Inquiry), Rodney Ledward (Richie Inquiry), Bristol (Kennedy Inquiry)</td>
<td>1990s</td>
<td>Common findings: Failures involve individuals and organisations Lack of central management systems Poor clinical and managerial leadership Introverted cultural systems</td>
<td>Themes from Bristol Inquiry: Establish two over-arching regulatory bodies: a Council for the Quality of Healthcare and a Council for the Regulation of Healthcare Professionals When things go wrong, patients are entitled to receive an acknowledgement, an explanation and an apology Consent process to include all clinical procedures and examinations</td>
</tr>
<tr>
<td>Ayling, Neale and Kerr/Haslam inquiries</td>
<td>1970-1980</td>
<td>Summary: Doctors misled employers on employment checks and one example of previous sexualised behaviour and mental health episodes</td>
<td>Includes: New guidance on processes to appointment, employment and employment performance of doctors Reporting of adverse events Training on sexualised behaviour for health professionals and organisations</td>
</tr>
</tbody>
</table>
| **Dr Shipman (Smith inquiry)** | 1990s | 250 deaths in many clinical settings and patients' homes  
Altering of legal documents including wills | 228 recommendations including:  
Changes to the structure of the GMC  
Special safeguards needed for controlled drugs  
Proposals for reform of the coroners’ system  
Monitoring and local discipline of health professionals and  
The handling of complaints and concerns (DH 2007) |
|---|---|---|---|
| **Northwick Park, Stoke Mandeville and Cornwall Partnership Trust** | 2004-2007 | High rates of maternal deaths  
Response to *Clostridium difficile*  
Treatment of patients with learning disabilities | Summary:  
Board understanding of the issues and statutory responsibilities  
Escalation and responses to serious incidents  
Poor culture of organisation  
Responses to patient experience |
| **Beverley Allitt (Clothier Inquiry)** | | Committed murders on children's ward by high dose insulin | |
| **Mid Staffordshire NHS Foundation Trust** | 2005-2009 | 290 recommendations  
Systematic failure of the provision of good care  
Inadequate staff numbers  
Failure to report incidents of deaths  
High mortality rates  
Corporate self-interest and cost control ahead of safety | Instigated the Keogh review of mortality rates  
Duty of Boards and healthcare professionals to comply with openness, transparency, candour  
Doctors, nurses and hospital managers could be prosecuted for either harming or killing a patient  
Whole units of hospitals could be closed if care concerns emerged  
No gagging clauses can be applied to employees when they leave  
NHS managers and Board members face fit and proper persons test (Campbell 2013) |

**Appendix 2.** Reported major care failings and subsequent inquiries – adapted from (Walshe 2010, Roberts 2013)
Appendix 3: Interview Guide

The perceptions of Directors of Nursing in NHS acute Trusts, on caring practices

1. Please can you tell me how long you have been in your current post as Director of Nursing? What attracted you to this role?

2. Please can you share with me what you mean by ‘caring practices’?

3. Please can you describe your contribution to ‘caring practices’?
   Prompt: what does it look and feel like

4. Please can you share with me your perception of what are the main challenges facing Directors of Nursing?
   Prompt: meso/micro & macro

5. Please can you describe the strategies you use to sustain caring nursing practices?
   Prompt: enablers, Board experiences

6. What skill set and experience do you think are the most important for your role as Director of Nursing?
   Prompt: experience, behaviours

7. What values do you think are the most important for your role as Director of Nursing?
   Prompt: behaviours and attitudes

8. Is there anything else you would like to share with me?

Thank you
Appendix 4: CNO Bulletin Advert

Invitation to Directors of Nursing of acute Trusts to participate in research relating to caring practices
I would like to hear about your perceptions as Directors of Nursing, and about your experiences regarding caring practices.
If you agree to participate, you will be invited to a single, recorded interview lasting up to 1.5 hours, conducted at your NHS Trust or another suitable venue.
If you are interested in participating in this study please contact Maggie Davies (Chief Investigator) 07876 401104 or m.davies@surrey.ac.uk
This study has been approved by the University of Surrey Faculty of Health and Medical Sciences Ethics Committee.
Appendix 5: Participant Information Sheet

Participant Information Sheet-18.3.13 v.8

PROJECT TITLE – Perspectives of Directors of Nursing in NHS acute Trusts, of caring practices

Introduction

I am a student studying towards a Doctorate in Clinical Practice at the University of Surrey and I would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

What is the purpose of the study?

This study seeks to gain a better understanding of the perspectives of Directors of Nursing of caring practices, in NHS acute Trusts in England. There is a lack of research in this area.

Why have I been invited to take part in the study?

You have been invited to take part in this study because you hold the position of a Director of Nursing in an NHS acute Trust in England. I intend to interview 10 to 15 Directors of Nursing and participation will be on a first-come basis.

Do I have to take part?

No, you do not have to participate. It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. There will be no adverse consequences in terms of your employment status if you decide not to participate in this study. You are free to withdraw at any time from the study, without giving a reason.

What will happen to me if I take part?

The researcher will interview you either at your place of work, the University of Surrey or another convenient location of your choice. The interview will take approximately 1.5 hours in total. If you consent, the interview will be recorded and transcribed so the researcher has an accurate account of what was said to analyse later. During the interview you will be asked to discuss your perspectives as a Director of Nursing, of caring practices.

What will I have to do?

If you would like to take part please contact me either by e-mail maggie.davies3@nhs.net or phone on 07876 401104. Please do not hesitate to contact me if you have any questions or would like to know more about the study.
What are the possible disadvantages or risks of taking part?

It is not anticipated that there will be any disadvantages of taking part in the study although you may feel uncomfortable discussing challenging aspects of your role. The interview can be stopped at any point.

What are the possible benefits of taking part?

It is unlikely that you will benefit directly but it is anticipated that this study will give us a greater understanding of the role and contribution of Directors of Nursing in NHS acute Trusts.

What happens when the research study stops?

All research participants will be offered a summary of the findings and I will ensure these are made available to you following the completion of the study in early 2014.

What if there is a problem?

Any complaint or concern about any aspect of the way you have been dealt with during the course of the study will be addressed. Please contact Dr Ann Gallagher, Supervisor, University of Surrey, on a.gallagher@surrey.ac.uk or 01483 689462.

Will my taking part in the study be kept confidential?

Confidentiality will be maintained and data will be anonymised so that those reading reports from the research will not know who has contributed to it. Data will be stored securely in accordance with the Data Protection Act 1998. The researcher’s code of ethics requires that she report disclosures suggesting a risk of significant harm to patients or others if not reported.

Who is organising and funding the research?

This study is part of my Doctorate of Clinical Practice study and I am currently supported by a scholarship from the Florence Nightingale Foundation.

Who has reviewed the project?

The study has been reviewed and received a favourable opinion from the University of Surrey FHMS Ethics Committee.

Thank you for taking the time to read this Information Sheet.
1st May 2013

Mrs Maggie Davies
Tanglewood
47 First Avenue
Worthing
West Sussex
BN14 0NJ

Dear Maggie

Ref: EC 2013 11
Title: The Perspectives of Directors of Nursing in NHS Acute Trusts on caring practices

On behalf of the FHMS Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 30th April 2013

The list of documents reviewed and approved by the Committee is as follows:-

Document Type: Proposal
Version: 2
Dated: 19th April 2013

This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research, and with the conditions set out below.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

You are asked to note that a further submission to the FHMS Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Prof Margaret Rayman
Chair, FHMS Ethics Committee

cc: Dr Anne Gallagher, Supervisor, FHMS
    Dr Carol Magnusson, Supervisor, FHMS
Appendix 7: Letter Requesting Amendment to FHMS Ethics

Professor Margaret Rayman & Dr Anne Arber
FHMS – Ethics Chairs
Faculty of Health and Medical Sciences
14 AX 01
University of Surrey
Guildford
Surrey
GU2 7XH

3 October 2013

Ref EC 20133 11

Title of Project - The perspectives of Directors of Nursing in NHS acute Trusts, on caring practices

I received confirmation of favourable ethical opinion on the 1st May 2013 from the Faculty. I have been recruiting my sample through advertising my study through the Chief Nurse Officer monthly bulletin. I have to date recruited 6 participants but hoped to achieve a sample size of 10-15 participants. I have discussed with my supervisors this week my recruitment and I therefore wish to apply for an amendment to ethics (protocol v10 attached).

I would aim to reach potential participants by publicising the research study at forthcoming CNO Business meetings, in the delegate packs. If there is a limited response I would like to be able to contact the Directors of Nursing at NHS acute Trusts via email, using the agreed wording in the CNO Bulletin. Finally, this research study is currently on ‘Twitter’ being discussed by Directors of Nursing who have been interviewed and by the charity funding the researchers’ scholarship. The researcher would like to be able to respond by using social media to promote the study.

In conclusion, I am not planning to change the wording in the recruitment, but utilise alternative methods to access the same sample through leaflets, email and social media.

I look forward to hearing from you.

If you have any queries please do not hesitate to contact me as below.
Yours sincerely,

Maggie Davies
07876 401104

Cc Dr Ann Gallagher
Dr Carin Magnusson
Appendix 8: FHMS Revision to Ethics Approval Letter

8th October 2013

Mrs Maggie Davies
Tangllwood
17 High Avenue
Winning
West Sussex
SMA 06W

Dear Maggie,

Ref: EC 2012 11 - Amendment

On behalf of the FHMS Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research project, as described in the attached protocol and supporting documentation.

Date of submission of ethical opinion: 20th April 2013

The list of documents reviewed and approved by the Committee is as follows:

- New Type Amendment
- Version: 2
- Date: 31st October 2013

The project is given ethical approval on the understanding that you will comply with the University’s Ethical Guidelines for Research and with the conditions set out below.

The Committee should be notified of any further amendments to the protocol, any changes in the research project, and if the study is terminated earlier than expected, within seven days.

You are advised to note that a further submission to the FHMS Ethics Committee will be required in the event that the research is not completed within two years of the above date.

Please inform us when the research has been completed.

Yours sincerely,

[Signature]

First Manager Research
FHMS Ethics Committee

Dr Alan Sturges, Supervisor, FHMS
Dr Carol Wragge, Supervisor, FHMS
Appendix 9: Demographic Data

Participant demographic data by NHS England regions (six NHS England regions were represented; London, East Midlands, South East, Yorkshire and Humber, North East and North West).
Appendix 10: Example of Interview Transcript
And what attracted you to the role, the substantive role?

Yeah. It’s a different role.

And what attracted you to the role, the substantive role?

Yeah. It’s a different role.

And what attracted you to the role, the substantive role?

Yeah. It’s a different role.

And what attracted you to the role, the substantive role?

Yeah. It’s a different role.

And what attracted you to the role, the substantive role?

Yeah. It’s a different role.

And what attracted you to the role, the substantive role?

Yeah. It’s a different role.

And what attracted you to the role, the substantive role?

Yeah. It’s a different role.
You think it dropped, we have a weekly meeting of the Board and I'm sorry, that only does manifest in behaviors day-to-day.

I think it doesn't say that some of the Board members don't drive the mad, but think it in general, and I think that integrated me. I would've worked a little bit, but the mental state, and I think it in general.

You think it dropped, we have a weekly meeting of the Board and I'm sorry, that only does manifest in behaviors day-to-day.

I think it doesn't say that some of the Board members don't drive the mad, but think it in general, and I think that integrated me. I would've worked a little bit, but the mental state, and I think it in general.

So, you walked about a non-aggressive, non-confrontational, but with Board, or the
such, in inverted commas Board, but how does manifest in behaviors day-to-day?

I think it doesn't say that some of the Board members don't drive the mad, but think it in general.

You think it dropped, we have a weekly meeting of the Board and I'm sorry, that only does manifest in behaviors day-to-day.

I think it doesn't say that some of the Board members don't drive the mad, but think it in general, and I think that integrated me. I would've worked a little bit, but the mental state, and I think it in general.

So, you talked about a non-aggressive, non-confrontational, but with Board, or the
such, in inverted commas Board, but how does manifest in behaviors day-to-day?
230


Why do you think that happens?

Easy target. I think again, it goes back to the emotion doesn’t it of. I genuinely don’t know how many Boards would have a Director of Nursing on them if they didn’t have to by statute, and I suspect very few, and it’s the value that that organisation places on that element and although I can speak very plainly I struggle at times to get what I need because why would you want. I’m just trying to think of something, we talked about getting in a system around electronic patient monitoring, but why would you want that when you’re overspent, ‘well because I’ve done da, da, da’, ‘well I’m sorry we’re overspent so off it goes’, and so there’s something about, I think the Director of Nursing role is a role, there are a lot of nurses around, they can usually fill them, not always but they can usually fill them, we’re not protected by all sorts of legal bits and legislation, and I just think it’s easier, it’s a sitting, you know, you do feel a sitting target at times.

does that worry...

Yes.

...Does it bother me, yes.

Yeah.

It’s very lon..., it is very lonely, it’s very isolating. I do worry, you know, personally, just around what the impact is on me as an individual, and then on my career. I, you know. I’m not old enough to say ‘I’m hitting retirement’ and I don’t want to really end my career right this moment in time. You do feel vulnerable, which I think is a, just probably a feeling that we get and probably don’t articulate to each other, we’re a very different breed of people, I went up to the local, you know, regional DoN’s meeting...

Yes.

...and I thought ‘well it’s interesting isn’t it’. I was sitting in the room and I thought ‘I don’t, you know, they all want to be heard, they all want to be...’, there’s a certain mould which I’m probably not in at the moment, so I just sat very quietly at the back, but I thought to myself ‘it’s interesting, the older ones who’ve been Directors of Nursing are leaving and I don’t think they will be replaced quite the same way’, and you know, if I think about it, probably eight years ago, ten years ago there would have been a Director of Nursing here, Conquest and the three PCTs, so that’s five people and there’s now me.

With Board responsibility?

Absolutely.

Yes
## Appendix 11: Example of NVivo Nodes and Word Cloud on ‘caring’

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<th>User Assigned Color</th>
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<td>Nodes\failure\and you’re piggy in the middle, and you know that there is a quality issue, you know, you could stand up and say ‘well actually, you know, maternity is really poor, we’ve had fifteen SI’s in the last month, we’re using locums that we don’t know the quality</td>
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<tr>
<td>Nodes\failure\But it does feel a much more toxic environment</td>
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<tr>
<td>Nodes\failure\career risk-impact</td>
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<td>Nodes\failure\Directors of Nursing being the sacrificial lamb where it’s failed,</td>
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<td>None</td>
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<tr>
<td>Nodes\failure\Year &amp; impact</td>
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<tr>
<td>Nodes\failure\I can sleep at night and if someone chooses, if some, if there is a failing in care and I know it won’t be down to my lack of leadership and it will be down to someone who’s chosen not to do what they should have done.</td>
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<tr>
<td>Nodes\failure\I don’t think you can sustain this pace forever</td>
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<td>Nodes\failure\I don’t think you’ll get that, I think the shelf life for a Director of Nursing is probably five years.</td>
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<tr>
<td>Nodes\failure\So you know, it does worry me and in my dark moments</td>
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<td>None</td>
<td></td>
</tr>
<tr>
<td>Nodes\failure\So you know, it does worry me and in my dark moments I think, you know, another case of C. diff, another case of patient having fractured, fallen and fractured or whatever that is, and I think ‘what have I not done that hasn’t stopped this’, and I do take</td>
<td>No</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Nodes\failure\Sometimes you get it wrong and sometimes, you know, and I’ve clearly boobbled</td>
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<td>None</td>
<td></td>
</tr>
<tr>
<td>Nodes\failure\Yes.~~~~~Does it bother me, yes.</td>
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<tr>
<td>Nodes\failure\zero tolerance failings</td>
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![Word Cloud Image](image-url)

**Hierarchical Name**
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- Nodes\failure\and you’re piggy in the middle, and you know that there is a quality issue, you know, you could stand up and say ‘well actually, you know, maternity is really poor, we’ve had fifteen SI’s in the last month, we’re using locums that we don’t know the quality
- Nodes\failure\But it does feel a much more toxic environment
- Nodes\failure\career risk-impact
- Nodes\failure\Directors of Nursing being the sacrificial lamb where it’s failed,
- Nodes\failure\Year & impact
- Nodes\failure\I can sleep at night and if someone chooses, if some, if there is a failing in care and I know it won’t be down to my lack of leadership and it will be down to someone who’s chosen not to do what they should have done.
- Nodes\failure\I don’t think you can sustain this pace forever
- Nodes\failure\I don’t think you’ll get that, I think the shelf life for a Director of Nursing is probably five years.
- Nodes\failure\So you know, it does worry me and in my dark moments
- Nodes\failure\So you know, it does worry me and in my dark moments I think, you know, another case of C. diff, another case of patient having fractured, fallen and fractured or whatever that is, and I think ‘what have I not done that hasn’t stopped this’, and I do take
- Nodes\failure\Sometimes you get it wrong and sometimes, you know, and I’ve clearly boobbled
- Nodes\failure\Yes.~~~~~Does it bother me, yes.
- Nodes\failure\zero tolerance failings
Appendix 12: Overview of the Timeline of Research Programme
<table>
<thead>
<tr>
<th>Timeline</th>
<th>Activity</th>
<th>Action</th>
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<tr>
<td>January 2011</td>
<td>Induction block 1</td>
<td>Commenced the Doctorate of Clinical Practice at University of Surrey. Mixed cohort of UK and international students. Multi-professional group of 12. Introduction to Doctoral Studies Module – thinking about positioning myself in research and whether I as a researcher can be detached from the process.</td>
</tr>
<tr>
<td>January 2011</td>
<td>U-learn</td>
<td>Communities of Practice Module. Online facilitated discussion with the January 2011 cohort of students. Seemed to prove difficult in maintaining the engagement from the cohort, a new technique to the group.</td>
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</tbody>
</table>
| March 2011   | Block 2 Policy, Politics & Power Supervision Professor Helen Allen & Dr Ann Gallagher | Met with supervisors Professor Helen Allen & Dr Ann Gallagher  
• Discussed characteristic of ‘good nurse’  
• Impact of culture and organisation  
• Francis report  
• Explored complaints, what do they say about the system |
| June 2011    | Block 3 Advanced Research Methods and Policy, Politics & Power Supervision with HA & AG | Annual review at the University of Surrey with supervisor and member of the Faculty of Health and Medical Science.  
• Developing ideas of compassionate practice and dignity to inform first formal assignment  
• Update on PPP assignment and positive impact on practice  
• Reading for ARM module, including ethnography |
| September 2011 | U-learn Assignment completed | Submit Policy, Politics & Power assignment ‘Essence of Care 2010–Benchmarks for the fundamental aspects of care’                                                                                      |
| September 2011 | U-learn                      | Commenced literature search ‘dignity & nursing’ evolved to the concept of compassion and care in nursing.                                                                                                  |
| October 2011 | U-learn                      | Advanced research methods module ‘Living well with dementia’, ‘A comparison of hospital and telephone follow-up treatment for breast cancer’ and ‘General Practitioners’ perceptions of effective healthcare’ |
| November 2011 | Supervision with HA & AG    | • Developing thinking about an ethnographic approach to observing compassionate care in clinical area such as ward in NHS acute trust  
• What has been done elsewhere? Winn Tadd’s & Wilf McSherry’s work  
• Themes of moral distress |
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2011</td>
<td>Assignment completed</td>
<td></td>
</tr>
<tr>
<td>January 2012</td>
<td>Block 4 Leadership in Healthcare module</td>
<td>Supervision with HA &amp; AG</td>
</tr>
<tr>
<td>March 2012</td>
<td>Block 5 Leadership in Healthcare module</td>
<td>Supervision with HA &amp; AG</td>
</tr>
<tr>
<td>April 2012</td>
<td>Supervision with HA &amp; AG</td>
<td></td>
</tr>
<tr>
<td>May 2012</td>
<td>Supervision with HA &amp; AG</td>
<td></td>
</tr>
<tr>
<td>June 2012</td>
<td>Annual reviews</td>
<td>Annual review at the University of Surrey with supervisors and Director of DCP programme</td>
</tr>
<tr>
<td>June 2012</td>
<td>Assignment completed</td>
<td>Submit Leadership in Healthcare assignment</td>
</tr>
<tr>
<td>July 2012</td>
<td>Supervision with HA &amp; AG</td>
<td></td>
</tr>
</tbody>
</table>

- Considered practical constraints of carrying out ethnography study
- Ethnography of caring, exploring the links to leadership and organisational culture
- Considered transferring to PhD route but decided to continue with DCP
- Start to scope ethnography
- Consider Rec application
- Select NHS site to conduct study
- Literature search: Compassion
- Developed thinking linked to the following:
  - concept of the ‘good nurse’, vocational nudges
  - impact of organisational culture on caring
  - moral dimension of compassion
  - language of compassion
  - emotional detachment vs. involvement
  - write 1,000 words for rationale for study
- Considering is there a crisis in nursing?
- Linking to leadership assignment
- Draft proposal – feedback
- Support for application to Florence Nightingale Foundation
- Further consideration on feasibility of ethnography
- ‘Service evaluation of introducing communication skills training package to support a reduction in patient complaints’ and ‘Improving Board cultures to drive up standards of care and reduce complaints’
- Discussed support for application to Florence Nightingale Foundation Scholarship
<table>
<thead>
<tr>
<th>August 2012</th>
<th>Reading of the literature and the role of nurse leadership in influencing standards of care. Further thinking regarding the 290 recommendations from the inquiry at Mid Staffordshire NHS Foundation Trust – regarding the influence of leadership and culture</th>
</tr>
</thead>
</table>
| September 2012 | Supervision with HA & AG  
Discussed using IRAS form. Issues of consent for patients and staff on the ward  
Start writing discourse of deficits in care from clinical ward perspective  
Further reading on compassion in nursing and social context  
Write timeline – Gantt chart – project milestones |
| November 2012 | Continue self-directed study  
Attended ‘Compassion in healthcare: exploring and sustaining compassionate practice in healthcare. A multidisciplinary conference’ at the Royal Society of Medicine. Developed thinking regarding barriers and facilitators of compassionate practice and introduction to concept of ‘slow ethics’ by Dr Gallagher. |
| November 2012 | Supervision with AG  
Dr Carin Magnusson taking over as supervisor from Professor Helen Allen  
Discussion with supervisors following attending the ‘Compassion in healthcare’ conference. There is a body of knowledge regarding the impact on staff and patients following uncaring practices. However, less is known about the impact on nurse leadership on caring practices in NHS acute Trusts. Supervisors agreed for a refined proposal to be written and submitted.  
The research question was developed and refined following a preliminary literature search. The perceptions of Directors of Nursing in NHS acute Trusts, on caring practices: a grounded theory approach. |
| December 2012 | Continue self-directed study  
Permission sought and obtained to advertise the research study through the Chief Nursing Officer (CNO) monthly bulletin to all Directors of Nursing in the NHS. |
| January 2013 | Supervision with AG & CM  
Narrowed down area of interest – what is the problem? What are the possible explanations? role of Directors of Nursing – refined title focusing on caring practices |
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2013</td>
<td>Supervision with AG &amp; CM</td>
<td>Timelines – feedback on proposal – aiming for March ethics panel at FHMS. Version control adjusted. Themes of macro, meso and micro impact – RCN defending dignity</td>
</tr>
<tr>
<td>February 2013</td>
<td>King’s Fund conference</td>
<td>The Francis Inquiry, assuring patient safety and quality across the system of care</td>
</tr>
<tr>
<td>March 2013</td>
<td>Supervision with AG &amp; CM</td>
<td>IRAS completed if required and set aside. Await R&amp;D advice, ascertain CNO bulletin deadline. FHMS ethics approval ready to submit.</td>
</tr>
<tr>
<td>April 2013</td>
<td>Supervision with AG &amp; CM</td>
<td>Submit for ethics approval to the University of Surrey Faculty Health &amp; Medical Science Ethics Committee Discuss feedback from FHMS ethics – amendments agreed and actioned Considered the role of social media in publicising this study</td>
</tr>
<tr>
<td>May 2013</td>
<td>Continue self-directed study</td>
<td>Re-submit to the University of Surrey Faculty Health &amp; Medical Science Ethics Committee. Amendments made as requested.</td>
</tr>
<tr>
<td>May 2013</td>
<td>Continue self-directed study</td>
<td>Advertised study in Chief Nursing Officer (CNO) Bulletin</td>
</tr>
<tr>
<td>June 2013</td>
<td>Supervision with AG &amp; CM Annual review with supervisors</td>
<td>Attended PhD writing retreat at the University of Surrey. Notes from the weekend – practised writing technique, met other students preparing for submission, swapped notes on good books to read to support grounded theory methodology</td>
</tr>
<tr>
<td>June 2013</td>
<td>Continue self-directed study</td>
<td>Practice interview with supervisor using interview schedule</td>
</tr>
<tr>
<td>July 2013</td>
<td>Continue self-directed study</td>
<td>Interview for second Florence Nightingale Foundation Research Scholarship Started data collection, first interview conducted</td>
</tr>
<tr>
<td>July 2013</td>
<td>Continue self-directed study</td>
<td>Data analysis commences alongside data collection</td>
</tr>
<tr>
<td>September 2013</td>
<td>Continue self-directed study</td>
<td>Transcripts: line-by-line coding, focused coding, developing sub-categories and</td>
</tr>
<tr>
<td>Date</td>
<td>Activity Description</td>
<td>Notes</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| September/October 2013 | Supervision with AG & CM                                                              | Discussed recruitment plan and forthcoming publicity at CNO business meeting  
Revision to ethics submitted to improve access to potential research participants  
to include the use of social media Twitter ©, publicity at forthcoming CNO  
meeting  
Aim to have 3,000 words of methodology completed before next supervision |
| November 2013      | Continue self-directed study                                                          | Attended Chief Nursing Officer (CNO) Summit, Birmingham, Delivering Excellence  
Through Compassionate Care                                               |
| December 2013      | Supervision with AG & CM                                                              | Feedback from CNO meeting on recruitment and approach for publication  
Timelines  
Recruitment and transcripts reviewed for codes and categories          |
| January 2014       | Supervision with AG & CM                                                              | Updated on completion of recruitment and data saturation  
Discussed demographic contextual data  
Discussed in detail Charmaz approach to grounded theory  
Reviewed project timelines and plan for May sabbatical – chapter proportions discussed |
| February 2014      | Continue self-directed study                                                          | Discussed methods chapter write-up – Constructivist Grounded Theory, Charmaz |
| March 2014         | Supervision with AG & CM                                                              | Discussed NVivo strengths and challenges, shared excerpts of transcripts and  
line-by-line coding and in vivo codes. Shared gerunds of codes.  
NVivo 1-1 support from CM.                                             |
| April 2014         | Supervision with AG & CM                                                              | Framework in chapter on methodology  
Memos and sub-categories explored  
Commenced findings chapter write-up                                     |
| May 2014           | Supervision with AG & CM                                                              | Commenced 3-month sabbatical to complete main chapters for DCP write-up  
In-depth reading on ethical practice, Tronto and historical accounts of uncaring  
practices since Bedlam  
Discussed emerging category of dichotomy of care – good care and failing care  
and the role of searching for ‘allies’ at the Trust Board  
Discussed possible external examiners                                     |
<table>
<thead>
<tr>
<th>Month</th>
<th>Activity</th>
</tr>
</thead>
</table>
| July 2014    | Supervision with AG & CM  
- Final annual review with supervisors  
- Findings chapter re-written and presented to supervisors – 3 categories and associated sub-categories and codes. A substantive theory presented of 'a post-Francis paradox of caring'  
- Interview for third Florence Nightingale Foundation Research Scholarship |
| August 2014  | Training at University  
- Attended Viva training at the University of Surrey |
| September 2014 | Supervision with AG & CM  
- Feedback on chapters 2, 3, 4 & 5. Amendments to be made.  
- Agreed nominations for external and internal supervisors.  
- Full detailed timeline – day by day – agreed until DCP submission end of November. |
| October 2014 | Continue self-directed study  
- Completion of all main chapters, research log and integration of knowledge, research and practice |
| November 2014 | Continue self-directed study  
- Submission of first draft to supervisors  
- Feedback on first full draft  
- Preparation of clinical academic paper |
| November 2014 | Continue self-directed study  
- Final submission |
| January/February 2015 | Continue self-directed study  
- Viva |

**Appendix 12**: Overview of the timeline of research programme
Appendix 13: Research Log

Introduction

This research log describes my journey as a Doctoral student at the University of Surrey. The four-year part-time Doctorate of Clinical Practice (DCP) programme commenced in January 2011 and I submitted my thesis in December 2014. Over the last four years, I have maintained both a reflective diary of the journey through my Doctoral studies, and field notes including memos throughout my research project. This is to support the demonstration of rigour throughout my research. Appendix 14 reflects an overview of the research timeline from beginning the Doctorate in January 2011 until submission of the thesis in December 2014.

The research project

I had successfully completed an MSc programme in Advanced Clinical Practice at the University of Surrey in 2001. Following this, I worked as a research fellow at the University of Southampton. This experience was invaluable in developing my skills in writing research proposals and managing research projects, and was an excellent introduction to commencing the Doctorate in Clinical Practice programme at the University of Surrey. The Introduction to Doctoral Studies module asked searching questions such as ‘what do I think of knowledge?’ My notes described my beliefs that we are socially and culturally constructed, therefore we come to research with these values and beliefs and they influence the research we undertake. Furthermore, that I see myself as a researcher and part of the research process and therefore not in isolation from the process. In my notes I state that I wish to undertake research so as to gain an enhanced understanding about the influences and interdependencies of promoting compassionate caring practices. I hold values and beliefs vis-à-vis being a nurse as to what I perceive to be the foundations of nursing, as a caring and compassionate profession. Notably, on reflection, these beliefs and values were
to be mirrored both in my choice of methodology for my research study, and the specific topic area of interest.

As a nurse with more than 20 years’ experience of nursing, I was immensely proud of being a nurse. I consider that nursing can make a great contribution to improve patient care, such as improving patients’ experience, raising standards of care, improving patient safety and reducing mortality rates. The public inquiry into the Mid Staffordshire NHS Foundation Trust failings in care had a profound effect on me both on a human level, and as a nurse. The tragic failings of essential and fundamental nursing care were on an egregious scale and were brought into the public consciousness with tragic poignancy. Accounts of patients drinking the water from flower vases, and call bells unanswered for hours, had a profound effect on me as a nurse and as a nurse leader. I wanted to understand more about compassionate care, the complexity of good caring practices and uncaring practices, and what the challenges are in sustaining good caring practices. Furthermore, I wished to consider specifically focusing on the role and impact of Executive Nurse leaders in leading and supporting caring practices within NHS acute Trusts.

**Refining and developing the research question**

My first thoughts and feelings in response to the reports of care failings was to consider whether uncaring and unethical practices could be managed and mandated to improve by applying improvement processes and systems. This line of thinking was critically appraised in the first taught assignment of the Doctorate – ‘Policy, Politics and Power’ – by exploring the ‘Essence of care – benchmarks for respect and dignity’. The conclusion from this assignment was that professional caring values and behaviours which impact on the standards of care are also influenced by leadership and organisational cultures. Therefore, aiming to improve caring standards solely through a process of benchmarking is more complex as it does not take into account external influences.
A preliminary literature review was conducted to explore caring practices and the impact on staff and patients. Much of the literature was from a qualitative paradigm. There was a dearth of literature about the perceptions of nurse leaders and caring practices. The broad literature pertaining to leadership and cultures I explored in greater detail during the Leadership in Healthcare Organisations/Service Evaluation taught module. This informed my critical thinking about this subject area. The conclusion from this assignment and reading of the literature was that positive patient outcomes are influenced by positive organisational cultures and effective leadership. In the final taught assignment, Advanced Research Methods, a critique of a grounded theory study was undertaken. This allowed me to gain a deeper undertaking of the grounded theory approach, as I considered this method as a possible approach in undertaking this research study. Originally I had considered undertaking an ethnographic study, observing caring practices on a NHS acute Trust ward. However, as I started to consider some of the issues pertaining to caring practices, I began to appreciate the broader potential complex and interdependent relationship between caring practices, organisational culture and effective nurse leadership. These complex areas were the macro political issues, meso organisational cultural issues and the micro issues of caring practices. Therefore, with the support of my supervisors I modified my research proposal and design, so as to be able to explore the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

**Networking**

It was imperative to keep up to date with current thinking about caring practices so as to inform my research topic. The inquiry into the failings at Mid Staffordshire NHS Foundation Trust, and the subsequent debate into standards of care, had propelled the theme of compassionate care into the forefront of topical health and social care debate. I maintained my network by attending relevant conferences including the Chief Nursing Officer’s (CNO) annual business meeting. I also attended more diverse multi-disciplinary conferences to broaden my perspectives and thinking around caring practices.
Methodological considerations

The rationale for selecting grounded theory was that there are significant gaps in nursing knowledge about the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices. However, the area I had to consider in greater depth was my own ontological and epistemological positioning with regard to the research. It was very important to me that as a nurse and also with experience as a nurse director that I came to this subject with my own perceptions and experience. I was far from the view that I could come to the research with an ‘empty head’. After extensive reading and accessing the main different approaches to grounded theory, I justified that the interpretative paradigm of co-constructing a theory of the perceptions of Directors of Nursing was most suitable for this research. The constructivist grounded theory method as outlined by Charmaz (2014) resonated with my ontological and epistemological positioning. I also found Charmaz’s (2014:17) constructivist method very accessible to me as a researcher: ‘we are part of the world we study, the data we collect, and the analyses we produce’. The rationale for selecting the constructivist grounded theory approach was, first, because I have experience and knowledge as a Nurse Director which I bring to the research area. Second, because I have worked with Directors of Nursing as my professional peer group it would be difficult to assume the position of objective outsider as detailed in the classic grounded theory (Glaser 1967). A further rationale was that the Directors of Nursing by virtue of their roles may assume many social realities.

Challenges

I think it was important that I was no longer in a Nurse Director role when I undertook the research project. Although I brought my views and interpretations to the constructivist approach I felt that I was not immersed in the operational issues of working in a large NHS Trust. My email contact details were linked to my host University and not an NHS email address; I am unsure whether this inhibited or promoted access in terms of participants coming forward to the study.
During the transition from the NHS Commissioning Board to NHS England in April 2013, one initial problem that arose for recruitment was a change in the frequency of the publication of the *CNO Bulletin*. The publication had been published monthly until the move to a new organisation. There was an unforeseen delay in the publication of the *CNO Bulletin* which caused two problems; firstly, a delay in publication and secondly an increased demand for space in the bulletin from competing parties. Despite the initial delay, the recruitment of the Directors of Nursing was positive during the early part of the summer. Later in the summer there were fewer Directors of Nursing coming forward for interview, and I was concerned that as winter approached the constraints on the Directors of Nursing would increase, as the NHS acute Trust inevitably got busier. An application to revise ethical approval to widen the opportunities and methods for recruitment was successful in the Autumn of 2013 and recruitment continued successfully.

One of the challenges of conducting the research was that the Directors of Nursing by virtue of their roles were extremely busy with significant time pressures. A few interviews were cancelled at the last minute, and were rearranged at a subsequent date. Due to the inevitable time constraints, it seemed popular to offer to interview the participants whilst they were attending conferences away from their work base. On reflection, access might have been easier to establish if telephone interviews had been the method of data collection; however, due to the nature of this research, telephone interviews might not have yielded the rich data that was shared through face-to-face interviews. Due to the sensitive nature of the interviews, many of the participants asked for reassurance about the anonymity and confidentiality of the data.

With hindsight I think my initial recruitment strategy was a little cautious. Seeking ethical approval to directly approach the Directors of Nursing might have saved time in the recruitment overall, although this approach would have risked obtaining a sample too large
to manage. Greater use of social media earlier on would also have publicised the study and might have created interest earlier to support recruitment.

**Data management QRS NVivo**

In order to manage the large amount of data appropriately, I decided early on in the process to identify a software package that would be suitable alongside a grounded theory methodology. I selected QRS NVivo 10 due to its compatibility with the chosen methodology of grounded theory. I undertook several hours of QRS on-line tutorials for QRS NVivo via YouTube and attended training and practical exercises as a component of the Advanced Research Methods module. This supported me to develop my practical skills in managing the data, an understanding of the ‘node’ and ‘node-tree’ functions, and how to search the transcripts for ‘key’ words and phrases. I was also able to systematically code the transcripts line-by-line and then undertake focused coding, whilst simultaneously listening to the audio transcripts. Bringer *et al* (2006:251) has described how the ‘tools in NVivo facilitate the continual oscillation between the open coding phase of analysis and deeper analysis’.

A further rationale for using NVivo was its function of being able to move the descriptive codes and in vivo codes to a memo, supporting the interpreting the data to theory development. On reflection, handling and managing the large amounts of data was more manageable using the QRS NVivo software and supported the systematic process of developing the constructivist grounded theory.

**Writing thesis**

There were challenges in managing the time pressures to both maintain a full-time job in the NHS, and successfully complete a Doctorate in Clinical Practice. I moved jobs several times during the course of the four years of study and left my role as a Nurse Director and no longer worked in an NHS acute Trust. These job moves enabled me to manage my study time most effectively, especially during the data collection and write-up phases in years 3
and 4. I also took the decision at the end of year 3 to apply for a sabbatical from my employer so as to concentrate on the writing up of the thesis. I was extremely fortunate to secure a 3-month sabbatical in May 2014, to allow me to focus on the in-depth reading and writing up of my research. Towards the end the sabbatical I was fortunate enough to secure a promotion in a new role which was to coincide with completing the DCP. My knowledge gained from undertaking this research played a large part in securing the new role.

Whilst I planned out the time over the four-year programme from writing the proposal and submitting for ethics approval, on reflection I think I should have allowed more time in year 3 for broader reading about previous documented failings in care and subsequent inquiries. This reading gave me a fuller appreciation of the historical context of uncaring practices.

**Conclusion**

Developing the research question through the combination of the taught elements of the DCP and significant amounts of reading has been a rewarding process. The research question has evolved over time and against a backdrop of topical searching debate about standards of nursing care. The research questions have been addressed and are presented through the co-construction of the theory of the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.
Chapter 7: Overview of Integration of Knowledge, Research and Practice

7.1 Introduction

In this chapter I will outline the four-year journey of professional, academic learning and discovery, through the Doctorate of Clinical Practice. This will focus on the integration of knowledge, research and practice and I will describe the influence that the Doctoral programme has had on my development as a nurse.

The Doctorate of Clinical Practice in an integrated framework of summative and formative assignments in years one and two, culminating in the research project in years three and four. Firstly, outlining the progress through the taught programme and formative assignments aims to demonstrate the learning that I have gained during the programme; this has been applied to inform my clinical thinking as a nurse leader. Secondly, I show how the research question for the research study also evolved over the course of the programme. Table 4 below outlines the programme over the four years.

<table>
<thead>
<tr>
<th>Date</th>
<th>Subject</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 September 2011</td>
<td>Submit Policy, Politics &amp; Power assignment</td>
<td>The Essence of Care – Benchmarks for Respect &amp; Dignity (DH 2010a).</td>
</tr>
<tr>
<td>Year 1 December 2011</td>
<td>Submit Advanced Research Methods assignment</td>
<td>Living well with Dementia A comparison of hospital vs. telephone follow-up after treatment for breast cancer General Practitioners’ perception of effective healthcare</td>
</tr>
<tr>
<td>Year 2 June 2012</td>
<td>Submit Leadership in Healthcare Organisations/Service Evaluation assignment</td>
<td>Service evaluation of a communication skills training package Improving Board cultures to drive up standards of care and reduce patient complaints</td>
</tr>
<tr>
<td>Year 3</td>
<td>Research project</td>
<td>The perceptions of Directors of Nursing in NHS acute Trusts, on caring practices</td>
</tr>
<tr>
<td>Year 4</td>
<td>Research project</td>
<td>Complete thesis and prepare for viva</td>
</tr>
</tbody>
</table>

Table 4. The four-year course structure
7.2 Taught Elements of the Programme

The application and integration from the learning from the six modules in the first two years was important to me and an important rationale for undertaking a part-taught Doctoral programme. I was able to apply the learning from the modules throughout the programme. Primarily this was evident through extending my skills in strategic thinking as a nurse leader. My area of clinical expertise had been focused on oncology and cancer networks, however, early on in the course I started to apply and transfer my knowledge to broader arenas of innovative nursing practice, including exploring benchmarking systems, extended nurse roles and planning services for 7-day working. Other aspects of integrating knowledge and research into practice focused on the development of my role as a nurse leader.

7.3 Policy, Politics and Power in a Specialist Field

For the first formative assignment (in part two) there was a critique of the introduction of the policy of *Essence of Care: Benchmarks for respect and dignity* (DH 2010a). This policy was introduced as a response to the high-level exposés of care failings in the NHS. It presented a national benchmarking system that could be implemented across similar NHS settings, aiming to systematically measure indicators pertaining to respect and dignity across NHS acute Trusts. The rationale for choosing this policy was to critique an example of a policy driver that had been implemented to address the issue of variability in standards of care. I had a keen interest in politics in healthcare, but on reflection, having undertaken this assignment I started to more fully appreciate the link between government politics and the application of health policy. The political context of care failings was a theme that would transpire throughout the four years of study. Notably, a further reflection on this topic area was the question of whether ‘compassionate care’ could be mandated or improved through policy or political drive. It could be argue that this approach may be viewing caring practice through a one-dimensional lens, which does not encompass other complex
interdependencies such as the impact of organisational culture and leadership on caring practices. The potential relationship between politics, policy and power and caring practices has remained an area of interest for me during the Doctoral programme.

7.4 Advanced Research Methods

Advanced Research Methods was a module that I expected to find the most challenging, particularly regarding the application of quantitative research methods and the use of statistical testing. The lectures offered on conducting quantitative studies and the application of statistical analysis were stimulating and invaluable in gaining a deeper insight into statistical testing. This knowledge was transferable when critiquing quantitative research papers which became more accessible with this knowledge. We had several thought-provoking lectures themed on ontological and epistemological positioning which were very fascinating during this module. We were encouraged to consider our individual ontological and epistemological positioning and how this might influence our research paradigm. It was fascinating to observe the variation of positioning within the group of DCP students. On reflection, I was able to identify why I was most comfortable reading research literature that was from the qualitative paradigm, as I was most able to identify with this research. I also had some experience as an MSc student and as a Research Fellow in conducting qualitative studies. One part of the written assignment was to consider the service provision for dementia care in the South of England. I selected a grounded theory methodology for this study. I was able to transfer some of the knowledge from this assignment regarding the key processes in seeking services users’ views in my role as a Nurse Director with cancer patients. This assignment also developed my knowledge and understanding about the suitability of selecting a grounded theory approach in research. The knowledge gained in this assignment was transferred to the chosen methodology in the main research project.
7.5 Leadership in Healthcare Organisations/Service Evaluation

The integrated module of leadership in healthcare organisations and service evaluation was carried out in two parts. Part one was the evaluation of a service development project which explored the effectiveness of a recognised and validated advanced communication skills training (ACST) course for clinicians. This was in response to an increase in patient complaints regarding communication with senior clinicians, reported through the DATIX system. This assignment was linked to developing my thinking about the research area that I wished to explore for the research project. This area was developing from the ‘Essence of Care’ benchmarking review that I had undertaken in the first module, to explore training and development as another method of aiming to improve uncaring practices. I was also able to imbed this process of service evaluation in my clinical role, as I was reviewing extending the training programme to other groups of staff in response to the annual National Cancer Patient Experience Survey.

In part two of the assignment I aimed to explore the impact of Board cultures on quality of care. This area was of importance to my role as Nurse Director working with large NHS acute Trusts, as I considered the different Board cultures and the possible impact on quality of care. There were some organisations that seemed to consistently rank highly in staff and patient experience surveys, and others that did less well. This assignment also explored the potential different power bases at the Trust Board and in particular how power exists between professional groups and groups of managers. The conclusion from this assignment was that having an effective and supportive organisational culture was an important component in improving standards of care. The learning from this assignment was introduced into developing my research proposal from an observational study of caring practices on a clinical ward area, to a focus on the perceptions of Directors of Nursing in NHS acute Trust, on caring practices.
7.6 The Research Project

On reflection, I came onto the DCP programme with a clear aim to try and understand much more about the impact of good caring practices, and the factors that could sustain and promote caring behaviours in staff. I also had some searching and critical questions regarding how caring practices between nurses and patients could become in some way uncaring and unethical. The accounts of human suffering and neglect that had been recently reported as everyday patient and family stories, and also the high-profile inquiries, had a profound impact on my thinking about nursing and caring. This was at my core and a searching question for me, as a nurse and in a leadership role. The overriding question for me is ‘how could nurses be anything other than caring and kind when faced with suffering?’ My journey through my Doctoral studies has been thought-provoking and broadened my perspectives on caring practices. Patients deserve the very best care from healthcare professionals every single day. Having undertaken the Doctorate programme and more specifically the research project has given me a greater understanding of complexities, environments and factors where caring practices can be influenced to become unethical and uncaring. The insights gained into theories of regulation and leadership alongside differing organisational cultures have been translated into my everyday practice. In addition, I have a greater awareness of the important role that Directors of Nursing have in leading large workforces and promoting caring standards and behaviours within organisations.

The thinking about the research topic for the main study evolved to consider and explore the external factors impacting on caring practices. I am pleased that my original research question progressed to a constructivist grounded theory, interpreting the perceptions of Directors of Nursing on caring practices. The research area is highly relevant in terms of implications for clinical practice, nurse leadership, policy, and nursing as a profession. The important role that Directors of Nursing play as operational and strategic leaders in NHS
acute Trusts is crucial to improving the standards of patient care and in developing a safe and effective workforce.

7.7 Dissemination

It is important to share the knowledge that has been gained through undertaking the research project. As a component of the programme I will be submitting a manuscript for publication. In addition, as a Florence Nightingale Foundation research scholar I will be writing a further manuscript for publication in a peer-reviewed journal. I will look to disseminate the findings widely through the CNO networks and the Royal College of Nursing Executive Nurse Forum. I would also hope to present the research to the participants at Trust-level events and national and international conferences in the coming months.

7.8 Conclusion

In this chapter, there has been a critical discussion of how the taught components of the programme have collectively built upon my thinking and reflections and been transferred into my clinical practice and leadership. I started the Doctorate in Clinical Practice programme with a clear indication about the subject area for the research project. This has evolved over time, as my knowledge and awareness of the subject area of caring practices has developed, alongside the learning from the formative assessment process. Presenting a grounded theory of ‘Directors of Nursing perceptions on caring: Post-Francis paradoxes’ has wide-ranging implications for sustaining and promotion caring practices in a complex challenging health environment. Greater scrutiny and regulation has been an output from the inquiry into the Mid Staffordshire NHS Foundation Trust (Francis 2013), but it is questionable whether increased regulation will have the desired effect of improving organisational cultures (Illingworth 2014).
Anecdotally, the impact on recruitment and retention of NHS acute Trust Directors of Nursing is problematic in some areas and variable across England. In some areas there are reported lengthy vacancy gaps in Director of Nursing posts, and those Trusts with high-profile reputations are finding it more difficult to attract nurse leaders and clinical ward staff. This seems to suggest a further paradox of caring in that those Trusts that are having difficulty recruiting have high levels of interim and agency staff which had an impact on staffing levels (Stephenson 2014).

Francis (2013:7) stated in the findings of the failings of care at Mid Staffordshire NHS Foundation Trust that ‘nursing needs a stronger voice. This can be achieved by strengthening nursing representation in organisational leadership.’ In concluding, it is argued that Directors of Nursing are well positioned to lead their nursing workforce and contribute to sustaining and improving caring practices and patient experience.

Undertaking this academic programme has assisted me in developing my clinical skills and knowledge and to become a more effective operational and strategic nurse leader.
Doctorate in Clinical Practice

by

Maggie Davies MSc, BSc (Hons), RGN

PART TWO

Clinical Academic Paper
Policy, Politics and Power Assignment
Advanced Research Methods Assignment
Service Evaluation Assignment

Faculty of Health and Medicine Sciences
Division of Health and Social Care

University of Surrey

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Chapter 8: Clinical Academic Paper

A Grounded Theory of Directors of Nursing Perceptions on Caring: Post-Francis Paradoxes

Abstract

Aim: This paper reports findings from a study of the perceptions of Directors’ of Nursing from NHS acute Trusts, on caring practices.

Background: The NHS Constitution states that the “NHS is there to improve and health and wellbeing, and it touches our lives at times of basic human need, when care and compassion are what matter most” (DH 2013:2). It is contended that the majority of professionals aspire to provide high quality care. However, there has been a number of recent high profile exposés of undignified care, neglect and uncaring practice. These inquiries have created a searching debate into standards of patient care, leadership, culture, practice, and the nursing profession. Directors of Nursing have a significant role to play in providing assurance of standards of care within NHS Trusts. However, there is little is known about Directors of Nursing perspectives on caring practices.

Design: A constructivist grounded theory (Charmaz 1990) approach was adopted to co-construct the theory by exploring how the participants constructed their worlds.

Methods: Directors of Nursing from 12 NHS acute Trusts in England were interviewed between July 2013 and January 2014 using semi-structured questions.

Results/Findings: The three paradoxes that emerged were: the need to produce reliable high-quality assurance about standards of care in the NHS which detracted from and impacted on the Directors of Nursing roles in supporting internal assurances processes. Secondly, external monitoring standards were not perceived to capture the ‘real’ warning signals of care failings. Thirdly, the reliance on intuitive skills to give assurances of caring practices was considered necessary to support the demanding monitoring and assurance processes.

Conclusions and implications for practice: This study captures a challenge, as perceived by Directors of Nursing, regarding how external regulatory demands can be accommodated alongside the internal organisational requirements to lead the improvement agenda of patient care standards. Directors of Nursing need then to balance the competing priorities in their roles whilst supporting and leading a nursing workforce to deliver ethical caring
### Key words:
caring practices, nursing, Directors of Nursing, regulation, intuition, policy, Francis report, leadership, constructivist grounded theory

### SUMMARY STATEMENT

#### Why is this research or review needed?

- Directors of Nursing are in a unique position to provide professional leadership within their organisations and influence the standards of patient care.
- The perceptions of Directors of Nursing and their responses to challenges in caring practices is vital in improving standards of patient care.
- There is a dearth of literature specially exploring the role of Directors of Nursing in NHS acute Trust on caring practices.

#### What are the key findings?

- The study confirms that as experienced nurses, Directors of Nursing placed more reliance on their skills of intuition in assessing the quality and standards of caring practices on the wards, than clinical metric systems.
- There has been a creation of three paradoxes in the Post Francis-era, with a contradictory impact on the role of the Director of Nursing.
- The first paradox was the need to produce reliable high quality assurance in the system about standards of care, whilst not detracting and unhelpfully impacting on the Directors of Nursing roles that are essential to raising standards away from internal assurances processes.
- A second paradox is found in the legacy from the Mid Staffordshire NHS Foundation Trust findings that external monitoring standards were incongruent and invalid in capturing the ‘real’ warning signals of failing care within an organisation. This tension was at the crux of the failings at Mid Staffordshire, the metrics and numbers were juxtaposed to the reality of standards of patient care.
The final paradox centred on the Directors of Nursing reliance on intuitive skills to give assurances of caring practices rather than the positivist approach to assurance mandated through regulatory processes.

**How should the findings be used to influence policy/practice/research/education?**

- The Directors of Nursing could lead and develop innovative first-hand clinical ‘feedback’ sessions describing and affirming good caring practices in clinical areas, and translate this into trust Board assurance processes.

- Directors of Nursing are well positioned to influence the development of the current regulatory system as all NHS organisations are inspected through the Care Quality Commission inspection regime. They could use this platform to describe the impact on their roles and support the development of the programme going forward.

- The findings should be used to develop greater awareness of the impact the paradoxical climate facing Directors of Nursing, and consider what support can be offered to mitigate against this paradoxical impact.

- There needs to be greater awareness and consideration to the seemingly ‘insatiable’ regulatory assurance processes on the role of Directors of Nursing, and the potential impact on the time to deliver organisational quality initiatives which will influence caring practices.
Introduction
The NHS constitution states that the “NHS is there to improve and health and wellbeing and it touches our lives at times of basic human need, when care and compassion are what matter most” (DH 2013:2). Whilst it is contended that the majority of professionals wish to provide care which is of good standards, there have also been examples of poor caring practices and neglect going back as far as the seventeenth century.

In more recent years, there have been a number of high profile exposés of undignified care, neglect and poor practice, which have been a catalyst for a searching debate into standards of care, practice and the nursing (The Patients Association 2010, Care Quality Commission 2011, Parliamentary Health Service Ombudsmen 2011, Tadd et al 2012, Department of Health 2012a, Andrews & Butler 2014, Francis 2010, Francis 2013). A significant example was the public inquiry into the failings at Mid Staffordshire NHS Foundation Trust and the publication of the Francis report in February 2013 (Francis 2013), which included 290 recommendations for improvements to care delivery and systems.

Directors of Nursing have an important role in influencing caring practices within their organisations. This paper considers the role of the Director of Nursing in leading and supporting caring practices in response to the backdrop of uncaring practices. There is a dearth of published research relating specifically to the role of Directors of Nursing and the relationship to developing caring practices. The significance of establishing the perceptions of Directors of Nursing of caring practices was important in identifying the potential levers and drivers in promoting and sustaining caring practices.
Background

Perspectives on caring practices

The definition of caring has evolved to “the work or practice of looking after those unable to care for themselves, especially on account of age or illness” (Oxford Dictionaries Online 2014). Van der Cingel (2014) suggests that caring is putting someone else’s need before your own needs. Caring practices are associated with the notions of “nourishing, cherishing, fostering, tender caring, conservation of energy, and providing curative care” (Wagner & Wait 2010:226). Chinn (1991) defined caring practices as being the vanguard of nursing and requiring commitment from the care-giver to provide caring.

However, Gaut (1981) questioned the motivation to create a definition of caring in relation to nursing and posited whether it was created by a will and need to professionalise nursing in some way. Accordingly, caring is seen as “a moral and human imperative to protect people when they are weak and vulnerable; to strive towards recovery and healing; and to ensure humanity of care” (Goodrich & Cornwell 2008:3).

The impact of poor standards of care, misdiagnosis and failings in communication can have a profound life-changing impact on patients and families (PHSO 2011, NAO 2008). There has also been an extensive public and media response to failings of care and at the impact of poor standards of patient care. The Parliamentary and Health Service Ombudsman (PHSO 2011) report identified the profound impact of individual and institutional attitudes, on standards of care and basic humanity. Basic humanity is described as being shown humanness, kindness and benevolence (Oxford Dictionary online 2014). Standards of care are laid out and are fundamental to the Nursing & Midwifery Council Code (Nursing and Midwifery Council, 2008) is unequivocal- ‘you must treat people as individuals and respect their dignity and you must treat people kindly and considerately’.
Contemporary healthcare challenges

In 1948, The NHS was founded on the principles of free health care to all those who need it most. The standards and quality of care are fundamental for organisations providing care, however potential conflicts exist between the provision of quality care, individual organisations and professional groups (Roberts, 2013). Whilst it is accepted that the majority of care is of good standards, there has been an extensive history or poor caring practices and neglect both in the United Kingdom and internationally.

A crisis was reported in the Francis Report into the failings of care at Mid Staffordshire NHS Foundation Trust in 2010 and subsequently in 2013. “A failure to listen to those who have received care through proper consideration of their complaints and a corporate focus on process at the expense of outcomes” (Francis 2010:24). The emerging themes in both reports were the apparent lack of board attention to the patients’ experiences, potentially seen as a barometer of quality and early warning system within the organisations. Poor standards of care, misdiagnosis and failings in communication can have a profound life-changing impact on patients and families (PHSO 2011, NAO 2008). There has also been an extensive public and media response to fallings of care and at the impact of poor standards of patient care. The Parliamentary and Health Service Ombudsman (PHSO 2011) report identified the profound impact of individual and institutional attitudes, on standards of care and basic humanity. Basic humanity is described as being shown humanness, kindness and benevolence (Oxford Dictionary online 2014). Standards of care are laid out and are fundamental to the Nursing & Midwifery Council Code (Nursing and Midwifery Council, 2008) is unequivocal- ‘you must treat people as individuals and respect their dignity and you must treat people kindly and considerately’.
Evolution of nurse leadership

The role of Chief Nurse or Director of Nursing was seen as a way on providing professional leadership in NHS acute Trusts. Nurse leadership was formally validated through the establishment of Directors of Nursing posts during the first wave of NHS trusts in 1991 (Kirk, 2009). The structure of the NHS has evolved considerably since then, with emerging Clinical Commissioning Groups and Foundation Trusts (FTs). FTs are required to have a registered nurse or midwife among their executive directors (DH 2006). Since then the role of the Director of Nursing has been synonymous with the role of clinical quality champion at the board (Machell et al. 2009b). However, in more recent years the role of Director of Nursing has become complex and more multifarious from providing the Board with quality assurance, to that of becoming accountable to the board for the standards of care within the Trust. It has been argued that the role and the skills required of the Nurse Director, is to both articulate the quality agenda and to balance competing board priorities such as finance (Machell et al. 2009b). Read et al. (1994) states that there has been a significant contribution made to the NHS from nursing roles. Although, there has been widespread concern in the UK and other parts of the western world that there are worrying deficiencies in the nursing contribution to care (Aiken et al. 2002, Taskase et al. 2006, Morris-Thompson et al. 2011, McSherry et al. 2012).
THE STUDY

Aims
The aim of this paper is to report the study which was undertaken to understand and interpret the perceptions of Directors of Nursing in NHS acute Trusts, on caring practices.

Design
The study approach selected was a qualitative interpretative approach of constructivist grounded theory, which facilitated an interpretation of the situation or phenomenon. Constructivism is derived from the work of Egon Guba and Yvonne Lincoln (Guba & Lincoln 1981) allowing for research focusing on peoples experiences and behaviours within their own social worlds. A central principle of the constructivist approach is that concepts are constructed as opposed to discovered as with classic grounded theory (Evans 2013). In constructivist grounded theory approach, the researcher is an integral part of the research process, as data is interpreted and co-constructed between the researcher and the participants (Charmaz 2006).

Aiming to provide explanations and make sense of experiences, by attempting to answer the why as well as the what and how questions (Charmaz 2006). Constructivist grounded theory aims to develop a detailed understanding of the underlying social or psychological processes within a certain context by exploring in more detail social interactions and social structures (Gardner et al 2012) In agreement, Charmaz (2006) acknowledges that constructivist grounded theories are contextually orientated, to a defined culture, time, place and situation.

Sample/participants
This research study was conducted between 2013 and 2104. The participants were accessed through the Chief Nursing Officer for England -Bulletin and publicity at the CNO business meeting. Participant information sheets were distributed to those participants who came forward to be interviewed in their respective different NHS acute Trusts across England. Twelve Directors of Nursing from their respective NHS acute Trusts across England were interviewed using a semi-structured framework. There are approximately 160
NHS acute Trusts in the NHS across England including 102 Foundation Trusts providing emergency services and acute inpatient care.

Inclusion criteria
Directors of Nursing at NHS acute Trusts- including the job titles of Chief Nurses, Executive Nurses and Nurse Directors (as those executive members of the Trust board with responsibility for professional nursing as fulfilling the duty of schedule 1 of the Heath & Social Care Act 2003)

Interviews were conducted with those Directors of Nursing who met the inclusion criteria In keeping with a grounded theory approach, open-ended interviews were the method of data collection chosen for this research study. A research diary was used as a contemporaneous record of the researcher’s notes, memos, feelings and comments during data collection and throughout the research process. The value of a research diary can be demonstrated in supporting an awareness of the subject, reflexivity and the feelings of the researcher (Hutchinson 1993).

The first two Directors of Nursing who were interviewed formed the pilot phase of the research study. A further ten Directors of Nursing were interviewed for the main study. Theoretical saturation was reached after a total of twelve Directors of Nursing from NHS acute Hospitals Trusts in England, were interviewed.

Data collection
A semi structured interview guide was used focusing on such questions as defining caring practices; the contribution of Directors of Nursing is to caring practices and the main challenges faced. Demographic data collected was the approximate range of length of service that the Director of Nursing had worked at the employing NHS Trust. In addition, the geographical location of each Trust by regional NHS England regions was noted. Across the twelve interviews, six different NHS England regions were represented; London, East Midlands, South East, Yorkshire and Humber, North East and North West. The main
interviews were carried out either in the host NHS Trust or another convenient location, between July 2013 and January 2014 and lasted between 50 mins and 1.5 hours.

**Data analysis**

A single researcher carried out the interviews and the data analysis process was supported by QSR NVivo 10. All the interviews were transcribed verbatim by the same person to achieve consistency. The first two interviews formed the pilot study. In keeping with the Charmaz constructivist grounded theory approach (Charmaz 2014), the process of fluid and evolving data analysis was carried out. An advantage to this approach is that the cyclical process of theory creation and data analysis, facilitating a constant relationship to co-exist between data and theory (Seale, 1999a). Two initial coding processes were undertaken. The first phase was initial or line-by-line coding, followed by focused coding. The coding supports the researcher to see the world from the participants’ world rather than their own. This is facilitated by immersing the researcher into the components of the narrative (Charmaz 2014). A further advantage is that line-by-line coding supports the interview focus as an evolving process by offering possible areas of enquiry (Charmaz 2006).

The initial coding was presented as ‘gerunds’ in keeping with constructivist grounded theory approach of nouns acting as verbs. Creating action codes or verbs, supports the process of constant comparison between data and categories (Glaser 1978).

In the second phase, focused coding takes place encompassing the conceptual level of the most frequent codes, where decisions have to be made by the researcher about which codes have the most analytical meaning. Sifting, sorting and analysing of the codes are required, in part to determine the suitability of the codes when analysing the data. This phase is more ‘directed, selective and conceptual that the initial coding ’ (Charmaz 2006:56).

Constant comparison was used to “establish analytical distinctions and thus make comparisons at each level of analytical work “ (Charmaz 2014:132). This facilitates the development of the theory derived from the analysis. Similarly, Seale (1999) proffers that this promotes a constant symbiotic relationship between the data and the theory. The third phase of coding, namely theoretical coding was implemented. Theoretical coding is used to
develop possible emerging relationships between categories. Glaser (1978:72) defined the process for theoretical coding as “weaving the story back together”. Therefore, a logical explanatory story-line emerges from the data when using theoretical coding. Memo-writing is a fundamental core part of grounded theory and are posited as the transitional step between data collection and writing drafts of papers. Glaser (1978) asserts that memos are intended to increase the level of abstraction. Memos are used to capture and analyse the thoughts of the researcher when analysing your data.

**Ethical consideration**

A favourable ethical opinion was received from the University of Surrey Faculty of Health and Medical Sciences (FHMS) Ethics Committee. Research and governance approval was sought at each of the twelve individual acute Trusts. The level of ethical review was appropriate for interviewing NHS staff. Participants were advised that they could withdraw from the research at any time, and also of their right to confidentiality and anonymity. Written consent was completed prior to the interviews taking place.

**Validity and reliability**

The process of data analysis in grounded theory is described as a fluid and evolving process (Charmaz, 2006). An advantage to this approach is the cyclical process of theory creation and data analysis, facilitating a constant relationship to co-exist between data and theory (Seale 1999).

**Findings**

Participants described working in a different and contrasting environment, and as such a different professional world following the findings of the Mid Staffordshire NHS Foundation Trust report (Francis 2013). The theory of “Directors’ of Nursing Perceptions of Caring: Post-Francis Paradoxes” is constructed from the three categories, associated sub-categories and codes. The three categories are described as “Trusting my senses”, “Avoiding becoming collateral damage” and “Being in a Different Place”.

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Figure 8. The Theory of “Directors of Nursing perceptions of caring: Post-Francis Paradoxes” and associated categories

**Trusting my senses**

*Trusting my senses* is defined as the participants sharing stories of caring practices that are interpreted to be centred on the human senses and the trust they placed in these senses to give them quality assurance.

When describing the picture of caring, one of the participant focused on the values and behaviours displayed during the nurse and patient interaction. She uses the phrase ‘it’s easier for me to visualise it’ as a visual ‘anchor’. She went on to explain that she finds it easy to visualise good care because she can ‘feel it’ and ‘see it’, again underpinned to the human senses:

“That’s the picture for me of kind of a caring, understanding, teaching, taking time to teach people about what’s happened, what they might need to do
differently, so not only dealing with the moment but dealing with what will happen,” (Participant I)

Another participant provided a powerful imagery of the caring interaction between the dying patient and the nurse providing comfort:

“I could you see that person sitting holding the hand of somebody who’s dying’, and that’s a real image for me, you have to look past what that person requires”… (Participant C)

Avoiding becoming collateral damage

Avoiding becoming collateral damage is defined as the participants feeling at risk of peril, when there were care failings within their organisations. Therefore, their appointments as Directors of Nursing within the Trusts were perceived to be at risk and vulnerable. Many of the participants felt that they have little control over this situation as they would inevitably become accountable for the care failings within the organisation. As such they perceived that they would become collateral damage of the failing care:

“It feels like the sword of Damocles at the minute hanging over me” because of the pressure that we’re under and there’s been a couple of times I’ve thought they’ve had enough …”(Participant D)

Both these participants suggests that within the Trust, that it is the post of the Director of Nursing who is most a risk of losing their post:

“Hold on here, they cannot be the sacrificial lamb’, because it’s really interesting, in every problematic hospital the Directors of Nursing is the first one to go. I think they’re easy to get rid of” (Participant B)

“I think that it feels a bit Draconian at the moment, you know, because increasingly we’ve seen Directors of Nursing being the sacrificial lamb where it’s failed, there’s got to be a better way, we can’t afford to lose everybody, and who’s going to do the jobs?” (Participant B)
Being in a different place

Described the disparate and different professional and occupational worlds in which the participants operate within, having shifted to a different position following the responses to recent exposés of care failings and in particular the Mid Staffordshire NHS Trust inquiry. Of interest in this category an in vivo code emerged from the data ‘feeding the beast’ which depicted the participants in their executive roles as being required to produce and submit an insatiable level of increased documentary evidence pertaining to the quality standards of care within their organisations. This complex and detailed documentary evidence was required by numerous parties including the Trust internal Boards and external agencies including the Care Quality Commission, the Trust Development Authority and the Clinical Commissioning Groups:

“I think we have to challenge that and that’s quite, that’s quite a growing thing we have to do because of the way that things are and how things post-Francis have been really”. (Participant F)

The intense feelings of pressure and scrutiny was described as she described feeling ‘sucked in’ as she ‘feeds the beast’:

“The demands are really high to respond, you know feeding the beast, you’re under scrutiny and with all the scrutiny on care at the moment so whether it’s Monitor, CQC, commissioners or patients groups”. (Participant C)

Co-constructing a Substantive Grounded Theory

A grounded theory of “Directors of Nursing perceptions of caring; Post-Francis paradoxes” emerged from the findings and coveys that several paradoxes had arisen from the recommendations of the Francis report into care failings at the Mid-Staffordshire NHS Trust (Francis 2013). A paradox is described as a contradictory or unhelpful consequence of an unintended outcome. In this research the paradoxes were perceived by the Directors of Nursing to inhibit, as opposed to improve standards of caring practices. The first paradox was the need to produce reliable high quality assurance in the system about standards of
care, whilst not detracting and unhelpfully impacting on the Directors of Nursing roles that are essential to raising standards away from internal assurances processes. A second paradox is found in the legacy from the Mid Staffordshire NHS Foundation Trust findings that external monitoring standards were incongruent and invalid in capturing the ‘real’ warning signals of failing care within an organisation. This tension was at the crux of the failings at Mid Staffordshire, the metrics and numbers were juxtaposed to the reality of standards of patient care. The final paradox centred on the Directors of Nursing reliance on intuitive skills to give assurances of caring practices rather than the positivist approach to assurance mandated through regulatory processes.

In summary a contradiction has occurred with more statutory monitoring, a newer framework of regulation and increased scrutiny seemingly hampering, inhibiting and over-burdening the system.

“Post Francis… I think now I think we’re working in an environment where everybody’s watching their backs and it’s, it’s, it was hard enough before, it’s even harder now, and there’s certainly zero tolerance at completely for failings of which I don’t disagree with whatsoever, but it does feel like we’re all being tarnished with the same brush. But it does feel a much more toxic environment”.

“I think the whole landscapes changed since The Francis Report really, it’s moved us into a whole different arena now”,

Discussion

This study offers an interpretation of the Directors of Nursing’s in NHS acute Trusts, perceptions of caring practices. In this discussion section the focus will be on two main areas of the findings: caring practices and the impact of regulation on the role of the Directors of Nursing.
Caring practices

A conjecture is offered that nursing staff are typically intrinsically and altruistically motivated to provide good care and enter into the nursing profession to support and help people. Corbin (2008) proposes that nurses are naturally caring and this may be the rationale for entering into the nursing profession. Stockdale & Warelow (2000:1261) agree that “it is beyond dispute that nurses should care and be caring”. However, the impact of organisational cultural behaviours and ineffective leadership can have a catastrophic impact on caring standards (Walshe 2010, Francis 2013 & Hammond 2013).

The descriptions of caring practices portrayed by the participants of their nursing staff in the findings seem to be comparable and aligned with Tronto's (1993:104) description of care of “care is both a practice and a disposition”. Whereby the nurses are carrying out particular interaction in a way that has concern for the patient, patient centred care would be one example of caring in this way, as the individual patient becomes the focus rather than the individual task. The ideals and values shared by the participants were important in setting the goals for standards of care in their organisations. In support, ideals rather than being viewed as unobtainable “represent the values and aspirations of professional nurses” (Maben et al 2007:99). “Care can characterise a single activity, in this regard caring is not simply a cerebral concern, or character trait, but concerns the living, active humans engaged in the processes of everyday living” (Tronto 1993:103). A similar interpretation of caring is Boykin & Schoenhofer's (2001) description of “nursing as caring” which defines the behavioural qualities of caring; honesty, being connected, entering into the patients world and being in the moment. This interpretation and perspective supports the findings in this study. However, both Tronto’s (1993) model of caring and Boykin & Schoenhofer's (2001) description of “nursing as caring” focus more on behavioural qualities and character traits of the nurse in caring, whilst recognising the two-way relationship between the nurse and the patient. Corbin (2008) also suggests that the emotional aspects of caring must be supported by technical expertise to be most effective. Roach’s seminal work on caring: the human mode of being, also supports the view that the meaning of caring encompasses aptitude,
practices and technical effectiveness (Roach & Maykut, 2010). The findings from this research study have shown that the Directors of Nursing as experienced nurses are reporting to use their intuitive skills when observing, interpreting and understanding standards of caring practices on the ward. The Directors of Nursing described their perceptions of caring practices by using intuitive cues as a method of self-confirmation regarding the level of quality assurance on the wards.

**Impact of regulation**

The impact of macro regulation on the role of the participants was a strong theme that emerged from this study and was supported by the sub-categories of feeding the beast (an *in vivo code*). The three main groups that fulfilled the participants definition of ‘regulators’ were; organisational, professional regulators and clinical commissioning groups (CCGs). The participants described the impact of the ‘bewildering’ bureaucratic system on their roles in trying to manage the assurance processes. The participants are describing a two-fold fundamental problem with the regulation process from their perspectives, an increased bureaucratic system which is causing an additional time burden on their roles, and a fundamental shift required to buy-in for the regulatory model as an assurance framework. Most of the participants surmised that the increased level of regulation was an inevitable legacy following the recommendations from the Mid Staffordshire NHS Foundation Trust inquiry. There was also a perception held by the participants that the rationale that the Director of Nursing holds the remit for quality within the organisation and it follows thereby that they would be at the forefront of the relationship with the regulator. This view is supported by Thorlby et al’s (2013:6) research conducted with NHS acute Trust one year following the publication of the Mid Staffordshire NHS Foundation Trust inquiry, which concluded that the Trust reported “greater pressure from external bodies seeking quality assurance in the wake of the Francis report”.

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Thorby et al’s (2013:6) research supports this perception that the external monitoring could feel “punitive at times”. One possible reason for an increased level of regulation could be the post Mid Staffordshire environment, where the system could be described as nervous of another systemic failure in the NHS which would further erode public confidence. Since the publication of the Mid Staffordshire NHS Foundation Trust report (Francis 2013), there has been subsequent reports of continuing egregious care failings. More recently Winterbourne view in 2012 (DH 2012) and the independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital (Andrews & Butler 2014). In discussing the impact of regulation on the role of the Director of Nursing it is important to set the context within the political landscape. Hayter (2013:1) argued that the failings at Mid Staffordshire NHS Foundation Trust Hospital “put the quality of nursing care in the spotlight”.

Regulation has historically been linked to managing the economy, however, more recently it has also been “applied to social arenas including health and safety, environmental and consumer protection” (Quick 2011:4). Regulation is regarded as a method of governing by managing ‘market failures’, using a ‘rules and rewards model’ supported by penalties and sanctions of the government (James 2000). Salter (1999:149) categorises regulatory tasks into; “standard setting, monitoring, evaluating and intervention”. It is widely accepted that regulation is a form of a mechanism to modify behaviours (Ogus, 1994). Further, it has been argued that the proliferation of regulatory bodies “reflect a public interest view seeing it as a means to mitigate government failures and improve public welfare” (James 2000:328). However, Berwick (2013) warned that the “current NHS regulatory system is bewildering in its complexities and prone to overlaps of remit and gaps between different agencies”. In support, Trubek et al (2008) suggest that the proliferation of regulators has created some duplication and confusion in responsibility with the remit to monitor and encourage behavioural changes. Bilton & Cayton (2013) state that although the role and methodology of the regulators are similar, they differ in their scope and remit, with “no consistent application of risk in determining which occupations are subject which level of assurance”.
The participants did not express a belief that assurance framework implemented by the regulators would improve the quality of care within their organisations. Dewar et al (2013:1743) states that there is a “potential misconception that focusing energy and attention on additional audit and inspection activities will eliminate care lacking in compassion”. This view would seem to support the perceptions described by the participants.

One paradox accordingly has emerged from the narratives of the participants, as to seemingly doubt the potential positive benefits of improving quality of care by regulating the system in this way. In addition to the perceptions of pressure and additional scrutiny, impacting on their roles by additional reporting to the regulatory body, became a distraction to the other elements of their roles. They perceived that they had an increased duplicity of work providing evidence and outcomes, which then reduced their ability to strategically drive forward quality improvements within the Trust. Managing the impact on their roles from the additional regulation was causing difficulty and tension and some of the participants saw this as adding bureaucratic burden on their roles. At the centre of the participants' perceptions of regulation was the paradox that additional regulation may not be the panacea to improve quality of care. A perspective as to the possible origins of a disconnect between the benefits of regulation versus the burden in providing regulatory evidence may be found in the narrative and interpretation from the Mid Staffordshire NHS Foundation Trust inquiry findings. Hayter (2013) discusses that the findings revealed that there was a culture at Mid Staffordshire where quantitative data on quality was accepted whilst the soft intelligence pertaining to quality such as patients feedback and staff concerns was ignored. A participant spoke about the tension between getting the balance right between providing the assurance and audit and leading quality improvements within the Trust. The findings from the Staffordshire report warned that “standards and methods of measuring compliance which did not focus on the effect of a service on patients” (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013:4). This interpretation of the potential perils of loss of confidence of
meaningful elements of the quality assurance mechanisms for feedback seems to be supported by the participants’ views. The inherent risk being that processes and outputs take precedence over the ‘softer’ metrics of quality, safety and patient experience. Power (1997) has outlined the expansion of monitoring through regulation since the 1990s and coined that phrase ‘audit explosion’ in response to government policy. This description would seemingly support the participants perceptions in this study view although they perceive that the ‘explosion’ of monitoring has come about after 2013 and the publication of the Mid Staffordshire NHS Foundation Trust inquiry.

In summary, the fear of failure and the participants’ anxiety about losing their posts by potentially becoming collateral damage are issues that were not highlighted in the original literature review, specifically related to the role of the Director of Nursing. Therefore, it could be argued that this research study has highlighted a gap in the literature pertaining to the anxiety and insecurity perceived by the Directors of Nursing in relation to their roles.

**Limitations**
The focus of this research was on the perceptions of Directors’ of Nursing in NHS acute Trusts. Further research is needed now to explore the perceptions of Directors of Nursing in a wider range of settings; such as non-NHS acute Trusts, private or voluntary sector, mental Health Trusts, Community Trusts and Clinical Commissioning Groups.

**Conclusion**
The constructivist grounded theory has identified that the Directors of Nursing used their intuitive skills when observing caring practices on the wards. These findings support the earlier work on expert practitioner and intuition of Benner (1985), Benner & Tanner (1987), and English (1993). Also at a macro impact regulatory and political level several paradoxes emerged centring on the impact of regulatory processes on the ability for the Directors of Nursing to function at a local operational level. The paradoxical effect occurred to that of driving up quality at a local level, impacting on the participant’s roles, fuelled by the
requirement to feed the ‘instable’ appetite of regulators. This finding is supported by Bilton & Cayton (2013) view of the impact of the ‘bewildering’ bureaucratic system’. The impact was felt on their roles in trying to manage the assurance processes. The overriding tension was the participants belief that although there was an inevitability to additional regulation, this was impacting on the time for the participants to successfully develop as clinical leaders and drive up standards of caring practices within the Trust.

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I wish to thank the Directors of Nursing who shared their stories and perceptions with candour and honesty. Their experiences made this research study possible, which has led to the submission for an award of Doctorate of Clinical Practice.
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Evidence of Submission

Dashboard

- Margaret Davies

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Chapter 9: Policy, Politics and Power Assignment

Preface

“To the typical physician, my illness is a routine incident on his rounds, whilst for me it is the crisis of my life. I wish he would give his whole mind just once, be bonded with me for a brief space, survey my soul as well as my flesh, to get to my illness, for each man is ill in his own way.”

Broyard (1992)
9.1 Introduction

In this assignment, the author will critique an identified policy by applying a policy analysis tool. The analysis will include an appraisal of the literature pertaining to the influencers and resistors in implementing the policy. There will be a critique of the effectiveness of the tool and examination of possible alternatives for the tool and policy. Finally, there will be a discussion on the impact on patients and recommendations for future policy implementation.

The identified policy is the Essence of Care 2010: Benchmarks for the fundamental aspects of care – ‘Benchmarks for respect and dignity’ (DH 2010a) (Appendix 1). The Essence of Care is a national benchmarking system of twelve benchmarks, used by front-line health and social care staff, and developed to address the fundamentals of quality of care and to drive forward best practice.

The rationale for choosing this policy is that currently, within the author’s role, there is local implementation of this policy to support the patient dignity and respect agenda. In recent years there have been several high-profile exposés of undignified care, neglect and poor practice, which have been a catalyst for a searching debate into standards of care, practice and the nursing profession (Francis 2010; Parliamentary and Health Service Ombudsman 2011).

The policy analysis triangle (Walt & Gilson 1994) will be applied as the analytical framework for this policy. The rationale for choosing this tool is that dignity is a complex, multi-faceted issue and the analysis tool allows for the effect of the complex convergence. Out of the four identified areas – process, actors, context and content – only three will be considered in depth. Due to word constraints, policy content is critiqued in an Appendix.
9.2 The health policy

‘A policy is a broad statement of goals and means that creates the framework for activity’ (Buse et al 2010: 4). Anderson (1975) and Fawcett and Russell (2001) concur that policies can be a deliberate plan of action to intentionally alter a pattern of behaviour.

‘Essence of Care’ was initially launched in 2001 (DH 2001b) following the publication of The NHS Plan (DH 2001a). In 2010, the publication of Equity and Excellence: Liberating the NHS (DH 2010c) supported a relaunch of Essence of Care: Patient-focused benchmarking for health care practitioners (DH 2001b) under the title Essence of Care: Benchmarks for the fundamental aspects of care (2010a) (Appendix 1). This is a distributive policy, aimed at improving patient care and addressing some of the fundamentals of care lacking in modern healthcare settings (Davies 2004; Ellis 2006). Regulators are also using the benchmarking system to assess quality of services (DH 2010a). The central tenet of this policy is to move patient experience from poor practice to best practice through a process of benchmarking. The definitions and principles guiding this document are respect: regard for the feelings and rights of others; and dignity: quality of being worthy of respect (DH 2010a).

The concept of dignity has its philosophical foundations in the work of Aristotle (Gallagher et al 2008). Chochinov (2007) outlines that in Latin the word ‘patient’ comes to mean to bear, endure or suffer and denotes acquired helplessness and exposure. Dignity is assumed to be the ‘worthiest goal’ for a public and government movement (Klein 1998). Aranda and Jones (2010) suggest that there is agreement that the moral view of dignity is a cornerstone in western healthcare (Seedhouse 2009; Beauchamp & Childress 2009).

However, there is a lack of consensus on the definition of dignity (Gallagher et al 2008) and Wainwright (2011) asserts that politicians, media and health professionals find the concept of dignity problematic in its inherent ambiguity.
Essence of Care (2010a) incorporates the underlying principles of respect and dignity which is aligned to *The NHS Constitution: The NHS belongs to us all* (DH 2010b). Both policies are centred on principles of collectiveness, values, pledges and responsibilities. However, the Constitution appears to have a lower prominence within clinical groups in the NHS, as a standalone policy with no requirement for demonstrable application. Essence of Care (DH 2010a) and the NHS Constitution (DH 2010b) also mirror the ideology underpinning the New Labour government rhetoric of liberalism, human rights, fairness and liberty (Harrison & McDonald 2008) and currently is supported by the Coalition government’s pledges on civil liberties (Brap 2010).

### 9.3 Policy analysis tool

![Policy Analysis Triangle (Walt & Gilson 1994)](image)

**Figure 9.** Policy Analysis Triangle (Walt & Gilson 1994)
The chosen policy analysis tool is the policy analysis triangle (Figure 9). It is a non-linear process, encompassing a retrospective deliberation on the interaction between all four factors: policy content, context, actors and processes (Buse et al 2010; Currie & Clancy 2010). Walt (1994) defines the affiliation between health policy and politics, in that they are extrinsically linked. This would appear to be the case in Essence of Care (DH 2010a) in that the health policy came from a political position and situation.

9.4 Process

The ‘stages of heuristics’ (Sabatier & Jenkins-Smith 1993) outline the processes required from policy identification to implementation. It would appear that Essence of Care has been revised on three occasions to absorb further clinical areas for benchmarking, rather than revision based on policy improvements (Appendix 2).

The author has applied Kingdon’s ‘three-stream model of agenda setting’ (1984) to the Essence of Care (DH 2010a) to allow for a more defined analysis of the policy windows in the policy process (Figure 10). Initially, following the NHS Plan (DH 2001a), and New Labour’s commitment to reducing inequity of care, we saw the initiation and launch of the Essence of Care Benchmarks in 2001, aligning two areas. However, it could be argued that it was not until nine years later, with a stronger patient voice through the Patients’ Association (PA), the findings of the inquiry into the Mid Staffordshire NHS Foundation Trust (Francis 2010) and the Care and Compassion Report (Parliamentary and Health Service Ombudsman 2010), that a significant ‘watershed moment’ transpired (Campbell et al 2007).

The convergence occurred between a ‘problem’, lack of patients’ dignity, and a ‘policy entrepreneur’, the PA (Kingdon 1984) and hence the political will of the ‘New Coalition Government’ to relaunch the dignity and respect benchmark (Essence of Care, DH 2010a). Buse et al (2010) stated that the union cannot be contrived and is defined as a ‘policy
window’ when all three situations converge. In agreement, Ham (2009) describes the convergence of three events to raise policy to the agenda.

![Diagram showing the three streams of agenda setting](image)

**Figure 10.** Kingdon’s ‘three-stream model of agenda setting’ (1984) applied to Essence of Care (DH 2010a)

### 9.5 Actors

Buse *et al* (2010) depicts the actors as being at the centre of the triangle. In applying this tool to the Essence of Care (DH 2010a) the key actors are the patient pressure groups, mass media, nursing profession and government. The actors should not be seen in isolation from each other, rather the collective effect each has on the other, to understand the interrelationships and powers that exist.
9.6 Patient pressure groups and mass media

Giddens (1982) defines political mobilisation and social citizenship as outputs from social struggle, therefore seen as the corollary of freedom and liberty. Since New Labour came into office 1997, participation and patient pressure groups have been higher profile and more visible in seeking to influence services via a bottom-up approach (Blears 2003). Harrison and McDonald (2008) acknowledge the shift of the effect of patients and carers wanting to have some political influence over the services they receive.

The PA is an active pressure group whose role is campaigning and active participation with the goal to ‘amplify the patient voice and drive forward change’. This redressing of power produces a discourse through campaigning, courageous activists. In 2010, the Francis Inquiry concluded that patients and carers who were directly in receipt of care were often ignored and there was insufficient consideration for correct and proper standards of care. It could be suggested that these events have been a catalyst for the pressure groups and the media to speak up against poor standards of care.

The PA’s campaign to fund a helpline for patients and carers (Patients’ Association 2010) was in part supported and funded by the Daily Mail newspaper. The impact of the mass media was to gain attention and support for the dignity campaign; it was successful in raising the profile of poor standards of care in the public’s mind and hence the opportunity for government policy to respond.

Public opinion and patient surveys formed the evidence base for the policy (Campbell et al. 2007) which was seen as direct government lobbying driven by public opinion. Further, the response to such situations can be the emergence of a social movement to bring about change (NHS Modernisation Agency 2004; Buse et al. 2010). Campbell et al (2007) emphasised the value placed by policy makers on surveys and attitudinal evidence provided by ‘on the ground’ participants. There was considerable media interest in the findings of the
Francis Inquiry (2010) and the relaunch of the Essence of Care was one measure which aimed to drive forward improvements to patient care.

9.7 Nursing profession

From a historical perspective, nursing has faced significant polarity. The trajectory of the mythologising, pervasive imagery of Florence Nightingale is contrary to the images of the modern, highly-technological, task-focused roles of advanced nurse practitioners. This role dichotomy is described as the profession’s ‘fall from grace’ by Maben and Griffiths (2008), as it struggles with contradictory and abstruse role definitions. The public have misunderstood the changing roles of nurses and this misconception is partly being reinforced in the mass media (Maben & Griffiths 2008). Scott (2001) refutes this position and looks to Alan Millburn (Secretary of State for Health in 2001) for the governmental role in creating contradictions in the nursing role, with expectations of expanding skills in medical domains whilst devaluing the softer aspects of the nursing contribution.

Fawcett and Russell (2001) suggest that society grants contracts with the nursing profession and in doing so permits high levels of self-determination in its practice. However, Donabedian (1966) warns that this contract needs be respected and that the partnership needs to be built on trust. In recent times there has been significant testing of this relationship with high-profile mass media reports of poor nursing practice. Delomothe (2011) proposes that, increasingly, healthcare professionals are now demonstrating levels of indifference to those most vulnerable in society. An opposing view is that standards of nursing practice appear to be poor due to system failure rather than individual indifference, poor leadership, overworked nurses and high burn-out (Metcalf et al 2011).

The nursing profession as actor has a significant impact on the implementation of the Essence of Care (DH 2010). Furthermore, nurses would play a pivotal role in developing and implementing national service frameworks and clinical governance. This policy attains to
solve a problem (DH 2010a), in this case to promote nursing practices which enhance respect or dignity.

9.8 Government

‘Government does not come to conclusions. It stumbles into paradoxical situations that force it to move one way or another’ (Kingdon 1984: 199). The New Labour government came into office in 1997, and occupied a new arena of political ideology, the ‘Third Way’. This was a unification of some of the old socialist ideologies of social justice and equality with inclusion of Conservative ideologies of privatisation and the free market (Giddens 1998). Critics observe that this signalled New Labour’s shifting of responsibility from society to individuals (Rose 1996). Bradshaw (2003) critiques the conceptual basis for the Third Way, defining the shift in quality of care so that excellence is guaranteed to all patients. In addition a mixed economy model converts patients into new consumers of healthcare.

The Coalition government popularised the phrase ‘no decision about me, without me’ (DH 2010c) and was widely supported by patient organisations (Brap 2010). This gave a strong signal that policies such as the Essence of Care (DH 2010a) which focused on driving patient experience would remain central to the Coalition’s political pledges. In the summer of 2011, David Cameron, the Prime Minister, used the discourse of ‘social moral collapse’ in light of the civil unrest in the United Kingdom (Yahoo News 2011). It will be of interest to see if this discourse permeates to the NHS dignity and respect agenda.

9.9 Context – Situational, structural and cultural factors

There are two significant situational ‘focusing’ events which impact on the Essence of Care Benchmarks for respect and dignity (DH 2010a); the new Coalition Government in 2010 and increasing undercover media exposés of poor standards of nursing care and the subsequent public outcry. Inadequacy of care is driving the political agenda (Payne 2011) and therefore
dignity is on the policy agenda as it starts from the premise that care is not being provided in a dignified way.

In 2010, the Conservative Manifesto was translated into a pledge (*Renewal plan for a better NHS*, Conservative Party 2010) and has defined the core values and principles within healthcare: patient-led, localism, outcomes not targets, and giving better patient treatment (King’s Fund 2009). Central to this message are civil liberties and reaffirmation of the NHS Constitution (DH 2010b; Brap 2010).

The Coalition government’s comprehensive spending review (HM Treasury 2010) and subsequent efficiency savings throughout the health economy could be seen as a real challenge for delivery of the Essence of Care agenda, with potential reductions in front-line staff whilst enhancing the dignity agenda. The King’s Fund (2009) identifies these transactional reforms to include proposed financial levers to drive up patient experience. This was seen as one way of trying to manage this unease. It remains to be seen how this balance can be achieved.

### 9.10 Policy content

The component parts of the Essence of Care (2010a) are detailed in Appendix 3. In analysis it is supported that there has been a partial uptake of the Benchmarks, focusing on single-sex environments rather than staff behaviours and attitudes.

### 9.11 Implications for practice

It has been ten years since the original launch of the Essence of Care through *The Essence of Care: Patient-focused benchmarking for health care practitioners* (DH 2001b; DH 2010a). At a micro-level in implementing the Essence of Care, Davies (2004) and Oxtoby (2004) state that many Trusts are self-selecting the visible quick-win benchmarks, such as single-sex accommodation, rather than addressing system change benchmarks such as respect...
and dignity. Hartley’s (2004) survey identified that only 46% of respondents were aware of the Essence of Care, 20% did not understand it and 25% had assumed it was a top-down management initiative. It is a substantial document over 200 pages long which could lead to staff disengagement (Davies 2004).

Further possible barriers to implementation are evidenced by Ellis (2006) who proposes that NHS managers are more focused on collating quantitative performance data rather than qualitative data in the benchmarking of this policy, due to the perceptions of difficulty in measuring the outcomes and the potential for subject bias. Essence of Care (2010a) can have a beneficial effect on patient care if nurses are given enough support to implement the benchmarks, as has been illustrated in many Trusts around the country (Oxtoby, 2004; Ho & Craig 2009).

A more complex rationale of barriers to successful implementation is the concern that dignity cannot be measured in the same way as the other metrics. Gallagher et al (2008) agree that there remains some ambiguity regarding a philosophical definition of dignity. Chochinov (2007) describes compassionate care as an intrinsic quality of the caregiver and not a skill that is easily taught or measured. In support, Clayton (2011) argues that compassion and dignity require a giving of oneself to another. He further suggests that episodes of ‘undignified care’ happen between two people and not a regulator. Here lies the paradox for Essence of Care and dignity: if it is innate how can it be measured in a meaningful way, and by saying it is difficult to measure this implies that we should avoid trying to regulate it and for it to become the hidden metric. Further, Scott (2001) observes that the principles within the Essence of Care are no more than simply the fundamentals of patient care, rather than a benchmarking toolkit.

A further consideration is the role of target monitoring in local decision making with a decentralisation model of New Labour and the Coalition. Propper et al (2007) define ‘targets and terror’ in that NHS managers have been relegated from clinical visibility to performance
assurance for the government targets. This could have an impact on the monitoring of the Essence of Care Benchmarks. Cann (2008) argues against dignity becoming a political buzzword, and calls for policy makers to keep dignity on the agenda. Gallagher et al (2008) urge both government investment and professional resolve to support dignity.

9.12 Discussion

In drawing the three areas of power, politics and policy together, the interplay and the impact of the three areas are evident. In the analysis triangle the power is seen as decision making within the actors and is weighted towards the Patients’ Association and the mass media due in part to public opinion and its ability to influence policies. Boulding (1989) outlined this as mutually beneficial power, or the ‘deal’. Whilst the PA and other consumer activist groups seek to influence those in power they do not seek formal political power for themselves. The context of democracy and participation were important in the PA’s raising the profile of cases of poor nursing care and loss of dignity.

There has been some success in the implementation of the dignity and respect benchmarks (DH 2010a) but these have focused primarily on environmental changes such as single-sex accommodation rather than attitudinal and behavioural changes. An alternative framework for driving the dignity agenda forward could be through the NHS Outcomes Framework 2011/12 which will span three areas of quality: clinical effectiveness, safety and patient experience. The framework will be made up of a set of national outcome goals which can be used to hold the Secretary of State to account for the overall performance of the NHS through the commissioning boards (King’s Fund 2009).

Conclusion

The policy analysis tool was effective in facilitating an in-depth analysis of the differing components of the policy. However, it appeared that some areas, such as actors, were more
prominent than others, and there was some blurring within the components which also confirmed the interrelationships such as between government actors and context. However, the tool was rather static and it did not facilitate an analysis of the effect of time on the policy or policy iterations.

With the challenges to how dignity is best measured in terms of professional behaviours, it is worth considering alternative models of ‘vocational nudges’ (Brap 2010) which focus on behaviours, attitudes and, crucially, leadership behaviours. Lack of clinical leadership is a recurring theme in areas of poor practice (Maben & Griffiths 2008; Francis Inquiry 2010; Parliamentary and Health Ombudsman 2011). A key shift in the new NHS reforms will be that commissioning and regulation must work together to ensure that dignity is embedded and delivered.

Another facet for successful implementation is that if dignity is seen as an issue for the multi-disciplinary team then the team may be higher profile, rather than Essence of Care being the domain of the nursing profession. Gallagher et al (2008) support the view that dignity is an issue for all clinical staff.

With NHS reform and the current fiscal climate, the issue of civil liberties and entitlement will be more heightened. The challenge will be how to deliver higher standards of care, with less resource. This could be an opportunity for nurses to have a central role in leading change, promoting patient advocacy, involvement in policy making and driving up standards of patient care.
References


Department of Health (2010c) *Equity and Excellence: Liberating the NHS.* London: Department of Health


Appendix 1: Essence of Care 2010

Essence of Care
2010

Benchmarks for Respect and Dignity

Department of Health
**Document Purpose**: Best Practice Guidance

**ROCR Ref:**

**Gateway Ref:** 14641

**Title**

ESSENCE OF CARE 2010

**Author**

DEPARTMENT OF HEALTH

**Publication Date**

1ST OCTOBER 2010

**Target Audience**

PCT CEOs, NHS Trust CEOs, Care Trust CEOs, Foundation Trust CEOs, Directors of Nursing, Local Authority CEOs, Directors of Adult SSs, PCT PEC Chairs, Special HA CEOs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations

**Circulation List**

PCT CEOs, NHS Trust CEOs, Care Trust CEOs, Foundation Trust CEOs, Directors of Nursing, Local Authority CEOs, Directors of Adult SSs, PCT PEC Chairs, Special HA CEOs, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NGOs, Universities UK, RCN, RCM, AHPF, SHA Lead Nurses, SHA AHP Leads, Patient Organisations

**Description**

Essence of Care 2010 includes all the benchmarks developed since it was first launched in 2001, including the latest on the Prevention and Management of Pain. All the benchmarks have been reviewed to reflect the current views of people requiring care, carers and staff.

**Cross Ref**

Essence of Care 2001, Communication, Promoting Health and Care Environment

**Superseded Docs**

Essence of Care 2001 Gateway No. 4656 and 6489

**Action Required**

N/A

**Timing**

N/A

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**For Recipient's Use**
Essence of Care 2010

BENCHMARKS FOR THE FUNDAMENTAL ASPECTS OF CARE

Benchmarks for Respect and Dignity
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Best Practice – General Indicators

The factors and indicators for each set of benchmarks focus on the specific needs, wants and preferences of people and carers. However, there are a number of general issues\(^1\) that must be considered with every factor. These are:

**People’s experience**
- *People* feel that care is delivered at all times with compassion and empathy in a respectful and non-judgemental way
- The best interests of *people* are maintained throughout the assessment, planning, implementation, evaluation and revision of care and development of services
- A system for continuous improvement of quality of care is in place

**Diversity and individual needs**
- Ethnicity, religion, belief, culture, language, age, gender, physical, sensory, sexual orientation, developmental, mental health, social and environmental needs are taken into account when diagnosing a health or social condition, assessing, planning, implementing, evaluating and revising care and providing equality of access to services

**Effectiveness**
- The effectiveness of practice and care is continuously monitored and improved as appropriate
- Practice and care are evidence-based, underpinned by research and supported by practice development

**Consent and confidentiality**
- Explicit or expressed valid consent is obtained and recorded prior to sharing information or providing treatment or care

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\(^1\) Also see Department of Health (2010) NHS Constitution The NHS belongs to us all. Department of Health: London accessed 07 May 2010 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets@dh@en/ps/documents/digitalasset/dh_113645.pdf
People's best interests are maintained where they lack the capacity to make particular decisions. Confidentiality is maintained by all staff members.

People, carer and community members' participation

- People, carers' and community members' views and choices underpin the development, planning implementation, evaluation and revision of personalised care and services and their input is acted upon.
- Strategies are used to involve people and carers from isolated or hard to reach communities.

Leadership

- Effective leadership is in place throughout the organisation.

Education and training

- Staff are competent to assess, plan, implement, evaluate and revise care according to all people's and carers' individual needs.
- Education and training are available and accessed to develop the required competencies of all those delivering care.
- People and carers are provided with the knowledge, skills and support to best manage care.

Documentation

- Care records are clear, maintained according to relevant guidance and subject to appropriate scrutiny.
- Evidence-based policies, procedures, protocols and guidelines for care are up-to-date, clear and utilised.

Service delivery

- Co-ordinated, consistent and accessible services exist between health and social care organisations that work in partnership with other relevant agencies.

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Care is integrated with clear and effective communication between organisations, agencies, staff, people and carers

**Safety**

- Safety and security of people, carers and staff is maintained at all times

**Safeguarding**

- Robust, integrated systems are in place to identify and respond to abuse, harm and neglect³
- All agencies working with babies, children and young people and their families take all reasonable measures to ensure that the risks of harm to babies, children's and young people's welfare are minimised.⁴

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Benchmarks for Respect and Dignity

**Agreed person-focused outcome**
People experience care that is focused upon respect

**Definitions**
For the purpose of these benchmarks:

- **respect** is:
  - regard for the feelings and rights of others.

- **dignity** is:
  - quality of being worthy of respect.

- **privacy** is:
  - freedom from unauthorised intrusion.

For simplicity, **people requiring care** is shortened to *people* (*in italics*) or omitted from most of the body of the text. **People** includes babies, children, young people under the age of 18 years and adults. **Carers** (for example, members of families and friends) are included as appropriate.

The term **carers** refers to those who ‘look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid’ (adapted from Carers UK, 2008). Please note, within these benchmarks it is acknowledged that the term ‘carer’ can include children and young people aged under 18 years.

The term **staff** refers to any employee, or paid and unpaid worker (for example, a volunteer), who has an agreement to work in that setting and is involved in promoting well-being.

The **care environment** is defined as an area where care takes place. For example, this could be a building or a vehicle.

The **personal environment** is defined as the immediate area in which a person receives care. For example, this can be in a person’s home, a consulting room, hospital bed space, prison, or any treatment/clinic area.
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<td>2. Personal world and personal identity</td>
<td>People experience care in an environment that encompasses their values, beliefs and personal relationships</td>
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<td>4. Communication</td>
<td>People and carers experience effective communication with staff, which respects their individuality</td>
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<td>5. Privacy – confidentiality</td>
<td>People experience care that maintains their confidentiality</td>
</tr>
<tr>
<td>6. Privacy, dignity and modesty</td>
<td>People’s care ensures their privacy and dignity, and protects their modesty</td>
</tr>
<tr>
<td>7. Privacy – private area</td>
<td>People and carers can access an area that safely provides privacy</td>
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Factor 1
Attitudes and behaviours

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

POOR PRACTICE
People and carers experience deliberate, negative and offensive attitude and behaviour

BEST PRACTICE
People and carers feel that they matter all of the time

Indicators of best practice for factor 1
The following indicators support best practice for respect and dignity:

a. general indicators (see page 4) are considered in relation to this factor
b. good attitudes and behaviour are promoted and monitored including consideration of non-verbal behaviour and body language
c. issues about attitude and behaviour are addressed with appropriate staff
d. partnerships exist between people, carers and staff that promote good attitudes and behaviours
e. add your local indicators here
Factor 2
Personal world and personal identity

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

POOR PRACTICE
People's individual values, beliefs and personal relationships are never explored

BEST PRACTICE
People experience care in an environment that encompasses their values, beliefs and personal relationships

Indicators of best practice for factor 2
The following indicators support best practice for respect and dignity:

a. general indicators (see page 4) are considered in relation to this factor
b. stereotypical views are challenged
c. diversity is valued and specific and special needs are accommodated
d. people's needs and preferences are ascertained and continuously reviewed
e. people's personal relationships are respected
f. add your local indicators here
Factor 3
Personal boundaries and space

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

**POOR PRACTICE**
People's personal boundaries are deliberately invaded

**BEST PRACTICE**
People's personal space is protected by staff

Indicators of best practice for factor 3

The following indicators support best practice for respect and dignity:

a. general indicators (see page 4) are considered in relation to this factor

b. personal boundaries are identified and communicated to staff, for example, by using people's own language

c. personal boundaries are assessed using psychological, physical, emotional and spiritual parameters

d. people's personal space is respected and protected

e. strategies are in place to prevent disturbing or interrupting people, for example, requesting and awaiting an invitation to enter before entering their personal area

f. privacy is maintained effectively, for example, using curtains, screens, walls, rooms, blankets, appropriate clothing and appropriate positioning of people
g. the acceptability of touch is identified with people
h. clinical risk is managed with consideration of privacy, dignity and modesty
i. privacy is achieved when the presence of others is required
j. *add your local indicators here*
Factor 4
Communication

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document.

POOR PRACTICE
People and carers are 'communicated at'

BEST PRACTICE
People and carers experience effective communication with staff, which respects their individuality.

Indicators of best practice for factor 4

The following indicators support best practice for respect and dignity:

a. general indicators (see page 4) are considered in relation to this factor
b. people are addressed as they wish and are spoken to using their preferred name. This information is documented
c. staff listen actively to people and carers
d. people's individual needs and views are taken into account
e. people are respected as individuals
f. people and carers are enabled to communicate effectively, for example, by the use of communication aids, or by the use of a competent translation and interpretation service which is available and accessible when required
g. add your local indicators here
Factor 5
Privacy – confidentiality

Please note that this benchmark must be used in conjunction with the
How to use Essence of Care 2010 document

POOR PRACTICE
Confidentiality is not maintained

BEST PRACTICE
People experience care that maintains their confidentiality

Indicators of best practice for factor 5
The following indicators support best practice for respect and dignity:

a. general indicators (see page 4) are considered in relation to this factor

b. precautions are taken to prevent information being shared
   inappropriately, such as, by telephone conversations being overheard,
   computer screens being viewed, staff discussing personal details in
   public places, and white boards being read

c. procedures are in place for communicating people’s personal
   information in a confidential manner, for example, during handover
   procedures, consultant and/or teaching rounds, admission procedures
   and telephone calls, and when calling people in outpatients and
   breaking bad news
d. explicit or expressed valid consent is sought from people when special measures are required to overcome communication difficulties, for example, when using competent interpreters

e. add your local indicators here
Factor 6
Privacy, dignity and modesty

Please note that this benchmark must be used in conjunction with the *How to use Essence of Care 2010 document*

**POOR PRACTICE**
People's privacy, dignity and modesty are not considered

**BEST PRACTICE**
People's care ensures their privacy and dignity, and protects their modesty

Indicators of best practice for factor 6
The following indicators support best practice for respect and dignity:

a. general indicators (see page 4) are considered in relation to this factor

b. staff are proactive in maintaining people's privacy, dignity and modesty, for example, by using signage to indicate when people are engaged in private activity

c. people are protected from unwanted public view, for example, by using curtains, screens, walls, clothes and covers

d. appropriate clothing is available for people who cannot wear their own clothes

e. policies are in place to support people to have access to their own clothes

f. people can have a private telephone conversation
g. modesty is achieved for those moving between differing care environments

h. the organisation has a designated person whose aim is to work in partnership with staff to ensure they care with dignity

i. *add your local indicators here*
Factor 7
Privacy – private area

Please note that this benchmark must be used in conjunction with the How to use Essence of Care 2010 document

**POOR PRACTICE**
People and carers are denied access to any area that offers privacy

**BEST PRACTICE**
People and carers can access an area that safely provides privacy

Indicators of best practice for factor 7

The following indicators support best practice for respect and dignity:

a. *general indicators (see page 4) are considered in relation to this factor*

b. A private area is created where care is delivered when required

c. Quiet areas are available at all times and people and carers are aware of how to access them

d. Clinical risk is managed with consideration of privacy

e. *Add your local indicators here*
## Appendix 2: Chronological Policy implementations and critique influencing the drive for Essence of Care

<table>
<thead>
<tr>
<th>Policy/Milestone</th>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration of Human Rights</td>
<td>1948</td>
<td>Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family</td>
</tr>
<tr>
<td>The NHS Plan</td>
<td>2000</td>
<td>Labour – Socialist ideology on taxation providing NHS revenue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New Labour first term 1997 ‘third way’ – Giddens</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Retained ideology old left – equality &amp; social justice but now accepted free market (Tory ideology)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Converts users of services into consumers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality agenda – NHS free to all – power devolved to local providers, reform comes from inspection &amp; regulation</td>
</tr>
<tr>
<td>Essence of Care</td>
<td>2001</td>
<td>National benchmarking system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To redress unacceptable variations in standards of care. Principles of patient focus and sharing best practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Labour re-elected 2001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NICE established introduction of clinical governance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blair &amp; Brown wanted greater control over NHS from Whitehall through performance management</td>
</tr>
<tr>
<td>DH Dignity in Care public survey</td>
<td>2006</td>
<td>Ivan Lewis launched an online survey to hear directly from the public about their own experiences of being treated with dignity in care services, or about care they had seen provided to others. 400 responses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£67 million resource to improve care environments. Use of Dignity champions to promote agenda</td>
</tr>
<tr>
<td>Lord Darzi ‘High Quality Care for All’</td>
<td>2008</td>
<td>3 components to Quality: safety, effectiveness and experience</td>
</tr>
<tr>
<td>Event</td>
<td>Year</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Locally led and clinical vision</td>
<td>2009</td>
<td>Dignity at the heart of everything</td>
</tr>
<tr>
<td>Support agenda to nursing workforce to</td>
<td></td>
<td>enhance care delivery and increase dignity awareness</td>
</tr>
<tr>
<td>NHS constitution</td>
<td>2009</td>
<td>The NHS touches our lives at times of basic human need, when care and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compassion are what matter most</td>
</tr>
<tr>
<td>Essence of Care – revision</td>
<td>2003</td>
<td>Benchmark of communication was added</td>
</tr>
<tr>
<td>Essence of Care – revision</td>
<td>2006</td>
<td>Benchmark of promoting health &amp; well-being added</td>
</tr>
<tr>
<td>Essence of Care – revision</td>
<td>2007</td>
<td>Benchmark of care environment added</td>
</tr>
<tr>
<td>Equality &amp; Excellence: liberating the NHS</td>
<td>2010</td>
<td>Coalition Government 2010 – putting patients at the centre of service- 'no</td>
</tr>
<tr>
<td></td>
<td></td>
<td>decision without me'</td>
</tr>
<tr>
<td></td>
<td></td>
<td>decentralisation of control and GP commissioning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater openness and transparency. Civil liberties infringements – fit with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dignity agenda</td>
</tr>
<tr>
<td>Relaunch new Essence of Care</td>
<td>2010</td>
<td>Benchmark of pain was added</td>
</tr>
<tr>
<td>Parliamentary &amp; Health Service Ombudsman</td>
<td>2011</td>
<td>Significant failings still exist and additional resource alone will not</td>
</tr>
<tr>
<td>(PHSO) Care &amp; compassion report</td>
<td></td>
<td>assist the NHS to fulfil its own standards of care</td>
</tr>
</tbody>
</table>
### Appendix 3: Policy Content – Essence of Care – Benchmarks for Respect and Dignity (DH 2010a: 7-8)

<table>
<thead>
<tr>
<th>Critique of content of the Essence of Care (DH 2010a)</th>
<th>Drivers</th>
<th>Restrainers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definitions</strong></td>
<td>There is general agreement that it is important to provide care based on dignity and respect</td>
<td>There are inherent difficulties with the ambiguity in the definitions of these terms</td>
</tr>
<tr>
<td><strong>Respect</strong> is regard for feelings and rights of others; <strong>dignity</strong> is quality of being worthy of respect; <strong>privacy</strong> is freedom from unauthorised intrusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aims</strong> Benchmarking/quality assurance</td>
<td>Requires buy-in and requires additional workload for clinical staff</td>
<td>Can be slow to get buy-in as seen as a qualitative tool</td>
</tr>
<tr>
<td><strong>Content</strong> Accessible document with clear guidance on how to evidence a shift from poor practice to best practice</td>
<td></td>
<td>The aim of the benchmark is to drive up care based on respect, dignity and privacy. However, the uptake has been focused on providing enhanced environmental factors – single-sex accommodation</td>
</tr>
<tr>
<td>7 identified person-focused outcomes 'factors'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Attitudes and behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Personal world and personal identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Personal boundaries and space</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Privacy – confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Privacy, dignity and modesty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Privacy – private area</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome</strong> performance and dissemination tool</td>
<td>Starts from premise that poor practice exists</td>
<td>Needs culture of improvement and leadership support to drive change forward</td>
</tr>
<tr>
<td>Evidence of compliance to registration with CQC and best practice</td>
<td></td>
<td>In most areas Trusts have picked the factors where they can make quick wins, e.g. providing all patients with single-sex accommodation has become high profile and is seen as a measurement of success for respect and dignity. Yet the Benchmark is intended to focus on respect, dignity and privacy. An insight into why the uptake has focused on these areas may be that these are visible environmental changes which, whilst requiring</td>
</tr>
<tr>
<td>Conclusion and implications for practice</td>
<td>Cornerstone in the NHS Constitution (2010b) and the themes in <em>Equality and Excellence: Liberating the NHS</em></td>
<td></td>
</tr>
</tbody>
</table>
Support from actors – media, Patients’ Association, government and nursing profession financial input, requires little investment in terms of leadership, cultures or behaviours. An environmental change is also a visible change which is easy to measure in terms of performance

**Agreed person-focused outcome**

*People* experience care that is focused upon respect

<table>
<thead>
<tr>
<th>Factor</th>
<th>Best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attitudes and behaviours</td>
<td><em>People</em> and carers feel that they matter all of the time</td>
</tr>
<tr>
<td>2. Personal world and personal identity</td>
<td><em>People</em> experience care in an environment that encompasses their values, beliefs and personal relationships</td>
</tr>
<tr>
<td>3. Personal boundaries and space</td>
<td><em>People’s</em> personal space is protected by staff</td>
</tr>
<tr>
<td>4. Communication</td>
<td><em>People</em> and carers experience effective communication with staff, which respects their individuality</td>
</tr>
<tr>
<td>5. Privacy – confidentiality</td>
<td><em>People</em> experience care that maintains their confidentiality</td>
</tr>
<tr>
<td>6. Privacy, dignity and modesty</td>
<td><em>People’s</em> care ensures their privacy and dignity, and protects their modesty</td>
</tr>
<tr>
<td>7. Privacy – private area</td>
<td><em>People</em> and carers can access an area that safely provides privacy</td>
</tr>
</tbody>
</table>
Chapter 10: Advanced Research Methods Assignment

10.1 Scenario 1 “Living well with dementia”

Introduction

The aim of this research study is to understand the service provision for dementia care within a specified locality in the south of England. In the assignment, there will be an analysis and justification of the proposed methodology, methods, sampling and ethical considerations. Researchers involved within all research must be qualified in Good Clinical Practice (GCP) to ensure that the rights and safety of all participants are protected (ICH GCP 2007).

The projected prevalence of dementia is expected to double over the next thirty years (Knapp et al 2007). Hoffman et al (1991) confirmed that dementia is one of the most widespread and severe disorders in the over 65s living in Europe. The National Service Framework (NSF) for Older People detailed new standards of care and access to services for older people including those with mental health problems (DH 2001). This set the direction of care, support and models of shared care for people with dementia.

Research design

A qualitative research design was chosen for this study because it was important to gain an understanding of people’s lives and behaviours. Qualitative research is concerned with gaining knowledge about human beings and their natural world (Polit & Hungler 1993). This approach is both inductive and deductive and facilitates an understanding of the empirical world from the participants’ perception (Duffy 1987; Cormack 1996).

A grounded theory methodology was chosen for this research so as to facilitate an exploration of individuals’ experiences within their social worlds and lead to theory generation which could add to the body of knowledge (Strauss & Corbin 1998).
A further rationale was that grounded theory is most appropriate when there is little known in the specified area (Benton 1996; Stern 1980). In conducting a preliminary literature review, three qualitative research studies exploring the experiences of dementia all concluded that there was a dearth of literature available in this subject area (Black & Rabins 2007; Lawrence et al 2009; Lawrence et al 2010).

**Data collection methods**
The data collection methods would be semi-structured interviews and focus groups for differing participants within the sample. Those people with dementia would be recruited to semi-structured interviews, and focus groups would be offered to the other stakeholders within the study.

The rationale for choosing semi-structured interviews would be to facilitate those people with dementia to give an in-depth account of their personal experiences, with rich narrative data, in the privacy of their own homes if preferred. Cormack (1996) and Barker (1996) argue that if participants are given freedom in the interview process they are more likely to discuss the issues that are most pertinent. A focus group would be a less suitable method of data collection for these participants, as a group setting may inhibit disclosure of personal experiences (Bowling 2009). Holloway and Wheeler (1996) suggested that the search for rich data may inadvertently cause emotional distress; a flexible interview time frame may be more appropriate for these participants.

A pilot interview would be conducted to allow for modifications to the interview. A research diary would also be maintained. The value of a research diary can be demonstrated in supporting an awareness of the subject and the feelings of the researcher (Hutchinson 1993). The performing of data collection and data analysis would be simultaneous in a process of ‘constant comparison’ to allow the data to guide further areas of discovery (Strauss & Corbin 1998).
Focus groups would be the data collection method for the rest of the sample (carers, commissioners, health and social care professionals and the voluntary sector). The advantage of this method of data collection is the rich, dynamic environment that facilitates social interactions (Holloway & Wheeler 1996; Robinson 1999). The sample would be invited to explore partnership working, differing models of service provision and the extent of implementation, and the enablers and barriers to quality dementia care in the locality. The focus groups would be offered in a suitable quiet meeting room.

**Sampling**

General practitioners (GPs) within a PCT Cluster in the South East locality would be contacted and asked to identify potential participants for the study, through practice clinical data, as this method would identify all dementia sufferers within a defined cluster as opposed to only those who are service users. Holloway and Wheeler (1996) argue that theoretical sampling is fundamental to a grounded theory methodology, and continues iteratively until saturation occurs. An information sheet explaining the study would be sent out to GPs to pass on to suitable participants. There may be some issues of access and ‘gate keeping’; in order to minimise this potential situation arising, good engagement with the GPs within the study would be vital. The GP practices within the cluster would cover a range of socially and ethnically diverse populations, so as to give a representative sample.

An information sheet explaining the study would be sent out to all dementia services within the PCT cluster, inviting those stakeholders to take part in the study. Participants from the voluntary sector and social care would be recruited through The Alzheimer's Society 'map of services' (2011) within the defined boundary PCT cluster.
Table 5. Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed diagnosis of dementia</td>
<td>Unconfirmed diagnosis</td>
</tr>
<tr>
<td>Patients who have capacity (Mental Capacity</td>
<td>Do not have capacity to consent and do not understand English language</td>
</tr>
<tr>
<td>Act 2005) to consent and understand the English language</td>
<td></td>
</tr>
<tr>
<td>Patients who are able to communicate effectively</td>
<td>Unable to communicate effectively so researcher would not be able to capture data</td>
</tr>
<tr>
<td>Service users of dementia services</td>
<td>Service users who are not accessing any support services</td>
</tr>
<tr>
<td>Stakeholders who are involved in caring for</td>
<td>Stakeholders who are not involved with people with dementia either through direct care or service provision and planning.</td>
</tr>
<tr>
<td>people with dementia or involved in the</td>
<td></td>
</tr>
<tr>
<td>commissioning or provision of services for</td>
<td></td>
</tr>
<tr>
<td>those with dementia.</td>
<td></td>
</tr>
</tbody>
</table>

Ethical considerations

Favourable ethical approval would be sought prior to commencing a research study.

Couchman and Dawson’s (1995) ‘Ethical principles of research’ are applied to this proposed research study in Table 6.
Table 6. Ethical principles

<table>
<thead>
<tr>
<th>Ethical principles (Couchman &amp; Dawson 1995)</th>
<th>Applied to the proposed research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not to be harmed</td>
<td>Suitably qualified researcher</td>
</tr>
<tr>
<td></td>
<td>Flexible interview time frame</td>
</tr>
<tr>
<td></td>
<td>Stopping the interview if too distressing</td>
</tr>
<tr>
<td></td>
<td>Signposting to support groups</td>
</tr>
<tr>
<td>Ensure informed consent</td>
<td>Consent must be informed and voluntary</td>
</tr>
<tr>
<td></td>
<td>(carer could be present as required)</td>
</tr>
<tr>
<td></td>
<td>Establish comprehension of English in order to fully consent</td>
</tr>
<tr>
<td>Enable voluntary participation</td>
<td>Participant opportunity to withdraw</td>
</tr>
<tr>
<td></td>
<td>Principles of ‘safeguarding a vulnerable adult’</td>
</tr>
<tr>
<td>To promote confidentiality, anonymity</td>
<td>Anonymised coded data</td>
</tr>
<tr>
<td></td>
<td>Back-up data (2 tape-recorders)</td>
</tr>
<tr>
<td></td>
<td>Locked storage for tapes and transcripts</td>
</tr>
<tr>
<td>Dignity and self-respect</td>
<td>Private, comfortable room for interview</td>
</tr>
<tr>
<td></td>
<td>Convenient time</td>
</tr>
<tr>
<td></td>
<td>Time to pause and have a break</td>
</tr>
<tr>
<td></td>
<td>Nurse researcher to be cognisant of dual role</td>
</tr>
</tbody>
</table>

**Conclusion**

Research into dementia provision, by exploring patients’ and carers’ views, is central to the new NHS reforms. Hutchinson et al (1994) claims that giving a voice to those who are seldom heard is an acknowledgement of purpose and worth. The positioning of the patient voice must be central, in service planning and delivery of NHS and social care services (DH 2011).
References


10.2 Scenario 2 “A comparison of hospital and telephone follow-up after treatment for breast cancer”

**Introduction**

In this assignment, there will be an analysis and justification of the proposed methodology, methods, sampling and ethical issues pertaining to the proposed research. The aim of the proposed research study is to compare traditional hospital and nurse-led telephone follow-up following breast cancer treatment.

In 2008, almost 47,700 women were diagnosed with breast cancer. Almost 2 out of 3 women with breast cancer now survive their disease beyond 20 years (Cancer Research UK 2011). This trend in survival rates is important in considering alternative models of follow-up care in patients with breast cancer.

Traditionally follow-up care has been led by specialist breast care nurses in the acute hospital setting. Evidence suggests that recurrence of the disease may not be detected through this method (te Boekhorst *et al* 2001). National Institute for Health and Clinical Excellence (NICE) guidance states that intensive follow-up is not effective in surveillance of breast cancer recurrence, although access to specialist nurse support remains important in providing support and information (NICE 2002). This model of follow-up can lead to an increase in anxiety and worry in this group of patients (Allen 2002; Macmillan Cancer Support 2006). Studies by Koinberg *et al* (2004) and Beaver *et al* (2006) identified the patient benefits from alternative models of breast cancer follow-up.
**Research design**

A literature search would be undertaken to inform the research methodology. The literature review process is crucial in gaining insight into a specific research area (Benton & Cormack 1996). A quantitative research design would be adopted. Quantitative research is appropriate when numerical data is required to calculate or quantify phenomena (Carter 1996). A randomised equivalence trial comparing the differences in two follow-up scenarios would be adopted. The benefit of an equivalence trial is that it allows the researcher to explore new interventions that have similar benefits to existing interventions to demonstrate that both methods work equally well (Lee 2000).

Within equivalence trials we work with a ‘null hypothesis’ which would establish that the traditional treatment is better than the new one by a predefined clinically important difference. If on analysis this ‘null hypothesis’ is rejected then the two treatments can be accepted as equivalent. Randomisation of the sample would occur to establish whether there are any differences between the ‘usual care’ hospital follow-up and the proposed telephone nurse-led model. A study by Beaver et al (2009) adopted a randomised equivalence trial in comparing two differing types of follow-up for breast cancer patients.

**Data collection methods**

Potential participants would be identified whilst attending the identified site (acute hospital) out-patient clinic. Written information sheets would be shared with potential participants and then those who were eligible and willing to take part in the study would be taken through the consent process. Allocation of randomisation would be computerised. In line with NICE’s improving outcomes guidance that follow-up should continue for 2-3 years, as defined by local Cancer Network, then this study would follow the agreed timeline of maximum 3 years (NICE 2002).
The State-Trait Anxiety Inventory (STA1) validated questionnaire would be used as a method of data collection, for exploring anxiety levels. This tool differentiates between anxiety as a result of current circumstances and trait behavioural anxiety (Spielberger 1983). An adapted Information Needs Questionnaire (INQ) to include a patient satisfaction survey would also be used to collect data (Luker et al. 1996). The advantage of these data collection methods is that large amounts of data can be collected and it is relatively low cost to administer, although there can be higher attrition rates (Barker 1996). Medical notes would be reviewed to ascertain evidence of recurrence.

**Sampling**

By convention the clinically important difference will vary depending on the study, and if looking for small differences a large sample size would be required – the converse would also apply (Lee 2000). For the results to be meaningful it would be essential for the sample to be of such a size as to eliminate type 1 and type 2 errors. This would be achieved by using a sample size with a significance level of 0.05 with a power confidence of 0.8 (Faithfull 1996). The advice of statisticians would be sought on sample size for this study.

Further, review of the relevant literature (Beaver et al. 2009, Kimman et al. 2010, Kimman et al. 2011) would enable a suitable equivalence region to be set to represent the clinically important difference.
**Figure 11. Flow of participants through trial**

This process of randomisation assists the researcher to have greater control over unrelated variables (Carter 1996) and attempts to eliminate variation between experimental conditions (Field 2009).

Participants would be recruited from Oncology Breast Clinics in an Acute NHS Trust subject to the inclusion and exclusion criteria in Table 7.
Table 7. Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion criteria for people with breast cancer</th>
<th>Exclusion criteria for people with breast cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed diagnosis of breast cancer (confirmed on histology grade 1 and grade 2 tumours with 3 or fewer nodes detected) at 6 weeks of initial treatment</td>
<td>Unconfirmed diagnosis of breast cancer</td>
</tr>
<tr>
<td>Patients who have completed primary treatment (surgery, chemotherapy and radiotherapy)</td>
<td>Patients who are still undergoing primary treatment (surgery, chemotherapy and radiotherapy)</td>
</tr>
<tr>
<td>Patients who are able to give informed consent</td>
<td>Patients who are unable to give informed consent</td>
</tr>
<tr>
<td>Low to moderate risk of recurrence</td>
<td>High risk of recurrence</td>
</tr>
<tr>
<td>Access to telephone</td>
<td>No access to a telephone</td>
</tr>
<tr>
<td>No existing co-morbidities requiring additional follow-up within other specialties</td>
<td>Existing co-morbidities requiring additional follow-up within other specialties</td>
</tr>
<tr>
<td>Not enrolled with another clinical trial</td>
<td>On other clinical trial</td>
</tr>
<tr>
<td>No current evidence of recurrence</td>
<td>Recurrent disease</td>
</tr>
</tbody>
</table>

Ethical considerations
Favourable ethical and R&D approval would be sought prior to commencing the research study. Couchman and Dawson’s (1995) ‘Ethical principles of research’ are applied to this proposed research study as shown in Table 8.
Table 8. Ethical principles

<table>
<thead>
<tr>
<th>Ethical principles (Couchman &amp; Dawson 1995)</th>
<th>Applied to the proposed research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not to be harmed</td>
<td>Suitably qualified researcher (GCP)</td>
</tr>
<tr>
<td></td>
<td>Signposting for additional support</td>
</tr>
<tr>
<td>Ensure informed consent</td>
<td>Consent must be informed and voluntary</td>
</tr>
<tr>
<td></td>
<td>Able to withdraw at any time</td>
</tr>
<tr>
<td></td>
<td>Establish comprehension of English in order</td>
</tr>
<tr>
<td></td>
<td>to fully consent</td>
</tr>
<tr>
<td>Enable voluntary participation</td>
<td>Participant opportunity to withdraw</td>
</tr>
<tr>
<td>To promote confidentiality, anonymity</td>
<td>Anonymised coded data, Data Protection Act</td>
</tr>
<tr>
<td></td>
<td>Access to a telephone</td>
</tr>
<tr>
<td></td>
<td>Locked storage for data</td>
</tr>
<tr>
<td>Dignity and self-respect</td>
<td>Suitable agreed time for telephone support</td>
</tr>
<tr>
<td></td>
<td>Time to pause</td>
</tr>
<tr>
<td></td>
<td>Nurse researcher to be cognisant of dual role</td>
</tr>
<tr>
<td></td>
<td>Equipoise</td>
</tr>
</tbody>
</table>

**Conclusion**

The assignment has justified the methodology, data collection, sampling and ethical considerations for the proposed research. NICE (2002) argues that scarce resources are still being used for largely ineffective traditional follow-up. Quality of care must evolve to meet the needs of our patients and this must include a critical review of our hospital follow-up models of care.
References


10.3 Scenario 3 “General practitioners’ perceptions of effective healthcare”

Introduction
This assignment will critically analyse and justify the rationale for the research design, data collection methods, sampling and ethical issues pertaining to Scenario 3. Accompanying PowerPoint slides can be found in Appendix 1.

Research design
A preliminary literature search using PICO framework (Stone 2002) (Appendix 1, slide 2) was undertaken from 1996 to date since the majority of the literature pertaining to General Practitioners’ (GPs’) practice and evidence-based medicine has been published from this time. Denton and Cormack (1996) state that the literature review is a vital part of the research process.

A mixed methods design was chosen for this research study. Mixed methods can enhance a research study where one methodological stance is insufficient in answering the research question (Guba & Lincoln 2005; Lawal 2009). Critics of mixed approaches argue that the methods cannot work alongside each other as the epistemological assumptions are juxtaposed (Bryman 2004).

Data collection methods
A mixed method approach of survey and focus groups will be adopted (slide 3). A quantitative rating using a visual analogue scale, closed questions and free text section will be incorporated into the survey for the general practitioners (GPs). This would inform the research questions exploring challenges, types of information and the drivers for altering clinical practice. Some descriptive statistics would also be collated to provide demographic data.
A study by McColl et al. (1998) stated that this approach would allow for themes to emerge informing qualitative data methods. The quantitative findings will be analysed using SPSS for Windows.

The data will be collected from the narrative of the GP focus groups, and analysed using thematic content analysis, searching for common themes or arguments (Braun & Clarke 2006). A focus group approach allows for participants to share experiences and for the researcher to elicit ideas and perceptions (Holloway & Wheeler 1996). However, the researcher is required to be highly reflexive and have excellent facilitation skills (Marks & Yardley 2004).

**Sampling**

Following the inclusion and exclusion criteria (slide 3), GPs within the SE Coast region will be randomly selected from the UK GP register. The sample size will be designed to eliminate type 1 and type 2 errors. By convention this would be achieved by using a sample size with a significance level of 0.05 with a power confidence of 0.8 (Field 2009).

A letter to the GP practices inviting them to take part in the study would be sent to Practice Managers to improve recruitment (slide 4). Following informed consent, a questionnaire would be sent to the sample of GPs to complete. Following data analysis of the survey, a purposive sample of GPs will be recruited for the focus groups, to gain a deeper understanding of the emerging themes. The optimum sample size for each focus group will be 6 participants (Holloway & Wheeler 1996).

**Ethical considerations**

Favourable ethical and R&D approval will be sought prior to commencing the research study. Couchman and Dawson’s (1995) ‘Ethical principles of research’ are applied to this proposed research study as shown in slide 5.
Conclusion
By adopting a mixed methods design for this research study it is anticipated that this approach will add further insight and depth to the research area in gaining insight into GPs’ perceptions of evidenced-based medicine.
Appendix 1 Slides

Advanced Research Methods

General Practitioners’ perceptions of effective healthcare

Mixed Methods & Inclusion & Exclusion Criteria

Randomised postal questionnaire

- General Practitioners (GPs)
- Focus groups

- General Practitioners (max 6 participants)

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>All male &amp; female GPs</td>
<td>Locums GP’s not attached to a GP Practice</td>
</tr>
<tr>
<td>GP’s practicing within SE Coast region</td>
<td>GP’s undergoing GMC investigation</td>
</tr>
<tr>
<td>All GP’s 1 year post qualification</td>
<td>Less than 1 year qualification</td>
</tr>
<tr>
<td>Ability to understand English</td>
<td>Unable to understand English</td>
</tr>
</tbody>
</table>

Research Design

- PICO framework (Stone 2002) for Literature review (research question 1)
- Key words: GPs, views, attitudes, evidence based medicine, opinions, effective healthcare
- Mixed methods: quantitative and qualitative (research question 2-4)
- Quantitative - GP postal survey, randomised sample (including descriptive statistics)
- Qualitative focus groups - thematic analysis

Data Collection & Sampling

- General Practitioners in SE Coast
- Random sampling using GP database (McColl et al 1998) inviting participation
- GP postal survey, descriptive stats & VAS, closed questions and free text. Reminders sent to improve response rate. Analysis - survey - SPSS
- Purposive sample-focus groups 6 participants (interview structure, themes from survey - defining healthcare, challenges, drivers in practice)
- Focus groups - Content thematic analysis. Transcribed with 2 researchers

Ethical Issues

- Ethical Principles (Cochran & Dawson 1995)
- Not to be harmed
- IRAS application and Local Ethics approval, Researcher (CP)
- Process for managing notification of poor practice
- Ensure informed consent
- Consent must be informed and voluntary
- Establish comprehension of English in order to fully consent
- Enable voluntary participation
- Participant opportunity to withdraw
- To promote confidentiality, anonymity
- Anonymised coded data, Data protection Act
- Locked storage for data
- Dignity and self-respect
- Facilitation skills, reflexivity for focus groups.
References


Chapter 11: Service Evaluation Assignment

Section 1 Service evaluation of introducing communication skills training package to support a reduction in patient complaints and improve quality of care

Introduction
The aim of the first section of this assignment is to critically analyse a proposed service development using suitable methodology and methods. This section will include a critique of the underpinning evaluation framework, a risk assessment and a discussion of the potential economic benefits. The second section of this assignment will propose a critical consideration of a key leadership issue arising from the service evaluation.

The service development that I have chosen to critically analyse is the implementation of a training package for nurses, to support a reduction in the level of patient complaints. I would evaluate this intervention using the Kirkpatrick four-level model (1996). The rationale for this choice is that this model is most suitable for evaluating training packages. Training requires investment in both time and resources and therefore it is important to implement a structured evaluation to assess outcomes (Smidt et al/2009).

Complaints in health care are an indicator of poor quality of standards of care and linked to failing outcomes (DH 2010). Poor standards of care, misdiagnosis and failings in communication can have profound life-changing impact on patients and families (Parliamentary and Health Service Ombudsman 2010, 2011; National Audit Office 2008). In 2009, the Parliamentary Health Service Ombudsman received 1,043 patient complaints attributed to attitude of staff and 855 attributed to communication. In summary, all Trusts in the UK should listen to their patients and learn from their patients' complaints (Parliamentary Health Service Ombudsman 2010). Therefore, improving staff communication skills may be an important step to supporting the reduction of patient complaints.
The National Advanced Communication Skills Training (ACST) programme has been developed in accordance with the NICE Supportive and Palliative Care Guidance (2004). It has been prioritised to multi-disciplinary cancer team members. The three-day intensive training programme is delivered using role play and actors to simulate difficult conversations, and has been shown to deliver staff behaviour changes (Fallowfield et al 2002; Moore et al 2009). Currently the ACST programme has not been rolled out to non-cancer staff. The driver for this service development is based on quality and equity of access; the proposal would be to offer this training to ward staff in a non-cancer setting. This is an example of goal-orientated evaluation with a drive to improve effectiveness through intervention (Scott 1998).

**Aims and objectives**

The aim of the service development would be to evaluate the effectiveness of an intervention of introducing ACST for ward staff within an Acute Trust setting. The clinical area for the intervention would be identified within a Clinical Division, where a high level of complaints has been reported via the Trust incident reporting system and adverse events reporting database (DATIX system).

The objectives would be:

- to implement a training package for ward staff to support a reduction in the level of patient complaints;
- to up-skill staff members’ communication skills;
- to ascertain what effect the ACST course has on staff self-reported confidence, behaviour and attitude;
- to explore whether there are any other unforeseen benefits this programme could have for staff, patients and the organisation.
Underpinning framework – Kirkpatrick four-level model to evaluate training (1996)
The underpinning evaluation framework for the service evaluation would be the Kirkpatrick four-level model (1996), which is designed for evaluating learning transference to behaviours (Kirkpatrick & Kirkpatrick 2005) (see Table 9).

The intervention of the ACST course would be offered following a pre-course self-report questionnaire including open questions exploring skills and confidence. Pawson et al (2005) argued that a limitation of the pre- and post-test was the linear design. In level 2, following the intervention, staff would be invited to participate in role play to be followed by semi-structured interviews to demonstrate learning and awareness at level 3. At level 4 the impact of the training would be measured by a post-intervention questionnaire, examining behaviour changes and up-skilling of communication skills. Over time, the complaints data could also be triangulated through the DATIX system. This would be measured at the three- and six-month points when the participants would be invited to complete the post-course questionnaire. Campbell et al (2000) stated that studies which demonstrated change to professional behaviours must show that it was the intervention that caused the behaviour modification. This, however, is more complicated as it is not possible to exclude other factors which may impact on communication skill changes.
Table 9. Kirkpatrick four-level model to evaluate training (1996)

<table>
<thead>
<tr>
<th>Level</th>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Reaction – How do trainees react to the ACST course?</td>
<td>Self-evaluation Measure pre-course knowledge, skills and staff confidence</td>
</tr>
<tr>
<td></td>
<td>Identical pre-course &amp; post-course questionnaire – including open questions related to confidence and skills (3- &amp; 6-month intervals)</td>
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<tr>
<td>Level 2</td>
<td>Learning evaluation – To what extent has learning occurred?</td>
<td>Demonstrate understanding and learning from ACST course</td>
</tr>
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<td></td>
<td>Role play-observation-anonymised scenario’s for actors role play</td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>Behaviours – To what extent have behaviours and competencies changed in practice?</td>
<td>Demonstrate whether up-skilling is demonstrated in practice</td>
</tr>
<tr>
<td></td>
<td>Semi-structured interviews using data from open ended questions in pre-test questionnaire</td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>Results – To what extent have results occurred and because of the training?</td>
<td>Measuring impact of intervention</td>
</tr>
<tr>
<td></td>
<td>Post questionnaire, DATIX system to compare complaints numbers</td>
<td></td>
</tr>
</tbody>
</table>

**Literature review**

A literature search using the PICO framework (Stone 2002) would be conducted to inform the research methodology. The literature review process is crucial in gaining insight into a specific research area (Benton & Cormack 1996). The search would be conducted on the electronic databases MEDLINE, OVID, PsycINFO and CINAHL, and confined from 1990 to present; citation tracking and grey literature searches would also be conducted. The following key words would be included: ‘patient complaints’, ‘standards of care’, ‘complaints
intervention’, ‘complaints service development’ and ‘communication skills’. The evidence base is that improved communication skills reduce patient complaints and have a positive impact on quality of care (Fallowfield et al 2002; Moore et al 2009; Shipton et al 2008).

**Methodology and methods**
A quasi-experimental research design used to complement the Kirkpatrick four-stage framework (1996): quantitative, in the first stage, through a pre- and post-questionnaire informing qualitative methods of observation and semi-structured interviews. Mixed methods can enhance a research study where one methodological stance is insufficient in answering the research question (Guba & Lincoln 2005; Lawal 2009; O’Cathain et al 2007). A qualitative research design would complement the quantitative approach. Conversely, Bryman (2004) argued that methodologies cannot be mixed as they originate from differing epistemological paradigms.

**Data collection methods**
A mixed method approach would be implemented. A quantitative questionnaire using a Likert-type scale, to provide ordinal data, with open questions would be incorporated into the questionnaire. This would inform the research questions exploring challenges, types of information and the drivers for altering clinical practice. McColl et al’s (1998) study stated that this approach would allow for themes to emerge informing qualitative data methods. The findings would be analysed using SPSS for Windows.

Qualitative data would be collated from observations of role play and semi-structured interviews. A thematic content analysis would be adopted. Braun and Clarke (2006) proposed that thematic analysis was appropriate when searching for common themes. Qualitative research is concerned with gaining knowledge about human beings and their natural world (Polit & Hungler 1993). This approach is both inductive and deductive and facilitates an understanding of the empirical world from the participants’ perception (Duffy
1987; Cormack 1996). The data would be triangulated to evaluate the overall impact of the ACST course and evaluate the effectiveness of the service development.

**Sampling**
The advice of a statistician would be sought in determining the sample size for the study.

This is a quasi-experimental design with non-randomisation. This design can be appropriate when the benefits are understood, such as a training programme, although Carter (1996) warns that this design is less rigorous without a control group. The sample would be taken from the ward staff within the Clinical Division with the highest number of complaints captured on DATIX. It would be important that this was seen as a learning opportunity, thereby promoting engagement with the development. By selecting one Division across the Trust there is potentially greater patient benefit to be gained if up-skilling can be demonstrated in those areas of high complaints, and hence is more likely to get funding from the Trust. Staff would also need to get support to leave clinical areas for the duration of the three-day course.

**Ethical issues**
The potential ethical issues pertaining to the staff undertaking the ACST programme are listed below. In particular, it will be vital to ensure staff and patient anonymity and confidentiality due to the nature of role play and semi-structured interviews.

**Table 10. Ethical considerations**

<table>
<thead>
<tr>
<th>Ethical principles (Couchman &amp; Dawson 1995)</th>
<th>Applied to the proposed service development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not to be harmed</td>
<td>Suitably qualified researcher</td>
</tr>
<tr>
<td></td>
<td>Flexible interview time frame</td>
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<td></td>
<td>Reflection support after role-playing patient scenarios</td>
</tr>
<tr>
<td>Ensure informed consent</td>
<td>Consent must be informed and voluntary</td>
</tr>
<tr>
<td>Enable voluntary participation</td>
<td>Participant opportunity to withdraw</td>
</tr>
<tr>
<td>To promote confidentiality, anonymity</td>
<td>Anonymised coded data, vital for staff and patient identity</td>
</tr>
<tr>
<td></td>
<td>Back-up data (2 tape-recorders)</td>
</tr>
<tr>
<td></td>
<td>Locked storage for tapes and transcripts</td>
</tr>
<tr>
<td>Dignity and self-respect</td>
<td>Private, comfortable room for interview</td>
</tr>
<tr>
<td></td>
<td>Convenient time</td>
</tr>
<tr>
<td></td>
<td>Time to pause and have a break</td>
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</tbody>
</table>
Risks and mitigation
The main risks to this proposed service development could be that staff are not engaged with the development, or they may not see that their skills need to be improved, or that clinical pressures attribute to a high attrition rate. Senior buy-in from Divisional Leads to support the development would be crucial. A further potential risk is that the Trust Board do not see high levels of patient complaints as an issue for the Trust, more as inevitable in a tight fiscal climate, and hence funding is not made available. Approaches of risk mitigation could be to identify clinical champions within the organisation to support the ACST course and to work with the Board to highlight the correlation of high complaint levels with poor standards of care.

Economic evaluation
Health economics is fundamental to healthcare delivery and increasingly vital during periods of austerity, scare resource and greater need (Smith et al 2005). Expenditure on nursing and midwifery accounts for half the total NHS budget (Jenkins-Clarke 1999). In 2010/11 the NHSLA received 8,655 claims under its clinical negligence scheme. The cost burden to the NHS is extensive and this service development would aim to support a reduction in patient complaints by up-skilling ward staff. In the absence of defined measurable outcomes, it may be more problematic to apply one of the frameworks such as cost minimisation or cost-benefit analysis (Jenkins-Clarke 1999). An alternative approach for nursing interventions could be to develop nurse-sensitive outcome measures (Bond 1992). Complaint management is more complex to measure on a cost-benefit analysis basis, although data would be available on staff costs associated with complaint management, such as time for data entry roles and HR input, and the costs of NHS litigation. The area that will be more difficult to quantify is the impact of complaints on patients’ quality of life, e.g. through quality-adjusted life-years (QALY) for receiving poor standards of care. However, this service
evaluation would benefit from an economic evaluation which may support the Boards to gain a more comprehensive insight into the impact of patient complaints and to secure funding.

**Conclusion**
The Kirkpatrick four-level model would be appropriate in evaluating the proposed service development. An organisational culture of improvement would be key to successful implementation of the ACST training within the Acute Trust, and would require organisational support and clinical champions. Also, consideration of the direct connection between complaints and poor standards of care would be crucial. Trevisan and Huang (2003) concluded that service evaluations which are most pertinent to decision makers are the touchstone of a successful evaluation.
References


More research is required to determine the usefulness of communication skills training for professionals working with cancer patients. Cochrane Summaries, London.


Section 2 “A critical consideration of improving Board cultures in order to drive up standards of patient care and reduce complaints”

The area of consideration which has arisen from the service evaluation is how Board culture within an Acute Trust organisation could be altered in a positive way. Section two of this assignment will now focus on the impact of Trust Board cultures on quality of patient care, and will include a critical consideration of my role as a clinical leader in developing and engaging the Board to facilitate positive change.

Political direction
Since the 1990s and the NHS reforms, there has been some repositioning and a shift to delivery of targets, processes, ‘pace setting’ and ‘command and control’ leadership (The Kings Fund 2012). Santry (2012) identified this as a model of a ‘centrally led’ NHS. Health policy in the United Kingdom is also focused on improving quality of care, improving outcomes, whilst achieving significant efficiencies within the system (DH 2010; Curran & Totten 2010). An NHS at risk of being diametrically opposed within itself has emerged, if David Nicholson’s £20bn savings are to be achieved by 2015 against unprecedented demand for high-quality services (Dowler 2012; Shipton et al 2008). In recent years, there have been several high-profile exposés of undignified care, neglect and poor practice, which have been a catalyst for a searching debate into standards of care, practice and the nursing profession (Francis 2010; Parliamentary and Health Service Ombudsman 2011). Davies (1999) and Smith (1998) proposed that scandals of poor care have pushed quality to the centre of healthcare policy. In support, inadequacy of patient care is currently driving the political agenda (Payne 2011). Lord Darzi’s (DH 2008) NHS next stage review was noted for affirming quality of care as the core business of Trust Boards, rather than being positioned at ward level.
**Structure of the NHS**

The Regulators, Care Quality Commission (CQC) and Monitor are assessing quality of care based on benchmarking systems, such as number of patient complaints and patient experience surveys (DH 2010), and the Commissioning for Quality and Innovation scheme (CQUIN) payment system is now used as a commissioning lever. All Trusts are required to have robust systems in place to capture data and to demonstrate organisational engagement in improving standards of care, in order to achieve maximum income.

These policy and political drivers are important in understanding the context to organisational cultures and what the levers and drivers are in the system for successful management of patient complaints. In support, Dickon Weir-Hughes (2011) indicated that successful leadership required an understanding of the external and internal politics within organisations.

**Board leadership and organisational culture**

The aim of Trust Boards’ assurance processes is to give confidence that the Trust is providing high-quality care (Garratt 2010). When patient care is poor and there has been organisational failure in patient care and safety, the Francis Inquiry (2010) reported fundamental Board failings: ‘A failure to listen to those who have received care through proper consideration of their complaints and a corporate focus on process at the expense of outcomes’ (Francis 2010: 24). In agreement, The King’s Fund (2009, 2012) warned that failings attributed to poor standards of care are most likely to cause the failure of an organisation.

In cultural anthropology, authors such as Malinowski (1922) regard culture as having positivist meanings and attributes. Culture is also defined as how influence, shared beliefs and common practices are used within an organisation; they are often preserved in folk tales, customs and rituals (Garratt 2010; Deal & Kennedy 1982). Schein (1992) outlined the
three levels to culture: ‘artefacts’, ‘shared values’ and ‘shared basic assumptions’. Geertz (1973) however described more fully the interplay in cultures as an ‘historically transmitted pattern of meaning’. There appears to be a divergent view, with culture seen as either an ‘attribute’ or what the organisation ‘is’ (Scott et al 2003). This is problematic in that it is important to establish the relationship between environment and behaviours and hence what strategies to implement to support change to organisational cultures (Scott et al 2003). The notion of culture as a predeterminant of performance has emerged (Deal & Kennedy 1982; Scott et al 2003).

Alongside organisational culture is the acknowledgement of the impact of effective leadership, to shape and improve organisational performance. In Shipton et al’s (2008) study there was a significant correlation between poor leadership and high patient complaints. Schein (1992) argued that organisational culture and leadership are intertwined and inextricably linked. In support, governance is endorsed through leadership which affects the organisational culture (Alimo-Metcalfe 2012). Garratt (2010) proposed that developing a healthy organisational culture is fundamental to a responsive organisation, and in turn it can be measured and evidenced. Therefore, a relationship is being suggested: one way to measure the healthiness of the organisation could be through patient satisfaction and complaints levels.

**Where is the power held at the Board?**

The organisation into which I would propose to conduct my service development and evaluation is a large teaching Trust in England. The hierarchy is four Clinical Divisional structures reporting to the large Trust Board via the Clinical Executive Group. The Board has six non-executive directors including a Chairman and six executive board members including the Chief Executive, and is predominantly positioned with male executives. Young (2000) portrayed authority and influence shifting within a hierarchical structure. In keeping with this hierarchical structure, the Medical Director and Director of Nursing and Quality are members
of the Trust Board. The Divisional Lead Nurses report to a Medical Director within the Division, but have professional accountability to the Director of Nursing. Triumvirate working across organisational and professional hierarchies can be problematic in terms of accountability. Any project initiations such as the training package for staff described would require two-tier approvals prior to going to the Trust Board.

In addition, the medical hierarchy within the organisation is prevailing and requires a negotiating and resourceful leadership style to work alongside the hierarchy. Buse et al (2010) argued that variances in power within professional groups exist and doctors are often seen as high status with access to finance and ability to successfully influence the organisation. Davies (2004) observed that nurses are still positioned as performing duties assigned by others, rather than showing complete autonomy. There is some debate surrounding the view of differing professional statuses, although differing pervasive sub-cultures are acknowledged (Scott et al 2003). In my experience, I have observed status and influence used very effectively by sub-cultures in both professional groups, to manage Boards, including the powerful ‘veto’.

The Trust Board currently tolerates a high level of patient complaints, as they are viewed as inevitable in delivering care in a financially challenging environment. The King’s Fund (2009) suggested that an explanation for this can be attributed when Boards are not positioned to receive bad news and are anxious to avoid the corporate ‘spotlight’ of poor care and complaints. I would need to use my leadership skills to change this culture to one of positive change in supporting initiatives that drive down complaints and improve the patient experience. I could draw on my credible clinical experience as legitimacy. I could also utilise my emotional intelligence of patients’ experience, although King’s Fund (2009) observed that often emotional intelligence can become fused with ‘emotional presentations’ which may undermine my credibility with the Board.
Leadership and culture

Leadership is more likely to be successful when centred on building a collective vision across the organisation. To improve the Trust Board culture would be to successfully place a higher value importance on driving complaints down, and by creating a collective agreement that complaints are inextricably linked to the barometer of patient safety and quality within the organisation and hence should be a Trust priority. I would need to work alongside medical colleagues both at Divisional level and Trust Board level and emphasise the value of team working and shared goals and visions.

Such an approach has been described as ‘engaging leadership’ (Alimo-Metcalfe & Alban-Metcalfe 2008), skilled in accessibility, transparency, engagement and with the strong ability to work in a matrix approach. Further, this leadership style would greatly influence altering organisational cultural issues such as driving up quality of care, as it is seen as having an ethos of listening and learning. The engaging leadership style also draws on assurance approaches such as ‘board to ward’ (King’s Fund 2009), by sharing patient experiences with the board. This contrasts with a style of ‘heroic leadership’ – one man’s mission – which is replaced by a collective engagement of organisational change (King’s Fund 2012). However, the ‘engaging leadership’ style may not be suitable for all situations and it is acknowledged that leadership styles need to modify to the given specifics of a situation (King’s Fund 2012).

A further strategy that could be implemented is utilisation of a ‘clinical champion’ identified through the clinical division to support my proposed service development to the Board. There is widespread support for the role of clinical champions in supporting the initial stages of organisational change (Dobson et al 2010; Hendy & Barlow 2011). A rationale for this is that formal hierarchies can be circumvented by less negotiation. This has been outlined to suggest that sense-giving provides clarity to proposed changes (Gioia & Chittipeddi 1991).
A method of supporting the Board could be the use of data triangulation to demonstrate improvements to patient care following the implementation of the communication skills training. Additional Trust income could be sought through the CQUIN quality incentive negotiated through the contracting process, by evidence of reducing patient complaints. This could be used as a motivator for the Board. Young’s (2000) framework of supporting organisational cultural change is defined by the six organisational levers (Figure 1). This framework depicts the interrelationship between all six levers so they are reciprocally working together, such as motivation and rewards, and could be implemented in this service evaluation.

**Figure 1**

*Linkages Among Culture and the Six Organizational Levers*

![Diagram showing the six organisational levers: Motivation, Conflict Management, Culture, Authority and Influence, Strategy Formulation, and Customer/Client Management.]

**Personal challenges**

The aim of my service evaluation was to implement a communication skills training package for ward staff, as a method of reducing complaints and improving standards of care. Poor
standards of care, misdiagnosis and failings in communication can have profound life-changing impact on patients and families (Health Service Ombudsman 2011).

**Conclusion**

Positive patient outcomes rely on positive organisational cultures (Curran & Totten 2010). The King’s Fund (2012) demonstrated the benefits of effective leadership and positive engagement, in improved patient experience, reducing errors, lowering infection and mortality rates, a more viable financial balance sheet, improved staff morale and fewer staff. Alimo-Metcalfe (2012) contended that with the unprecedented efficiencies savings to be made, it was crucial to have Board cultures responsive and effective in upholding high standards of patient care, and credible clinical leadership.
References


