HEAD NURSES' PERCEPTIONS OF THEIR ROLES

by

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Abstract

The purpose of this study was to explore head nurses' perceptions of their roles. The head nurse is in a crucial position of management in a nursing department, acting as a link between upper management and the work group. It is the head nurse who sets the standards and directions for nursing practice on a nursing unit and who manages the staff delivering care. Owing to the decentralization of managerial decisions in many nursing organizations and the change from functional to primary nursing in the care delivery systems, the head nurse's role has changed considerably. Despite this, research into the work of head nurses has been limited and based largely on the perception of others such as staff nurses and directors of nursing.

An exploratory, descriptive research design was used to collect and to analyze data. Data collection was based on semi-structured interviews using Mintzberg's framework of ten managerial roles. The procedure of content analysis was used to analyze the data.

The findings showed that the head nurses were able to describe their work within the context of each of the 10 managerial roles described by Mintzberg. Roles which were more familiar to them were those of monitor, disseminator, entrepreneur, disturbance handler, resource allocator, leader, and liaison. Roles that were less familiar were those of spokesman, negotiator, and figurehead. Mintzberg's framework was useful as a basis for describing the head nurse position and identifying areas of future development for head nurses.

Several general themes were identified from the findings of the

study. First, many of the activities of the head nurse in the manager position are unstructured and informal but nonetheless effective. Second, there is a variation in emphasis among roles depending upon the skill of the manager and the situational requirements. Third, the ability of the head nurse to see the whole organization from a systems perspective may require development in future. Finally, head nurses favour a highly participative management perspective, encouraging staff involvement in many ways.

The two roles that were particularly significant for head nurses were those of leader and resource allocator. The leader role enabled the head nurse to set directions for the nursing unit and create an environment in which staff were motivated. The resource allocator role was one which focussed the head nurses' attention on the staff, equipment, and supplies available to the nursing unit. The importance of the resource allocator role may have increased over the past few years, since scarce financial resources have become the boundary for many decisions on nursing units. The knowledge about the behaviours described by the subjects in this study may provide information to improve the educational preparation necessary for the head nurse position. As well, increased understanding about the managerial roles should enable head nurses to facilitate the provision of high quality patient care.

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CHAPTER ONE

INTRODUCTION

The head nurse is in a crucial position of management in a nursing department. S/he provides the link between upper management and the work group (Fralic, 1978) and can promote, change, and influence the development of a professional standard of nursing practice (Clifford, 1981). In order to accomplish these and other activities, individuals in head nurse positions must assume a variety of roles. It is the exploration of the head nurses' perceptions of these roles, which will be the basis for this study.

The Problem

The importance of the head nurse position is becoming increasingly apparent. The delivery of high-quality nursing care is related to the quality of management provided (Clifford, 1981; Gillies, 1982). The head nurse is directly responsible for the care delivered by the staff on a nursing unit and thus is in a key management position (Sullivan & Decker, 1985). It is the head nurse who sets the standards and directions for nursing practice on the nursing unit and who manages the staff delivering the care.

As nursing organizations increasingly decentralize, the head nurse's responsibilities change. For example, some wish to expand the head nurse's responsibilities in order to utilize the front line manager in a nursing department more effectively (Boutillier & Nelles, 1985; Fralic, 1978; Kirsch, 1988; Sullivan & Decker, 1985). Head nurses are taking part

in budgeting, employee hiring, quality assurance, and other activities formerly thought to be administrative duties outside the realm of the first line manager.

As methods of nursing care delivery change from a functional or team-based approach to primary care nursing, in which individual nurses are responsible for decisions about patient care, the role of the head nurse must also change (Harrison, 1981; Maguire, 1986; Rotkovitch, 1983). In the traditional setting, the head nurse made many of the patient care decisions. In primary nursing, however, the head nurse focuses on personnel management, patient care management, and unit management (Maguire, 1986). Thus, as the staff nurse's role as an autonomous decision-maker is being supported, the head nurse's role is concomitantly evolving into another realm, one that is more managerial in nature. The head nurse has less direct contact with patients than previously and is increasingly responsible for coordinating the activities of other people.

Since changes are occurring in both the structure of nursing service organizations and methods of nursing care delivery, it is timely to examine what these changes mean to head nurses. What impact have the changes had on their way of thinking and acting? What do they perceive to be the resultant changes in their own role?

Studies into the work of the head nurse are limited. Some have focused mainly on the staff's perception of the effect of leadership style on staff job satisfaction and the nursing unit environment (Campbell, 1986; Duxbury, Armstrong, Drew, & Henley, 1984; Fretwell, 1983a, 1983b; Pryer & Distefano, 1971). Other studies have identified the tasks performed by head nurses (Beaman, 1986; Vance & Wolf, 1986), but not the

perceptions of head nurses about their roles. From these studies, we have some knowledge about categories of leadership styles but little about how or why the head nurse came to use a particular style. Similarly, the studies have identified what subordinates think about head nurses, but not what head nurses think about themselves. As well, we have knowledge of the tasks performed by head nurses but not about the thinking which underlies their management behaviour.

Outside the field of nursing, there is a variety of research and writing about the manager's role. Management has been described as a skill set encompassing activities such as interviewing, decision-making, delegation, and conflict management (Whetton & Cameron, 1984), as a set of functions that includes planning, organizing, directing, and controlling (Fayol, 1949; Ivancevich & Matteson, 1987) and as a process that is directed towards achieving the organization's goals and objectives by effectively integrating the efforts of a group (Ivancevich & Matteson, 1987; Levy & Loomba, 1984). The role of the manager has been described as coordinating the work of other people by means of management activities, functions, and processes (Ivancevich & Matteson, (1987).

The role of the manager has further been distinguished from that of a leader. Sergiovanni (1984) described management as the technical foundation of leadership. Other authors have described management and leadership as highly interconnected and mutually reinforcing (Murphy, Hallinger, & Mitman, 1983). Another position is that the role of leader is just one of the managerial roles, albeit the most significant (Mintzberg, 1973).

Several authors have investigated managerial work behaviour. The

nature of the work has been described through exploration of the skills necessary (Katz, 1974) and behaviours exhibited by managers (Kotter, 1982; Mintzberg 1973). Some authors have recognized a need to account for variations in behaviour and differences in jobs before attempting to generalize about managerial work. They suggest that managerial work varies to the extent that the manager is able to make choices about the way in which the work will be done (Stewart, 1976, 1982; Whitely, 1985). In contrast, Mintzberg (1973) found that the work of managers is remarkably similar across organizations.

Researchers in the fields of business, education, and sociology have started to look beyond the traits and activities of managers and have attempted to understand more about the thoughts, attitudes, and perceptions of managers. These ideas are encompassed in the study of role perception and provide a useful focus for the study of head nurses.

Conceptual Framework

The framework of roles used by Mintzberg (1973) to describe the nature of managerial work provides an appropriate basis for study of the head nurse position. He claimed that the roles are carried out by any manager. Since the head nurse is a manager, the framework provides a structure whereby the components of the head nurse position can be examined in detail.

Mintzberg identified the ten basic roles common to all managers. He has, furthermore, categorized these major or basic working roles as interpersonal (derived from the manager's authority and status), informational (derived from interpersonal roles and the access they

provide to information), and decisional (derived from the manager's authority and information).

Interpersonal Roles

- figurehead - the manager, by virtue of position, is obliged to perform a number of routine duties of a legal or social nature.
- leader - the manager is responsible for staffing activities and for fostering an environment which motivates subordinates.
- liaison - the manager maintains a network of outside contacts who provide information and favours.

Informational Roles

- monitor - the manager seeks and receives a wide variety of information to develop an understanding of the organization and the environment and thus acts as the "nerve centre" of internal and external information of the organization.
- disseminator - the manager transmits information from outsiders and from other subordinates to members of the organization. This information may be interpreted and integrated with the values of the organization.
- spokesman - the manager transmits information to outsiders on the organization's plans, policies, actions, results, etc., and serves as the expert on the services provided by the organization.

Decisional Roles

- entrepreneur - the manager searches the organization and its environment for opportunities and initiates changes to improve the organization.
- disturbance handler - the manager is responsible for corrective action

when the organization faces important but unexpected disturbances.

- resource allocator - the manager is responsible for the allocation of organizational resources of all kinds including staff, equipment, and supplies.
- negotiator - the manager is responsible for representing the organization at major negotiations.

In this study, Mintzberg's framework has been used to develop the interview questions and to guide the collection and analysis of data. As such, it provided a basis for the study and permitted an evaluation of its usefulness in describing the head nurse position.

Problem Statement

Although some studies of the head nurse position have been undertaken, they have not been based on head nurses' perceptions but rather on the perceptions of others such as staff nurses and directors of nursing. Without knowledge about head nurses' own perceptions of their roles, the understanding of a position which has an important impact on the quality of nursing care provided in a nursing department is limited.

Purpose

The purpose of this study is to explore head nurses' perceptions of their roles. This will be accomplished by asking the question: What are head nurses' perceptions of their roles?

Definitions

The following terms will be used extensively throughout the study and

are defined as follows:

. Head Nurse - the first level manager in the organizational structure of a Nursing Department in a hospital. Other terms commonly used for this position include nurse manager, unit manager, first line manager, and patient care coordinator.

. Role - a set of behaviours which is associated with a given job or position. Interpretation of the way in which these behaviours are acted out is dependent upon the personality and skill of the individual manager (Mintzberg, 1973).

Methodology

The lack of literature about head nurses' perceptions of their roles makes the choice of an exploratory, descriptive research design appropriate for collection and analysis of data. This type of research design is predominantly aimed at describing phenomena and discovering the relationships among the various components (Polit & Hungler, 1978).

Semi-structured interviews based on Mintzberg's framework were the basis for data collection. The procedure of content analysis was used to analyze the data. Such a procedure enabled the researcher to categorize verbal or behavioural data for the purpose of identifying, measuring, describing, and making inferences about specified characteristics within the data (Fox, 1982; Waltz, Strickland & Leuz, 1984).

Assumptions and Limitations

Two assumptions underlie the researcher's approach to the study. It was assumed, first, that head nurses in all clinical areas perform similar

management functions and, second, that the management roles of the head nurse are similar to the roles of other managers who are not head nurses.

In this study, subjects were a convenience sample drawn from a single agency's head nurses. Therefore, the findings will not be generalizable beyond the study group.

Significance of the Study

Since head nurses are responsible for setting the standards and directions for nursing practice on a nursing unit, they directly influence the quality of patient care delivered. This is accomplished through management of the staff delivering care. In order to manage staff effectively, head nurses must have the knowledge and skills necessary to set patient care standards, coordinate activities of a variety of workers, and create an environment in which staff are motivated.

The knowledge required to manage a nursing unit cannot be obtained from nursing theory alone but must also include an understanding of the managerial roles assumed by head nurses. This understanding is instrumental for the preparation and development of people in this key management position.

Because the perspective of head nurses themselves has received little attention in the past, the study may provide new information from their perspective. With this information, it may be possible to improve the educational preparation for the position of head nurse and to suggest areas for research which could further enhance that position.

Use of Mintzberg's framework of 10 managerial roles permits an evaluation of the utility of the framework's application to describe the

evaluation of the utility of the framework's application to describe the work of nursing managers. It may provide a valuable framework for describing the roles of nursing managers in future.

Scope of the Study

The thesis is organized into six chapters. Chapter One reviews the context of the problem, explains the conceptual framework, and outlines the purpose of the study. Chapter Two reviews the relevant literature on role theory, head nurses, and managers. Chapter Three outlines the research methodology. Chapter Four describes the sample and presents the data from the interviews. Chapter Five discusses and analyzes the findings. Chapter Six presents the summary, conclusions, and implications.

CHAPTER TWO

REVIEW OF THE LITERATURE

The dearth of empirical studies about the position of head nurse makes a revealing comment about both the lack of recognition of the head nurse's importance and the apparent difficulty in studying the position. In order to establish the basis for studying head nurses' perceptions of their roles, several questions need to be addressed: what is currently known about head nurses?; what information from other fields of literature is relevant?; and, what methodologies need to be considered?

This chapter examines both research and opinion literature. The review is divided into three sections. First, the nursing literature is reviewed to summarize the current thinking about and investigations into the head nurse position. Second, related professional literature is examined to identify relevant findings associated with managerial roles. Finally, a summary of appropriate methodological considerations is presented.

The Head Nurse Position

Current Descriptions of the Head Nurse

In a discussion paper concerning the role of nurse administrators, the Canadian Nurses Association (1988) described the head nurse as a beginning level manager who has the authority and responsibility for a single, specified unit of nursing service. Some authors have described the responsibilities of head nurses as being carried out through management functions of planning, organizing, directing, and controlling

(Gillies, 1982; Sullivan & Decker, 1985). In contrast, Kirsch (1988) suggested that it is crucial to go beyond the classical conceptualization of management in order to find fresh perspectives and a realistic view of what the nurse manager may actually be called upon to do in that position. She used Mintzberg's (1973) conceptualization of the interpersonal, informational, and decisional roles to describe the work of nurse managers.

Despite these current descriptions, several authors who have developed management education and training programs for nursing managers have commented on the lack of information available about the actual work of nurse managers at various levels (Cleland, 1984; Dunne, Ehrlich, & Mitchell, 1988; Fralic & O'Connor, 1983). Because of this lack, they have used the general management literature to provide conceptual frameworks for describing the skills and behaviours of managers. These frameworks have then been applied to nursing.

Research Findings

Research into the role of the head nurse is limited. Areas which have been studied include leadership style of head nurses, tasks and activities commonly carried out, and role perceptions of head nurses in different hospital settings. Some studies have examined the effect of the head nurse's leadership style on staff nurses' job satisfaction and work-related stresses. Four examples of such research will be described here.

Pryer and Distefano (1971) studied individuals at three different levels (attendants, psychiatric aides, and staff nurses) to determine how they perceived the leadership behaviour of their immediate supervisors and how these perceptions related to job satisfaction and general expectations

about reward. The leadership behaviour was assessed through the use of Fleishman and Harris's (1962) two-factor questionnaire which describes leadership style as composed of consideration structure (an orientation to the group and two-way communication) and initiating structure (an orientation to task and goal achievement). The findings showed that consideration structure was positively related to job satisfaction among all levels of employees.

Fretwell (1983a, 1983b) reported a study in Britain of the role of the ward sister in creating a ward learning environment (ward sisters have a role similar to that of the head nurse in North America). The authors of this project assumed that it would be possible to introduce ward sisters to the concept of a ward learning environment and to encourage them to make changes as a result of research findings. The project used action research, a cyclical process of data collection, feedback, planning change objectives, action, and evaluation. The findings indicated that, when objectives for change were set by the ward sister without consultation, they were resented and resisted by subordinates. Those people who adopted an autocratic leadership style tended to make less progress than those who were more democratic and willing to mobilize support and enthusiasm. Using the Leadership Opinion Questionnaire (Fleishman & Harris, 1962), Fretwell found that the three most successful sisters were above average in both consideration and structure; that is, they could establish good relationships and direct activities towards goals. The findings highlighted the crucial role that ward sisters play, and the authors concluded that the ward learning environment could be influenced significantly by these people.

Duxbury, Armstrong, Drew, and Henley (1984) described the effect of head nurse leadership style on staff nurse burnout and job satisfaction in neonatal intensive care units. After administering Fleishman and Harris's (1962) questionnaire to staff nurses to determine their perceptions of the leadership style of the head nurse, Duxbury and associates concluded that head nurses who achieved higher scores on the consideration style of leadership administered units on which there were higher levels of staff nurse satisfaction and lower levels of staff nurse burnout. These findings supported Duxbury's earlier work in 1982, which claimed that the leadership style of the head nurse contributed significantly to the incidence of staff nurse burnout.

Campbell (1986) found that the leadership style of the head nurse was a major factor in job satisfaction and job-related stress for staff nurses in a coronary care unit. She administered a questionnaire asking staff nurses to rate the head nurse on 10 leadership qualities in relation to her ability to improve patient care. Job satisfaction and stress reduction were also explored. Over 60% of the staff reported that, when the leader used a collaborative style the majority of the time, they experienced increased job satisfaction and reduced work-related stress.

Although all of these researchers studied head nurses, they focussed mainly on the effect of leadership style on the staff and nursing unit environment. Their orientation was thus the perceptions of the staff. There was no indication as to factors which influenced the choice of leadership style used by head nurses or the head nurses' own perceptions of their roles.

In a different vein, Beaman (1986) studied the actual tasks performed

by first-line managers (head nurses), asking whether these tasks varied in hospitals of different sizes. She surveyed 73 Directors of Nursing and asked them to select all tasks for which they considered their first-line nursing managers to be responsible. She found a total of 31 similar tasks that occurred across all hospital sites. These included preparing time schedules, making recommendations regarding budgets to nursing administration, justifying budget variances, setting goals for the nursing unit, developing nursing staff through inservice and orientation, acting as a resource for problem-solving, and participating in quality assurance activities. Beaman concluded that the tasks were common to all first-line nursing manager positions and should be used to develop job descriptions and educational programs for managers.

Similarly, Vance and Wolf (1986) reported 15 skill areas needed by nurse managers. The essential skills they identified included managing financial resources, communicating effectively, diagnosing and solving staff problems, managing conflict, implementing change, building cohesive work groups, and using motivational strategies.

These studies provide knowledge about the tasks performed and skills used by head nurses. The staffing, budgeting, and planning tasks are similar to the skills related to financial management, communication, and staff development. However, it is difficult to apply knowledge about tasks and skills alone to interpret the roles assumed by head nurses in order to carry out their work. The head nurses' own perceptions of their roles is a perspective which is essential to the full understanding of the head nurse position.

In order to reach a clearer and more practical description of what

head nurses do, Jones and Jones (1979) focussed on delineating the role of people in head nurse positions. Using Mintzberg's (1973) framework, they assumed that "the head nurse position is basically managerial in nature" (p.46), and employed expert observers to study both head nurses and assistant head nurses (when the latter were functioning as head nurses). All of the work activities for the eight subjects were identified and then classified in terms of Mintzberg's framework. The findings provided a description of activities within each role, as well as a breakdown of the percentage of time spent in each major category. According to Jones and Jones, the head nurses spent 10% of their time in the three interpersonal role activities, 15-20% in the informational, and 75-80% in the four decisional role activities. Of the last group, they noted that an inordinate amount of time was spent in the resource allocator and disturbance handler roles at the expense of other role responsibilities. Although the study used Mintzberg's role framework, as does this study, it was based on observers' categorizations of activities performed by head nurses. Therefore, it did not attempt to provide an understanding about how the head nurses perceive their roles.

Only one study was found that explored the role of the head nurse from the perspective of the incumbents. Miller and Heine's (1988) study sought to distinguish differences in the head nurses' role perception between various hospital settings. Forty-three head nurses in seven acute care hospitals completed a Head Nurse Role Questionnaire based on the job design module of Van de Ven and Ferry (1980). This model suggests that the hospital organization influences four components of the head nurse role: role perception, role ambiguity, role conflict, and role attitude.

Standardization (norms and routines) affects role perceptions and role attitudes whereas formalization (written documents that denote specific rules and procedures for the organization's function) influences the degree to which role ambiguity and conflict occur. This model enabled Miller and Heine to investigate organizational differences in head nurses' perceptions of job variability, job expertise, job definition, job capacity, and job incentives. Job variability was measured by the percentage of time spent in specified tasks. Job expertise reflected formal education, inservice, and job-related reading. Job definition included a review of the job description and other written or unwritten procedures for specific tasks. Job capacity queried the degree to which the head nurse perceived her/his authority, task pressure, and accountability in the role. Finally, job incentives studied the perceptions which head nurses held about job sanctions and rewards.

Miller and Heine found that perceptions did vary somewhat based on the degree of standardization and formalization which existed in the hospitals. In the bigger centres, where there was more standardization and formalization, the head nurses had a higher level of job expertise than in the smaller centres. As well, they had greater head nurse role fulfillment in relation to job variability. Head nurses in the smaller hospitals had more control and authority. Job incentives varied in the sanctions applied but not in the perception of rewards received; job sanction was highest for the head nurses in the larger hospitals and rewards through job advancement were equally unlikely in all institutions. The study concentrated largely on tasks and activities, measuring job satisfaction rather than the actual perceptions of the head nurses about

their behaviours and reasons for actions.

In summary, the nursing literature presents a limited view of the head nurse position. Although some authors present a traditional management view of head nurses (Gillies, 1982; Sullivan & Decker, 1985), others believe in using new perspectives for addressing the nurse manager role realistically (CNA, 1988; Kirsch, 1988). Some research has been done on determining the leadership style that most effectively promotes staff satisfaction (Campbell, 1986; Duxbury, Armstrong, Drew, & Henley, 1984; Fretwell, 1983a, 1983b; Pryer & Distefano, 1971). In addition, several studies have identified the tasks and activities which are essential to the job of head nurse (Beaman, 1986; Jones & Jones, 1979; Vance & Wolf, 1986). But, on the whole, only one study has examined head nurses' perceptions of their roles (Miller & Heine, 1988), and its major focus was the specific issue of job satisfaction.

Managerial Roles in Other Fields

Managers and management have been the subject of much study in fields other than nursing. Information about managerial roles is found in the literature concerning the theoretical construct of role, the nature of management, and leadership as distinguished from management. Although several studies will be presented throughout this section, only four major studies will be examined in detail in order to present the findings most relevant to the study of head nurses as managers.

The Concept of Roles

The study of roles is encompassed within role theory, a collection of concepts and hypothetical formulations that predict how people will

perform or behave in a given role, or under what circumstances certain types of behaviours can be expected (Biddle & Thomas, 1966; Hardy & Conway, 1978, p.17). Biddle (1979) described roles as consisting of behaviours that are characteristic of a set of persons and a context. That is, they are overt action or performances which can be observed and "are normally limited by contextual specification and do not represent the total set of behaviours exhibited by those persons at home, work, or play" (p.58). Although roles tend to overlap or interlock with each other, they are also unique in that the proportion of behavioural elements making up one role is dissimilar to behavioural elements of other roles. Thus, application of role theory to the study of management can serve as a useful avenue for exploring the nature of managerial work.

The Nature of Management

There have been several perspectives on the nature of management articulated in the literature. The classic management functions were initially described by Fayol (1949) as planning, organizing, commanding, coordinating, and controlling. Although these functions are still recognized today, management is more generally considered to be a process directed towards achieving the organization's goals and objectives by integrating the efforts of various groups (Ivancevich & Matteson, 1987; Levy & Loomba, 1984; Munson & Zuckerman, 1983).

Management is also described as a set of skills by which the functions or processes are carried out (Whetton & Cameron, 1984). These skills received recognition through Katz's (1974) work, which categorized the key managerial skills needed for successful performance. He described three major groups of skills: first, technical skills, which concern the

use of tools, techniques, and procedures in a specialized manner; second, human skills, which relate to working effectively as a group member and building cooperative skills within the team; and finally, conceptual skills, which are associated with understanding the total organizational picture by integrating and coordinating key areas of responsibilities.

The role of the manager, then, is to coordinate the work of other people through the skills, functions, and processes of management (Ivancevich & Matteson, 1987). The manager's roles can best be described by the behaviours observed (Kurke & Aldrich, 1983; Mintzberg, 1983), although the behaviours will vary according to the demands and choices of the particular managerial position (Stewart, 1982; Whitely, 1985).

Management and Leadership

It is necessary to distinguish between the concepts of management and leadership. Although the two terms are frequently linked, they cannot be used interchangeably. Sergiovanni (1984) described management as the foundation of leadership, which he envisaged in a hierarchical mode. In his view, management (otherwise known as technical leadership) is composed of the lower level skills. These are prerequisites for strategic leadership, which requires higher level skills and is composed of the philosophical mindset, the belief system, and the organizational culture. Murphy, Hallinger, and Mitman (1983) viewed management and leadership as highly interconnected and mutually reinforcing activities. Leadership, however, may be seen as the umbrella or superordinate concept which includes management (Immegart, 1988; Murphy, Hallinger, & Mitman, 1983; Sergiovanni, 1984).

Mintzberg (1973) described leadership as the managerial role which

defines the manager's relationships with his subordinates. Included in this role are staffing (hiring, training, judging, remunerating, promoting, and dismissing) and other activities which are primarily motivational in nature.

Mintzberg states that "the leader role is clearly among the most significant of all roles...and that leadership permeates all activities" (p. 61). He specifies that the purpose of the leader role is to integrate individual needs and organizational goals. Also, it is in the leader role that managerial power most clearly manifests itself: although the formal authority of the manager gives her/him great power, leadership activity determines how much of it will be realized.

In summary, management is a technical process related to the present whereas leadership has a future orientation. Leadership is the product of inspiring people to work together toward a common goal. Managers carry out the process of management and may also exercise leadership, but leadership itself is a broader concept which encompasses management.

Major Studies of Management

Several studies of managers in general are relevant to nursing. Four major studies merit being discussed in some detail since they provide significant insights about managers in business, industry, and, most appropriately, health care.

Mintzberg's (1973) initial study of managers observed five executives to determine the purpose or outcome of each interpersonal contact and each piece of mail. In his findings, he described 10 managerial roles. Using this role set, he subsequently studied senior and middle business managers, hospital administrators, chief executive officers, and others.

From the results of these studies, Mintzberg concluded that the work of managers is remarkably similar across organizations, with 10 basic roles common to all. He categorized the manager's major or basic working roles as interpersonal (figurehead, leader, liaison), informational (monitor, disseminator, spokesman), and decisional (entrepreneur, disturbance handler, resource allocator, negotiator).

In contrast to Mintzberg, Stewart (1976) suggested that too much emphasis had been placed upon the similarities in managerial jobs and too little upon the differences. She studied 450 managers in order to classify the differences in the demands that jobs make on the behaviours of the incumbents. Through interviews and questionnaires to all 450 people, as well as a further detailed study of 16 managers by means of interviews, observations, and self-recorded diaries, Stewart concluded that work varies according to the demands, constraints, and choices of the job. In her later model for understanding managerial jobs and behaviours (1982), Stewart described an inner core of demands (work that managers must do), an outer boundary of constraints (the extent to which the work to be done in a manager's unit is defined by the resource limitations and structure), and an intermediate area of choices (how and what work is to be done). In her view, choices were limited by demands and constraints, both of which are dynamic and subject to change over time.

In contrast to Stewart, Kotter (1982) supported Mintzberg's contention that the daily behaviour of managers is hard to reconcile with traditional notions of what top managers do (i.e., planning, organizing, controlling, directing, staffing, etc.). Between 1976 and 1981, he studied 15 successful general managers in nine corporations through

personal interviews, observations of daily routines, and interviews with the key people with whom they worked. Each manager also filled out two questionnaires and provided relevant documents (e.g., business plans, appointment diaries, and annual reports). Kotter found that effective managers approach their jobs through two key activities: agenda-setting and network-building. Agenda-setting refers to the act of using continuously acquired information to set loosely connected goals and plans that address the manager's long-, medium-, and short-term responsibilities. Network-building refers to the time and effort taken by managers to develop a network of cooperative relationships among those people they feel are needed to satisfy their emerging agendas.

Whitely (1985) studied 70 managers in the business and hospital sector to identify similarities and differences in the behavioural content and process characteristics of managerial work and to determine the extent to which these content and process characteristics overlap. His findings showed that there are large differences in the work of managers, not only in the behavioural activities but also in the manner in which the behaviours are carried out. That is, even when managers carried out the same activities, the process varied. Whitely interpreted the findings to mean that "to some degree, managerial work is what the manager decides to make of it" (p.359).

The four studies described above have provided valuable insights about the role of managers. Management was viewed as a process rather than a collection of tasks; especially significant for the present study is the fact that the analysis of the role of managers included the perspective of the managers. Any data obtained from people other than the

managers were sought for the purpose of describing effective managers. Two of the studies identified common behaviours (Mintzberg, 1973; Kotter, 1982) whereas the others focussed on the differences among behaviours and the reasons why these occurred (Stewart, 1976, 1982; Whitely, 1985). In both, the description of the role of managers was made more explicit through the analysis of behaviours and attitudes of the people working in those roles.

Methodological Considerations for Studying Managerial Roles

Describing the nature of managerial work has challenged writers and researchers for some time. Some authors have analyzed the work of people in managerial roles through the functions they carry out (Fayol, 1949; Gillies, 1982; Sullivan & Decker, 1985), whereas others have considered the style of leadership as it relates to the staff (Campbell, 1986; Duxbury, Armstrong, Drew, & Henley, 1984; Fretwell, 1982a,b; Pryer & Distefano, 1971). Analysis of skills has been another avenue of exploration for research and discussion (Beaman, 1986; Katz, 1984; Vance & Wolf, 1986).

In reviews of management and leadership literature, some authors report that it is time to move beyond the study of leadership style, management activities, and traits to the study of behaviours themselves (Carroll & Gillen, 1987; Immegart, 1988; Murphy, Hallinger, & Mitman, 1983; Sergiovanni, 1984). Others argue that managers' behaviours and the elements affecting those behaviours would be better described by studying the people acting in the roles rather than the people who report to them

(Murphy, Hallinger, & Mitman, 1983).

Managerial behaviours have been the basis for studies by a number of people. Similarities in such behaviours have been presented as common managerial roles by Mintzberg (1973), Kotter (1982), Kurke and Aldrich (1983), and Klein and Posey (1986). Variation in managerial behaviours has been studied by Stewart (1976, 1983) and by Whitely (1985). Each of the studies used a combination of surveys and interviews to obtain the data for analysis. Some also used direct observation to delve further into managerial behaviour (Kotter, 1982; Kurke & Aldrich, 1983; Mintzberg, 1973).

Biddle (1979) cautions that self-reporting by managers can be biased because the respondent inevitably selects only certain aspects of behaviour to remember and, in so doing, distorts evidence, filters out contrasting details, and integrates experiences into her/his own assumptional systems. Nurse researchers, however, look more favourably on the products of self-report techniques. Polit and Hungler (1987) suggest that while researchers can only observe behaviours occurring at the time of the study, self-report techniques, such as questionnaires and interviews, gather retrospective data about activities and events occurring in the past as well as prospective data about projected future behaviours. Thus, the most fruitful way to obtain descriptions about the head nurse role may be to accept the latter perspective and to use interviews to determine what people perceive their roles to be. After the initial descriptive study, observation and hypothesis testing may be necessary to validate the findings further.

Although studies of the head nurse position have been confined to

examining the effects of leadership style on nursing staff and the tasks or activities performed by head nurses, the nursing executive role has been explored in more depth. Nursing executives occupy the senior administrative positions in the nursing organization, either at the director of nursing or vice-president level. Research into the role of nursing executives has described the structure and function of the role (Poulin, 1984), as well as role stress and coping strategies (Scalzi, 1988). Using a descriptive research design involving interviews and content analysis, these studies provided a description of the behaviours involved in the nursing executive position and discussed the ability of the incumbents to deal with role stress. The success of the descriptive research design may support the choice of a similar approach for studying the head nurse position.

Summary

In this chapter, literature relevant to the current knowledge about head nurses and managers has been examined. In nursing, the majority of the research related to the head nurse position has been from the staff perspective. It has been suggested that the study of roles, and of the behaviours which make up those roles, can best be approached through the perspectives of the people in the roles rather than the people reporting to them, the approach taken by research into the role of general managers.

While nursing studies have added to the knowledge about the head nurse position, they are rarely from the viewpoint of the head nurses themselves. Studies of head nurse leadership style identified the desired leadership actions from the staff nurses' perspectives but not in relation

to the beliefs or attitudes of the head nurses involved. Other studies described the tasks performed by head nurses, but the lists of activities and comparative analyses between agencies did not address the head nurses' rationales for action. Little is known about what head nurses think about their work, why they make particular decisions in different situations, and what their role behaviours mean to them. As well, the perspective of the head nurse as a manager has not been explored in any systematic manner.

In contrast, much is known about the work of managers in the fields of business, industry and general health care. Role theory provides a basis for exploring the role of managers. Management, as a set of skills, a set of functions, and as a process has been described extensively. Various methodologies including observations, questionnaires, and interviews have been used to determine both similarities and differences in managerial roles and work behaviour.

Knowledge from the general management literature is beginning to be applied to nursing as studies of nurse executives seek the perspective of the incumbents. A similar approach to the study of head nurses is now warranted.

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology by which the study was carried out. It outlines the research design, sample selection, ethical considerations, and methods of data collection and analysis.

Research Design

Owing to the dearth of literature on head nurses' perceptions of their role, the study used an exploratory, descriptive research design for collecting and analyzing data. Polit and Hungler (1978) define descriptive research as that which aims predominantly at describing phenomena rather than explaining them. Exploratory research, as an extension of descriptive research, is directly oriented towards the discovery of relationships. While exploratory research focusses on the phenomenon, it questions "what factor or factors influence, affect, cause, or relate to this phenomenon" (p. 24). As such, exploratory, descriptive research was appropriate for this study.

Sample Selection

A convenience sample of 20 head nurses was selected from a large, tertiary level care hospital in the British Columbia Lower Mainland. Because the head nurses needed to describe and to reflect upon their roles, it was necessary to select head nurses who were comfortable with their job responsibilities. Therefore, the subjects selected had been head nurses for at least one year.

The sample was obtained from volunteers contacted through their regular

nursing management meetings. The researcher provided a brief explanation of the study, requested volunteers to indicate their interest, and provided them with a letter of information (see Appendix A). Potential subjects were invited to indicate their willingness to participate at that time or to initiate further contact by telephoning the researcher. All but one of the subjects volunteered immediately. Once the potential subjects were identified, the researcher telephoned each participant to clarify the study process and to schedule an interview at a mutually convenient time.

Data Collection

Semi-structured interviews were used as the process for exploring head nurses' perceptions of their role. A standardized interview guide, based on Mintzberg's framework, was designed specifically for the study. In order to address what were anticipated to be more familiar roles first, the framework was re-ordered and the interpersonal roles were placed after the informational and decisional roles. The interviews were tape-recorded and transcribed verbatim.

The data were collected by interviewing each of the 20 subjects once. The interview explored the subject's perceptions about the head nurse position in relation to the categories described by Mintzberg. Prior to the start of the interview, the subject was given a brief written summary of Mintzberg's 10 managerial roles to be used as the basis for discussion (see Appendix B). Questions directed to each role asked the subject to describe his/her perceptions of activities that fell within the bounds of the role description.

The first section of the interview guide was primarily designed to obtain demographic data about the subjects. The second section addressed each of the

10 roles (see Appendix C for the detailed interview guide). The interview guide was reviewed by thesis committee members and then pilot tested on two content experts who were experienced head nurses. The pilot test enabled the researcher to determine if the questions in the interview guide adequately represented the categories suggested by Mintzberg and if the categories defined by Mintzberg were sufficient to encompass the roles of the head nurse. On the basis of this testing, only minor adjustments in wording were considered necessary. A further suggestion, which was acted upon, was that, prior to the interview, the researcher should clarify Mintzberg's use of the term "organization" in relation to the nursing unit.

Data Analysis and Interpretation

The transcribed data were organized into the 10 categories defined by Mintzberg's framework. All findings were summarized and tabulated using the procedure of content analysis, which aims at categorizing verbal or behavioral data for the purpose of identifying, measuring, describing, and making inferences about specified characteristics within the data (Fox, 1982; Waltz, Strickland & Leuz, 1984). Descriptive statistics were applied to the demographic data and used to summarize the frequencies of the categorical findings.

Category reliability was addressed in two ways. First, the findings were reported so that the categories of data in relation to each role were explicitly described (Fox, 1980; Waltz, Strickland & Leuz, 1984). Second, to ensure consistency of the category descriptions, a second rater completed a random categorization on one transcript and compared this to the criteria described by the researcher. Agreement upon categories was achieved for 80%

of the descriptions.

To ensure validity of the code categories, each category must be organized in a logical, rational, and defensible manner that clearly reflects the research purpose (Fox, 1980). Therefore, the categories must be sufficiently valid that other people using the same criteria can replicate the study. The use of an organized, multistep procedure to examine the data provides the basis for making inferences and drawing conclusions (Waltz, Strickland & Leuz, 1984). In the analysis phase of the study, the data were sorted into each one of the managerial roles, then reviewed for similarities and differences among the responses of the 20 subjects. Emerging themes within each of the roles were summarized by the use of descriptive statistics where appropriate. The data were then compiled into a description of each role and relevant quotations from the subjects were used to explain the themes.

Ethical Considerations

Prior to recruiting the subjects, approval for the research proposal was obtained from the University of British Columbia Behavioral Sciences Screening Committee and the hospital's Research Committee. Use of an informed consent and protection of confidentiality addressed the rights of the subjects.

The purpose of the study was explained to the subjects verbally and in writing (see Appendix A). A written consent (see Appendix D) was obtained from each subject prior to the interview. Details pertaining to the typing, storage, use and disposition of the audiotapes and transcripts were discussed. Confidentiality of results was maintained by coding the subjects' names so their identity was known only to the researcher. Subjects were asked not to

mention names during the interviews, and any names accidently mentioned were deleted from the transcripts. Access to the data was limited to the researcher and her advisory committee. Subjects were not identified by their responses. All of the subjects' responses to the study, including the consent forms and interview tapes, will be destroyed after completion of the study.

Summary

A descriptive research design was used to collect data for the study. Twenty subjects were interviewed about their perceptions of their roles as head nurses. The taped interviews were reviewed and summarized through the procedure of content analysis to enable the findings to be reviewed in relation to other relevant studies.

CHAPTER FOUR

PRESENTATION OF FINDINGS

This chapter summarizes the data obtained from 20 interviews conducted with head nurses from the study sample. The presentation of findings is divided into three main sections: the first section describes the study sample; the second presents the 10 managerial roles as described by the subjects; the third summarizes the comments made by the subjects about the managerial roles in general. An analysis of these findings is presented in the following chapter.

Description of the Sample

The study subjects consisted of 20 head nurses employed in a large tertiary, university referral centre, with 900 acute care beds and 200 extended care residents. Head nurses from acute care and extended care areas participated in the study. They represented in-patient units ranging in size from 11 to 35 beds, as well as short stay areas for surgery, diagnostic procedures or observation.

As shown in Table 1, the average number of years spent by these 20 subjects in nursing was 19.6 with a range of 6 to 38 years. The average number of years spent as head nurse was 6.8 with a range of 2 to 28 years. The number of staff for whom they were responsible varied considerably, ranging from 5 to 150 people.

The educational background of the head nurses varied, as can be seen in Table 2, with 11 (55%) prepared at the diploma level, six (30%) at the baccalaureate level, and three (15%) having masters preparation.

Table 1: Years of Experience and Number of Staff

	Years in Nursing	Years as Head Nurse	Number of Staff
Range	6-38	2-28	5-150
Mean	19.6	6.8	33
SD	10.2	6.3	35
Median	16.5	5.5	20.5

Table 2: Educational Background

Diploma / Degree	Number	%
R.N. Diploma	11	55
Bachelor of Science Nursing	6	30
Masters Degree (in Nursing)	2	10
Masters Degree (other than Nursing)	1	5

Table 3 indicates that more than half of the subjects (11, or 55%) described themselves as having no formal management training, even though most of them had taken workshops or courses. Of the total group of head nurses, 16 (80%) had taken workshops or courses, either presented by the hospital or at community colleges. Eight (40%) had completed such recognized programs as the Nursing Unit Administration Program through the Canadian Hospital Association, the Effective Head Nurse Program at Vancouver Community College, and the Health Care Management Certificate

through the British Columbia Institute of Technology.

Table 3: Management Training

Description	Number	%
Workshops / Courses	16	80
Nursing Unit Administration	3	15
Effective Head Nurse	4	20
Health Care Management	1	5

The study sample consisted of head nurses with varied experiences, educational backgrounds, and areas of responsibility. Even though the management jargon was at times unfamiliar to the most experienced subjects, it did not preclude their understanding of the roles. Educational background could have been a factor in the clarity of responses for some of the subjects, but people with the same preparation had significantly different perceptions for some of the roles. The size of staff for which the subject was responsible did not appear to affect the responses. For example, the subject with the largest number of staff had similar responses to the one with smallest number. Finally, the clinical services incorporated in the individual nursing unit affected the clinical expertise required by the subject, but had little impact on the subjects' perceptions of the managerial roles themselves. In summary, there seemed to be no correlation between the demographic information and the subjects' responses.

The Ten Managerial Roles

The exploration of the managerial roles was the main focus of the interviews. The subjects were asked first whether the major role group category--that is, informational, decisional or interpersonal--applied to their positions as head nurse, then each of the 10 managerial roles was discussed. All subjects confirmed that the roles were relevant. The specific roles were then discussed in detail. The results are presented separately in order to explicate the themes and significant findings within each of the 10 managerial roles.

Monitor

The first interview question related to the monitor role. Subjects were asked to describe their perceptions of their managerial behaviours. After some initial hesitation, all of the head nurses described activities that allowed them to individually monitor the progress of their units. In general, there tended to be more informal than formal measures. The measures for monitoring the unit internally were generally informal and fairly consistent, whereas the external monitoring (i.e. in relation to other units) was carried out in a variety of formal ways. The internal monitoring is presented first, followed by a brief discussion of the external monitoring in relation to other units.

In order to monitor the operation of their individual nursing units, most of the head nurses used informal methods of observing and checking the operation. These included making patient rounds, talking to staff, talking to other health professionals, listening to reports, and just being on the unit. The internal methods used and frequency of use are presented in Table 4.

Table 4: Internal Monitoring Methods

Description	Number	%
Observe patients and their care through rounds.	15	75
Check charting (chart audit)	10	50
Talk to nursing staff for information	9	45
Talk to other disciplines for information	9	45
Listen to report	7	35
Be present on the unit	3	15
Talk to Clinical Nurse Specialist (CNS) or Instructor	3	15
Talk to Assistant Head Nurse (AHN) or senior nurse in charge	2	10
Complete performance appraisals / anecdotal records	2	10
Review incident reports	2	10

The term "patient rounds" was used frequently to describe activities such as observing patient care, talking to patients, and assessing the workload. For example, one subject said, "I make daily rounds on the patients, so...I can basically monitor the actual nursing care that's going on." Another stated that "making rounds gives me some idea of what the nurses have to cope with and do, and I try to see wounds and dressings to see also how long the dressings might take." A third stated, "As I'm seeing and talking to the patient, I'm also getting a feel for what the

R.N. has and has not done up to that point in the day versus what I think should already be accomplished."

In addition to making patient rounds, the subjects checked charts and made general observations to monitor the unit's operation. One subject said, "As far as monitoring the patient care, I make rounds at least once a day or twice if possible. Also, I read the chart and depend on my own observations."

Talking with nursing staff and other disciplines also facilitated the monitoring process. As one subject explained, "talking with the staff, talking with patients, making plans with doctors, social worker, home care nurse, ostomy therapist, physio, and a whole host and variety of people who you interact with throughout the day" allowed her to monitor the operation of the unit.

Listening to report and "just being on the unit" were common ways of assessing the unit's functioning. As one subject described these activities:

> First thing in the morning it's sort of getting a sense of what the unit's doing when you walk on the unit. Are the nurses all scrambling or are they sitting around chatting or whatever. That kind of gives me a feel for how the day might end up, or how the night's been. Then listening to report gives me a feel for not only how the patients are doing but how much my staff know about how the patients are doing.

Another subject said, "the feedback from your night staff as well as being there with your day staff...[provides] a lot of information...in the early morning when you first come in."

External monitoring methods, as shown in Table 5, tended to take a more formal approach. The regular head nurse meetings were described as one of the main forums for discussion, with feedback from other head

nurses through informal meetings or incidental discussions a close second. For example, one subject stated, "We have head nurse meetings every two weeks, and I share what goes on here and I hear what goes on elsewhere." Another reported that at the weekly head nurse meeting, "someone reports quality assurance on their unit, and I sort of evaluate myself as to where they are at and how I am doing."

Table 5: External Monitoring Methods

Description	Number	%
Regular Head Nurse meetings	11	55
Informal feedback from other Head Nurses	10	50
Safety audits / quality assurance	7	35
Review of goals & objectives	4	20
Informal feedback from other disciplines	4	20
Meeting with Director	3	15
Incident reports	2	10
Informal feedback through committee work	2	10

In addition to head nurse meetings, safety audits and quality assurance activities were described by six (30%) subjects as ways to monitor activities in relation to other units. These were used "in terms of planning and trying to reach the goals that we set for ourselves each year. Keeping documented reports on how we are doing on each of those is my [the head nurse's] job, essentially."

There were mixed feelings on the merit of monitoring one unit in relation to the rest of the nursing organization. As one head nurse said,

"I'm in a big hospital in my own little world, but I see the big hospital." One head nurse said that using quality assurance as a means of comparing units would not be her "choice" at all. Another stated, "I think the units in this hospital are so specialized that it's difficult to compare them. It's like comparing apples and oranges."

In summary, the monitor role was explored in terms of the internal (unit) focus and the external focus (relative to the nursing organization as a whole). The internal or unit focus was achieved mainly through informal means, such as observations, making patient rounds, talking to staff, and listening to reports. The external focus used a combined approach through formalized meetings, quality assurance activities, and review of goals and objectives, as well as informal feedback from other people both in and out of the nursing organization.

Disseminator

The disseminator role was seen by the subjects to be one of the most important of the 10 managerial roles. They emphasized the large volume and variety of information and the importance of the head nurse position in dealing with the information. The process of disseminating incoming information was described as being much more difficult and complex than the process of taking information outside the unit. The two processes will thus be presented separately. Methods of disseminating incoming information are presented in Table 6.

All subjects said they dealt with a great deal of information. As one said, "It's coming at us constantly from all angles." Another stated, "It comes in the way of paper, telephone calls, and verbal communication given down at meetings." Another subject described the volume in her

Table 6: Methods of Disseminating Incoming Information

Description	Number	%
Communication book	16	80
Staff meetings	12	60
Bulletin board	9	45
Post report (summary of important items)	8	40
Informal talks with staff	8	40
Extra notes (in strategic places)	5	25

mailbox alone as "10 to 15 pieces of mail a day. It can be anything from minutes of meetings to mail from outside agencies asking for favours, to just the basic paper flow of staffing." One subject called it "almost an information overload."

Several subjects spoke of the importance of the head nurse role in disseminating information. One stated:

> The head nurse is pivotal in the administrative structure. I think that a lot of us aren't really aware of that. I think something we need to be more aware of is our strength in our role--we are the disseminators. If anything wants to get through the unit, it has to be supported by us.

Another perceived her role as "being a funnel." She dealt with information "specific to the nursing division" or from other departments. She described the need to "triage" information into items which had "to go to the nursing staff on an immediate basis" or items which could be "deferred until a staff meeting." She summarized her disseminator role as follows:

> Any other department in the hospital will have information that's funnelled into the unit and I have to get it to the appropriate

person and appropriate place so that the appropriate people can implement whatever that particular change is. I also disseminate information from outside the hospital in through the unit.

The most common method of disseminating information used by 18 (80%) of the subjects was the communication book which contains notes and memos to be read by all nursing staff. One subject described it as "a binder that we just keep all the paper that flows through that the staff need to read but don't necessarily need to read their very first shift back to work." Twelve (60%) subjects found staff meetings to be useful, although two others were skeptical about their utility because attendance was generally low. Several of the subjects used bulletin boards for posting information and talked informally with staff.

Another common strategy used by the subjects for disseminating information was to give a brief summary of urgent or important items immediately after report in the morning. As one subject said, "Every day after report I try and think of the highlights of our head nurse meeting and then have to repeat this for several days in a row." Another stated, "If it's something really critical to ensuring its success, I will bring it up every morning in report."

The variety of techniques used was thought to be necessary owing to the rotation of staff through various shifts, the large number of staff on some units, and the type, urgency, and importance of the information. In general, there were three priorities for disseminating information. The first priority was information concerning patient care and the function of the unit or staff. This information was generally transmitted verbally in a post-report format and through informal discussion with staff, accompanied by written information posted in strategic places, such as the

front of the assignment sheet, on the blackboard in the report room, in the medication room, and in the communication book. The second priority was staff concerns (e.g., educational opportunities), generally communicated in the form of notices posted on the bulletin board. The third priority was general concerns and medical administrative matters, communicated in the form of memos posted on the bulletin board or noted in the communication book.

Although a variety of methods were used to deal with outgoing information, as shown in Table 7, the problem of disseminating information outside the unit was not as difficult as handling the incoming information.

Table 7: Methods of Disseminating Outgoing Information

Description	Number	%
Meet regularly with Director of Nursing	12	60
Talk to other departments directly	6	40
Talk with Head Nurses at meetings	5	25
Send memos to Director of Nursing or other departments	4	20
Meet/talk to other Head Nurses (informally)	2	10

Most of the subjects said that talking to their Director of Nursing in regularly scheduled meetings was adequate for passing on much of the outgoing information. In some cases, subjects talked to the appropriate departments directly or raised concerns in the regular head nurse meetings in order to ask if others had problems or solutions. Writing memos and

talking to other head nurses were identified as further ways of disseminating information.

In summary, subjects had less concern with moving information out of the unit than with disseminating information sent or brought into the unit. In the latter case, information was processed based on the priority assigned to it by the head nurse who decided what was to be passed on as well as how and when. The importance of the head nurse position in making these decisions was emphasized.

Spokesman

All of the subjects felt they were the spokesmen for their units but most did not consider the role to be particularly significant. The activities described by the subjects are presented in Table 8, followed by a selection of comments about this particular role.

The majority of subjects described the spokesman role as representing their unit on committees, at head nurse meetings, and during follow-up of problems or concerns with other departments and disciplines. The committees included quality assurance, procedure, medication, and other similar in-hospital committees. Three subjects also sat on committees outside the hospital. In so doing, they represented not only their units, but the particular practice specialty with which they were involved.

Following up problems and concerns with other departments and disciplines was described as part of the spokesman role by eight (40%) of the subjects. As one head nurse stated:

> I do that verbally with a lot of other staff. I meet quite regularly with the home care liaison nurse, the physio, our dietician, and our social worker. I've also written many letters to different people - we're having trouble with physio right now...[so I've written] to the manager and also to home care with some problems we've had.

Table 8: Summary of Spokesman Role Activities

Description	Number	%
Committees: In-hospital	14	70
Out-of-hospital	3	15
Head Nurse Meetings	9	45
Follow-up of problems/concerns with other departments or disciplines	8	40
Attendance or presentations at conferences	5	25
Clinical resource to other units/hospitals	4	20
Nursing Division meetings	4	20
Social conversation outside the hospital	3	15
RNABC chapter/practice meetings	3	15
Multidisciplinary meetings	3	15
Incidental meetings with senior management	2	10

Another subject had contacted many other departments in an effort to improve the physical environment of her unit: "I've become well known all over the place because I keep asking for things--anything to improve the unit."

Some of the subjects felt quite strongly that the spokesman role was very significant for the head nurse, as illustrated by the following statement:

> I think it's my nature to present a reasonably intelligent and calm exterior regardless of the interior. It's important to be a spokesperson at head nurse meetings, to be visible at management and divisional meetings, and to be present at nursing forums. Also you have to be alert enough to know when something externally is going to affect your unit and be able to have a say at those important

> meetings. I think the head nurse has to get off the unit and be visible at crucial and important meetings and be part of committees where input into documentation systems or other topics is needed.

This comment reflects the subject's belief that "first of all I am a role model to the staff." Another subject felt she acted as spokesman on the "new program management committee...trying to make sure we don't get lost in the shuffle." In contrast, one subject had done very little of what she would consider to be spokesman activities because she perceived the clinical nurse specialist for the program to be more skilled in this role.

The spokesman role was seen to be an aspect of the head nurse position, but was described in little depth beyond the obvious function of representing of the nursing unit at committee and head nurse meetings. Only a few subjects represented their units outside the hospital by committee work or by attending conferences.

Entrepreneur

The discussion of this role explored the head nurses' involvement with initiating and implementing change. Three themes came to light: the types of changes with which the head nurses were commonly involved; the positive and negative orientation of the head nurses to change; and the significance of the head nurse position in the implementation of change. In addition, a significant finding was that the subjects generally reacted to change or implemented change introduced by others, rather than initiating it themselves.

The majority of changes involved staffing issues (rotations, responsibilities, attitudes), clinical practice issues, and physical or environmental changes, as presented in Table 9. Later, more specific descriptions of the changes identified by the subjects will be explored.

Table 9: Types of Changes with Which Head Nurses are Involved

Description	Number	%
Staffing (rotations, complements, responsibilities)	18	90
Physical/environmental changes (includes moving, splitting units)	16	80
Patient care/clinical practice	15	75
Introduction of new equipment	2	10

The subjects described a number of staffing-related changes including variation in "staffing patterns," changes in "rotations, who works when and where, who's in charge, preceptor roles, development of educational standards on the unit," and going from the "7.5 hour shift to the 11.25 hour shift." For many of the units, the responsibilities for the charge nurses changed when the shift supervisors were deleted. One subject created "a decision-making tree for what to do if something happens without supervisors around."

Changes in clinical practice, such as in protocols, charting, patient teaching, and methods of administering particular treatments, were also common to all subjects. Several units had changed the type of patient care delivered from team to primary nursing or total patient care. One subject related an example of a change in policy with regards to the "use of sitz baths and measuring hats [urine specimen containers]--we used to wash them to save money. But as part of quality assurance, we found we were saving money but were not doing the best for patient safety and

infection control. So we changed the policy."

Physical and environmental changes included relocating units, splitting units, redesigning units, changing the size of units, and improving the existing patient facilities. For example, as one subject said:

> When we moved over here I was greatly involved in the planning for the new unit and that was a big change when we came over here. We got all new equipment and a lot of things that we wanted and we were very definitely involved in that.

One of the frequent changes involved splitting the large units into two smaller ones, with a head nurse for each unit rather than having a head nurse with two assistants. One subject described her experience:

> Several years ago we split the unit, so that was a major change that we underwent. It was very traumatic and emotional, but we all lived through it. We work very well side-by-side with the other unit, so I think that in itself has been a major accomplishment.

The physical and environmental changes were implemented by the head nurses in reaction to requests from the staff, directives from senior hospital management, or identified patient needs.

Whereas all of the subjects said they were involved in changes on their unit, most described reaction or adaptation to changes suggested or started by other people rather than changes initiated by themselves. As one subject said, "...a lot of changes happened on the unit that were beyond my control." Along with these reactive changes, the subjects seemed to describe themselves as having a positive or negative orientation to change. For example, two subjects described their frustrations over changes imposed upon them and into which they had had little input:

> The changes that keep coming through from administration sometimes directly affect the unit, but you wonder whether you've had any input or whether anybody has listened to you. Also sometimes things change very quickly, and there hasn't been time to either trial the change

or accommodate suggestions for improvement.

> I also see it [the entrepreneur role] as a frustrating role. You can see things that need to be changed to make them more efficient or how other departments are affecting you, and you can see solutions, but other departments don't see the same solutions that you do, or it's not an important issue to them. So it's at the bottom of the heap for them while it might be at the top of the heap for us.

Only five (25%) subjects were able to describe a change which they initiated. These happened "mostly in the beginning" or "when I first came." One who viewed change more positively stated:

> I have a lot of autonomy and a lot of control over my unit. Pretty well I can do whatever I want as long as I don't create a big uproar that upsets the staff, and I think that most of the time I let them decide what they want as a group with of course the pulling veto power sort of like the president. Luckily I haven't had to use it. You can't help but in nursing be involved in changes on a weekly basis.

Another subject commented, "I initiate a lot of change...I love coming up with new ideas and throwing them around and seeing how they go."

Whether initiating or reacting to change, all the subjects described the head nurse as "frequently" or "constantly" involved in change. Some identified the importance of the position in making these changes happen.

> I think the head nurse is a pivotal point as far as implementing change on the unit. Things can come down from administration, but unless you have a head nurse who's going to support that decision, your plan is going to fail because your head nurse is the person who instructs or communicates with the staff nurses.

> I think that if the head nurse is positive about the changes, the staff pick up on that. I think that if she gives a lot of lead-in time to it, and I find that the more time I give them the more they can adapt to it, the more they can come up with their questions and have them responded to so that when the change is actually implemented they go into it very enthusiastically and very positively. My attitude about the change directly reflects on how my staff handle the change.

Most of the subjects reported that they "heavily involve the nursing staff" because "it is the person at the bedside who knows." They talked

about "staff input," "encouraging nurses to use their ideas," and giving staff "a lot more responsibility."

In summary, the types of changes were similar in content, with the majority related to staffing concerns, clinical practice, or environmental changes. The subjects' philosophical orientation to change varied from positive to negative. Most of the changes were reactive rather than initiated by the head nurse. It was clear that the head nurse position was perceived to be pivotal to the implementation of change as was the importance of staff involvement in the operation of the unit.

Disturbance Handler

The disturbance handler role was one of great interest to the subjects. They were able to describe the types of conflicts or disturbances they frequently dealt with. Examples of each are presented, along with a discussion of how the subjects dealt with conflict, why some felt they had very little conflict, and why all felt it was necessary to invest the energy necessary to manage conflict effectively.

Several categories of conflicts or disturbances were identified in the many examples described by the subjects. As shown in Table 10, these included interpersonal conflicts, conflicts over performance expectations, conflicts over the allocation of resources, and conflicts over role expectations.

The interpersonal conflicts generally revolved around people, such as staff, physicians, patients, and families, not working together or communicating effectively. Difficulties in attitudes toward working with other people are as described in the following scenario:

> It was getting to the point where the nurses were saying that if they [the orderlies] are going to continue with the attitude that they've got right now, we [the nurses] don't want them at all...that was a big conflict and it remains to a certain extent.

Table 10: Types of Conflicts or Disturbances Dealt with by Head Nurses

Description	Number	%
Interpersonal	26	45
Performance expectations	13	23
Resource allocation (staff scheduling, bed utilization)	9	15
Role expectations	9	15

Conflicts with patients, families, and visitors also required mediation by the head nurse. A common occurrence was a misunderstanding about when the patient was to be discharged. The nursing staff frequently had to clarify what was said by the physician and deal with the patient's anger. Other examples of such conflict required different approaches:

> It was tricky to handle and to pacify the fellow who visits and make him feel that something had been done and that he had been listened to and at the same time support the staff person and listen to phone calls from administration.

> There's one way to deal with that kind of visitor that is right, and there is another way to deal with it that's inappropriate. What will happen is the nurse will respond with her emotions rather than her professional approach.... Again, I will approach that staff person and sit down and talk about it and how we could approach it differently.

Conflicts related to performance and role expectations are illustrated by the disturbances with physicians. These conflicts surrounded such issues as the physicians not attending patients on the unit, the physicians trying to introduce changes in medical practice which affect nursing, and ethical concerns about patient treatment. Some examples follow:

> If I ever get into conflict, it's usually with the consulting team in terms of trying to get them up on the unit to see a patient and having to sort of come down as the head nurse as opposed to a staff nurse.
>
> It may be that the physician decides that he knows everything and tries to promote something that the nurse feels is compromising the patient's well-being. That can end up being a major conflict...yelling in the unit in front of staff and relatives. So then we have to deal with our conflict.
>
> One of the areas that's really difficult to mediate is the ethical one where the physician may feel that he wants to treat this patient who's 92 and the nursing staff is feeling ambivalent about why we're treating this particular individual. There is a conflict between the nurse and the patient or the nurse and the doctor about why we're doing what we're doing for this particular individual. Those can be very difficult to mediate.

The subjects' descriptions of handling disturbances sometimes made them sound like referees, as in the following remark: "It was almost like you go to your corner, and you go to your corner." Techniques for handling disturbances varied, but many of the head nurses had a basic "personal philosophy" or "rule of thumb" to guide their decisions about when to get involved. The following examples illustrate such philosophies:

> My personal philosophy is that I don't really want to hear about it unless you talk to the person who's got the problem. The two exceptions to that are if it's an issue of patient safety...or if it's an issue that's repetitive.
>
> I always tell my staff that they're adults and they're independent practitioners. They're working for an organization with the policies and procedures to give them the scope of their limitations as to how they can do that practice, and I expect the same thing with their conflict resolution. I hope that they can sit down and work some of those problems out.
>
> I tend to take the attitude that I'm not your mother, that you are adults, and that you should be able to resolve your own differences. If in attempting to resolve them you can't, then I'm willing to meet with the two of you together and mediate it, but I'm not willing to listen to complaints unless you have dealt with the issue with that person and have received no response.

To deal with conflicts with physicians, the subjects use a variety of methods. As one said, "I try to talk to them...and if I hear of some problem, I talk to that specific doctor or to my staff." Another explained that she had talked to the staff about "how to approach doctors and how to leave notes for the doctor not implying he's stupid."

Some head nurses felt they had "a lot" of conflicts and disturbances, and one was "exhausted just thinking about it." Another said, "There are conflict situations that arise anywhere and everywhere. So I don't want to be involved with just the day-to-day 'somebody's mad at somebody else,' because otherwise I would never get anything done."

The energy invested in disturbance handling appeared to reflect a commitment to both quality of patient care and staff satisfaction. As one subject said, "We always have to remember that primarily we're here for the patients, and the solution has to be equitable, and the patient has to come first." Another stated:

> I've had a lot of little problems, nothing really great, because I try to get them right at the beginning in that I really want the unit to be a happy place because it's hard enough to come to work.

Some subjects reported they had relatively little conflict between nursing staff members because "they've worked together for a long time," or "I'm lucky to have a staff that is quite mature in dealing with people. Once in a while when it's busy, tempers erupt but they can talk among themselves and deal with it." Those subjects who described themselves as having little conflict on the unit accepted conflict as a normal part of people working together and used preventive measures to keep it under control. For example, one subject stated, "It's part of my expectations [that people resolve their own conflicts], and when I come in it's only

when patient care is being compromised." Another said, "It's part of the screening process. When you screen your staff you look for certain characteristics. The most important thing to me is their communication skills...and I outline my expectations in terms of how they deal with conflict." The same subject also stated:

> I anticipate conflict and sort of hit it off at the pass, either by backing off or by changing how I approach it...by forcing people to be direct. People often choose not to deal with the issue rather than to be direct...it takes more energy just to ignore it as opposed to dealing with it themselves.

Two subjects admitted they were not comfortable dealing with conflict and felt it was an area of personal development for them. They cited more experience and going to workshops as avenues for improving their skills with conflict management.

In summary, the role of disturbance handler was one with which the head nurses were very familiar. Conflicts or disturbances between staff members, with physicians, with patients, families and visitors, and with other departments and disciplines were all part of the job. Approaches to conflict resolution varied but were generally based upon a personal philosophy that encouraged people to be direct and deal with their own conflicts unless patient care was compromised. All subjects described the role of disturbance handler as being important and, with the exception of two subjects, were comfortable in dealing with conflicts or disturbances.

Resource Allocator

The subjects described the role of resource allocator as important to the head nurse position. In general, the subjects used very similar terms to define the role, to identify the frustrations they experienced within the role, and to discuss the factors that influenced their decisions about

resource allocation.

That the subjects were familiar with the role is indicated by the consistency of terms used to describe what the resource allocator role involved. Eighteen (90%) said the resources for which they were responsible were human or staffing resources and material resources such as supplies and equipment. Two subjects did not describe the role this way. One was responsible only for the staffing budget, because another head nurse in the area was responsible for equipment and supplies. The other subject had difficulty answering the question and required much prompting to define the meaning of resource allocator. Her example of resource allocation was "sharing with others what we have."

In the allocation of staffing resources, the head nurses were involved with making up daily assignment sheets, reallocating patient workload when staff were sick, justifying staff utilization, and controlling when and where the staff floated or were absent for educational purposes. A recent change, perceived by the head nurses as a positive alternative was closing beds to reduce, or at least limit, workload rather than bringing in extra staff when workload was high. As one subject said:

> I have a rotation designed to give me the staffing that I need to run my unit at 78% occupancy, and when I have 78% occupancy I don't have a problem at all. When I get up to 100% occupancy, I have a problem. Now instead of going into additional nursing care, which then comes out of the budget and leaves you in a position where you were over budget all the time, we go into restricted admissions, which helps us maintain our budget and yet safely care for the patients on our unit.

This change had given the head nurses one additional way to deal with allocating staffing resources. Although absenteeism management could be another way to control staffing resources, only one subject mentioned it

as having an impact on staffing utilization.

Supplies and equipment allocation involved activities such as identifying lack of resources, evaluating equipment, justifying what resources were used for, and making submissions for capital budget requests. In this area, frustrations arose over lack of control. Many subjects stated that their lack of control over the budget was very frustrating because they could not control all expenditures:

> I'm responsible and accountable. However I don't have a lot of power to change the amount of dollars we have or I don't have a lot of power to even set limits on what's being allocated to my cost centre. So I'm finding that whereas I may be accountable for it, I may have no control over the expenditure.

> I just don't have a sense of control...I think people think they're a part of budget planning, but I don't believe we are....So I think I look at trying to be creative in staffing or supplies and equipment but the bottom line is that we need these things. So I feel I am a resource allocator to a point.

> I don't control the doctors ordering expensive antibiotics if that's what they think the patients need, nor the amount of dressings that are used with some of our patients.

> We have no idea of what's going to come rolling through the door. For example a burn patient can cost us up to $85,000 in one month in equipment and supplies.

In most cases, this frustration led them to be skeptical about how effective they, as head nurses, could be in controlling resource utilization.

Responses to the question about factors influencing decisions are summarized in Table 11. The major factors that influenced the subjects' decisions about resource allocation were patient needs and safety issues. When describing factors that influenced decisions about resource allocation, one subject stated, "patient acuity would be number one." Another said her decisions were influenced by "the types of patients you

Table 11: Factors Influencing Resource Allocation Decisions

Description	Number	%
Patient care needs / safety	14	70
Staff job satisfaction	6	30
Cost / budget	4	20
Staff competency	2	10

get in, the care that's required, and the equipment that's required to facilitate the care." Second to patient care needs was staff job satisfaction. The subjects described the need to create a "stimulating environment for staff where they are learning and getting job satisfaction."

The allocation of resources required complex decisions to be made, and most head nurses made these decisions according to clear-cut priorities. Two descriptions follow:

> Patient care is a priority obviously. That's why we're all here. I would not compromise patient care because the monthly reports said I'm over budget. I would certainly let my director know I've got a one-to-one on the ward and I need this type of care, or I need additional nursing care and I'm going to call in one of my casuals because I just can't cope with my ward or whatever. But I certainly wouldn't let it compromise nursing care if I could do anything about it.

> I developed what I call an acuity profile which weighted a type of surgery on any given day post-op with a figure....So my staff can very easily get a sense of whether they can handle the workload or not when I'm not around. That's how we make our decisions about the allocation of staff and restricting of admissions--it's based on the workload....The other thing that you do is take a look at the individuals you have working on your ward. My senior staff can obviously handle the sicker patients, can handle a bigger load then a brand new staff member can so you take a look at the needs of the patients and the abilities and skills of the staff nurses and do your best to match them.

In summary, the themes within the description of the resource allocator role were reasonably consistent. There was general agreement about what the term resource allocation meant and a common frustration about lack of control over resource utilization. The major factor that influenced decisions about resource allocation was patient care needs, followed closely by consideration for staff satisfaction.

Negotiator

Describing the negotiator role presented some difficulty for the head nurses. Although 12 (60%) answered affirmatively to the question ("Are you involved in negotiations with other people?"), eight (40%) had difficulty answering the question. The results of this section are, therefore, categorized according to those who were familiar with the term and those who had difficulty with it.

Those subjects who were familiar with the term defined it as "trading-off," "talking to other people, cooperating, finding out what's happening, working out different things," "negotiating for salary," and "compromising." A summary of those people with whom head nurses negotiate is presented in Table 12.

Table 12: People with Whom Head Nurses Negotiate

Description	Number	%
Other disciplines or departments	9	45
Staff (with and between)	8	40
Director	5	25
Other Head Nurses	4	20
Patients or families	3	15

One subject said she spent most of her time "negotiating with the doctors and the patients regarding discharge." Other examples follow:

> It's negotiating with the family as to when they think they can take grandma home or not take grandma home, and negotiating with the social worker as to how fast she can move on the case; negotiating with physiotherapy to get them to the gym one more time before they go home; negotiating between departments when patients have a number of tests and somebody thinks that their test is more important then somebody else's.

> You negotiate with people when you're doing vacations. There's a lot of negotiating there....I think you negotiate with your own peers for coverages for your unit....Sometimes [you negotiate with] other departments and sometimes you work indirectly without going through the proper channels in negotiating what some of your needs or supplies, equipment might be.

Several subjects negotiated with other head nurses about transferring patients, floating staff to other units, and sharing equipment. Most subjects negotiated with their staff regarding vacation hours and working overtime. Other areas cited which required negotiation were the admission and discharge of patients, and the purchase of equipment.

The subjects who had difficulty with the question generally associated the term with labour relations or conflict, an association which seemed to block their understanding of the role. Said one subject, "negotiating is communicating, labour relations...both people trying to come to an understanding...I see it as implying conflict of some kind." Another said, "I haven't had too many major conflicts and I'm not in the union or anything, so I haven't done too much of that." One subject was unable to envision negotiating as part of her job, even though she saw other head nurses doing it:

> I haven't ever been grieved, so the labour thing isn't a problem. We have a very specialized unit, so I don't trade with anybody. My staff are my staff, and we've been so busy that I've needed all my staff and more, so I haven't had extra staff that I could float to wherever. So I don't see a negotiator as a big part of my role.

> Certainly I can see that other head nurses are being faced with that, but I don't consider myself to be....[The staff] know that they're allowed to trade shifts any time they want. I don't care so long as the shift is covered. Again, they just run a paper by me so I can see who's coming in and I can keep the records straight. But they don't have to negotiate with me for shift trades. For vacation, I guess there's some negotiation. Not really a whole lot because it's seniority and it's fairly straightforward who gets what. So I don't have that.

Those people who had difficulty with the question had been in their positions two or three years and, in general, were less assertive in their responses to all of the questions.

In short, not all subjects saw themselves in the negotiator role. Some readily explained their views about the role and activities that they carried out within it, whereas others seemed to be offended by the term and were unable to relate to it.

Figurehead

As in the case of the negotiator role, the subjects had difficulty answering the question related to the figurehead role and the symbolic activities of the head nurse position. Twelve (60%) head nurses were unable to answer without the researcher presenting some possible examples. Eight (40%) were able to describe figurehead activities, but the answers they gave were less consistent than those offered for other roles. This section describes the responses about the symbolic activities of the head nurse position and presents the reasons suggested by the subjects for their lack of knowledge about the figurehead role.

The subjects who had some ideas about the symbolic activities of the head nurse described them in several ways, as shown in Table 13.

Table 13: Symbols of the Head Nurse Role

Description	Number	%
Problem solving and handling complaints	8	40
Acting as a representative on committees	6	30
Acting as a role model for staff	6	30
Legal activities (talking to lawyers, making policy decisions, etc.)	4	20
Attending social events	3	15
Coordinating operation of the unit	3	15
Having a title (on office door/name tag)	3	15

The head nurse as figurehead was described frequently as the person who was expected by other people to solve problems and deal with complaints. Some specific examples include:

> I think that people come to you expecting you to know answers, and you may or may not know them. You're expected to find out where you might get the answer, and I think that's good. I may not always know, but I usually find out. If there is conflict, people will come to you to make the final decision.

> I think probably people still look for a head nurse as the person to complain to and I think the patients, staff, other departments, doctors, if there is a complaint, want to speak to [the head nurse].

The head nurse was still expected to deal with a variety of situations and be the first line of defence for the unit against outside interference.

When the subjects were asked specifically if they carried out activities of a legal or social nature, as Mintzberg had described, some of their responses were:

> I was the first contact for the lawyer in terms of which nurses were involved in the case and where to go from there. In terms of a

> social nature, it's kind of funny, but you tend to put appearances in at things and events that you really may not want to go to, but because you're the head nurse you go.
>
> Every time we have a little gathering, if somebody's leaving I feel obligated to be there....There are certain duties, routine duties of a legal nature, certainly my daily routine is. Even though I may be doing administrative work all day, I make sure that I go into the back in the morning, see the patients, speak to the staff.
>
> There are certain retirement dinners for various members of the hospitals that I will attend as head nurse of the ward. Sort of farewell teas with a variety of people, I attend those as a representative....If there's a farewell dinner for one of the staff members, I represent the hospital for my staff. I believe that when we have the annual Christmas party the doctors throw for the nurses, I represent the ward nurses and encourage my staff to come, but I'm sort of the figurehead.

Others described the figurehead role as a role model. One subject said, "Being a figurehead, I guess I'm somewhat of a role model." Another stated, "You set the tone...trying to symbolize or live out the philosophy" of the unit. To another subject, the head nurse was "a role model as far as appearance, attitudes, body language, how you speak."

The title "head nurse" still seems to symbolize prestige for some of the head nurses, mainly in relation to the community. One subject said, "With the patients you do notice the impact of introducing yourself as the head nurse. That still holds significant societal opinions." Another subject stated that her title as head nurse is an important symbol:

> When there's a problem with the staff or with one of the patients, it's usually me they come to just by virtue of my being head nurse. It's the same with the doctors. If there's a problem, they come directly to me, and that is being a figurehead. There's a little bit of prestige being a head nurse. Not financial as much as I think respect. I think we do still get some respect, maybe, not as much as an executive or something, but I still think in the community we still do get some respect out of being a head nurse.

The title had limited effect on other head nurses who felt that they shared much of the power and decision-making with their staff. One

subject described this view in the following way:

> The title's on the door...everybody knows who you are and that I want to be informed of what's going on all the time. But I'm not the only person that says yes or no to things that I want them to do.

According to the subjects, the physicians had a more traditional perspective of the head nurse as a figurehead. The physicians were apt to view the head nurses in the traditional role of making rounds, dealing with the charts, and coordinating patient care. As one subject said, "The physicians are not in tune with the changing role, so they do see us as the coordinator, which in fact we are, but they still have the old...views of the head nurse." Another subject did not agree that this traditional role was entirely negative:

> I think that there's a lot of people who feel that making rounds with the physician and making patient rounds is not the head nurse role. Perhaps I'm still of the old school, but I cannot associate a chart with a patient if I haven't seen that patient, or I haven't looked at an incision ...I think the physicians also rely on us to make some judgments.

Each of the subjects was given the example of the traditional symbol of the head nurse as making rounds with the physicians and pushing the chart rack around. They were then asked if this practice still occurred and, if not, why not? Most of the subjects no longer did regular rounds with the physicians, but there were varying opinions as to why this practice had changed. Some of the responses were:

> Women don't need to be handmaidens anymore. I would think that that's just a change in society, I don't know. I don't feel the need to do that. I don't think that makes me a head nurse, and I don't know what has taken its place if anything has.

> Doctors take their own charts around. I don't know why that's changed or why that would be different. I think we're seen more as equals; I mean we're not the subservient servant anymore. I think certainly our physicians are good.

All of the subjects were also asked why, in their opinion, the role

of head nurse seemed to be devoid of any specific or common symbols. Although several did not respond to this question, five (25%) suggested that increased staff participation in operating the unit was a factor, and three (15%) suggested the change from team to primary care nursing as a method of patient care delivery was the cause. The following examples illustrate:

> Primary nursing, I think, has taken away that role... [the nurse] follows through from beginning to end and then just keeps me informed. I think dealing with...phone calls from the families or concerns or requests from families, my staff deal with many of those things. I only step in if it becomes a real problem.
>
> It is related to what is common to the head nurses that everyone does. But in the last five years, everything has changed in the head nurse's role, so there is no symbolic thing, making rounds with doctors. Head nurses don't even make phone calls for the nurses anymore. We are encouraging the charge nurses to do that themselves.
>
> I feel the nurses have to be accountable and if a doctor comes and he wants to do rounds on his patients and I feel it shouldn't be me because I don't know what's going on with the patient. I know a little bit, but I don't know all the details of all 17 patients and I think the nurse caring for that patient should go with that doctor if he requests it. But I don't feel we have to march to the doctor's drum.

While there were only a few responses to the question of why there were no specific or common symbols of the head nurse, those responses are illuminating. One subject thought it was because of "all the meetings that the head nurses are expected to go to." Another said the head nurse role was so "diverse" now that it was hard to recognize common characteristics. Other reasons included the following:

> I think that over the last number of years, positions got deleted and there were less resource people, that more and more was given to the units to the head nurses and to the RNs per se as well.
>
> I think we're getting away from the hierarchy of the different roles and nurses are finally...starting to become individuals instead of having to be told....I don't think we need the structure of hierarchy of head nurse and the power.

> As we get away from the sort of army model of nursing and get more into a professional role and a team coordinator kind of a role....It used to be the nurse and the doctor, and now nursing has become very pivotal for all the departments interacting. I think that's where you stand as a symbol and the doctors are almost just another spoke in [the wheel]. So it doesn't stand out in isolation as much as it used to and that's the changing roles of doctors and nurses in hospitals. That may be one of the issues that causes this less overt picture of what a head nurse is about.

In summary, the figurehead role was initially difficult for most of the subjects to describe. After much probing and discussion, the subjects offerred illuminating responses. Most described the head nurse as a symbol of problem-solving and taking action. The traditional symbols generally did not apply for reasons ranging from the advent of primary nursing and increased staff participation in the operation of the unit to the changing and diverse role of the head nurse in today's organizations.

Leader

The discussion of the leader role addressed two main areas: first, how the head nurse set direction for the unit and, second, how the head nurse created an environment in which people could be motivated. The responses are presented in two separate categories: setting direction and motivating staff.

All but three of the subjects described themselves as being responsible for setting the direction and purpose of the unit. The techniques used for setting direction are presented in Table 14.

The methods of setting direction fell into two main categories, formal and informal. The formal methods, such as philosophy, goals, objectives, protocols, and procedures were described in the following ways:

> We have the nursing division philosophy, objectives and goals and

then from that, we have the unit philosophy, goals, and objectives. Every year we're having new objectives for the unit and input from the staff, written guidelines anywhere from standard care plans to directions what specific doctors may like.

I have specific objectives for my unit, and I think that's the groundwork. Where the objectives are--they can be very specific in that we're going to develop an audit tool for 'x' or they can be broader saying we're going to revise our documentation system this year and get the staff involved in some way in doing that.

Table 14: How Head Nurses Set Direction for Their Units

Description	Number	%
Discussing philosophy, goals, objectives	17	85
Talking to staff, going on rounds, acting as a resource person	11	55
Using written standards/protocols/programs	7	35
Role modelling	5	25
Discussing expectations at staff meetings and interviews	4	20
Articulating vision about future direction	2	10
Completing performance appraisals	2	10

The informal methods, which included talking to staff and going on rounds were described as follows:

I make rounds regularly with my staff to make sure that I know what is required, what's needed, what they're doing. Then if I see any problems, I can facilitate the problem-solving process.

A lot of it is also informal, just on-the-spot training and on-the-spot teaching, and also discussion with staff if they've had any difficulties, say on the weekend, that they might come forth with to me and also on shift. They sometimes want to discuss whether I think they handled it well or what I've felt about it.

Role modelling was also seen as a way of setting direction. As one

subject said, "my staff are so young that they haven't had the experience, and I think, more than anything, that's where I set a lot of direction in a leadership role." In agreeing with the role model idea, one subject said, "with me being on the unit, being accessible to patients and staff, they see what my approach is and can learn from it."

Finally, the role of leader was described as complex in the area of direction setting. Said one subject, "I think being a leader is being all the roles that we've already talked about in that you have to use all those roles to make a leader." Most subjects brought in previous examples and talked about other roles while they were describing their role as leader.

The second main category in the leader role concerned how the head nurse created an environment in which people were motivated. There was general agreement that "you can't motivate people unless they're motivated internally." Ways in which the head nurses attempted to do motivate people are presented in Table 15 with illustrations following.

Many subjects became very enthusiastic in answering this question. They had strong beliefs about creating an environment where staff are motivated. The most common method they employed was to listen to the staff in order to know their needs, talents, and ideas. As one subject said:

> It's really active listening--listening for any kind of a little squeak that I get from any of them either of discontent with the way something is or of an idea of something that they would like to see changed.

This point was further emphasized by one subject who spoke of knowing "the staff really well...and trying to promote in them what I see to be helpful to the unit," and by another who felt it was important to "sit

Table 15: How Head Nurses Create an Environment in Which People Are Motivated

Description	Number	%
Listen actively to staff, know them, use their ideas	12	60
Be flexible with rules and schedules	8	40
Send staff to/have them present inservices	6	30
Act as a role model	4	20
Encourage participation/give responsibility	4	20
Be fair in decision-making	3	15
Select motivated staff in initial interview	2	10
Give staff positive feedback	2	10

down with them individually and help them set goals and help them work through those." Another subject said she sets the tone for the unit. She stated:

> Work should be enjoyable. You should be able to come to work and laugh and feel good about what you do. Because I set that tone staff pick up the tone and pass it on down to the patients.

Most subjects were emphatic about using the ideas of the staff in order to encourage further participation. They talked about the value of the staff's ideas. One subject reported that she followed up on the staff's suggestions first because she felt that "it whets their appetite when they see outcomes happen. Then I find that they're more ready to get involved the next time that you want to implement something."

The importance of being flexible with the staff in relation to shift

changes was emphasized, as was the need to treat them as mature adults with the ability to make decisions on their own. One subject said she tried "not to make too many rules and regulations about [what happens] while you work...[because the staff] spend eight hours of every day with each other...and it's important to make it a positive experience when we're here." Another subject expressed clearly what many of the other subjects agreed with in relation to shift changes:

> One of the things I feel very strongly about is that nursing is not conducive to having a social life for staff nurses who are rotating and working weekends and things like this. So whenever they want a shift trade or a shift change or vacation change, they can have it even though I know it generates a lot of workload for me and it generates the paper which generates workload for other departments.

Positive feedback was described as being important for encouraging motivated staff. "Acknowledgement of jobs well done" was said to be crucial in this regard. One subject described her feelings about the staff's work:

> What they do is really important. So hopefully they become motivated through that. Making them feel that they make a difference in the lives of the residents and in the lives of the staff members that they're working with [is important].

Encouraging participation through power sharing and involving the staff in decision-making were common themes. However, one subject cautioned:

> One of the things they dread most in participating is that they take it home and they feel that they are doing too much already with the workload, working overtime which they don't sign for, coming in for staff meetings. They come on their off days as well...and any kind of whole-day inservice, we can't afford to pay them, so they come on their own...they feel that some of the projects should be done on work time, so I try to do that.

One subject described herself as "the wick of the candle. But to get the candle to burn it means some sort of drive to have staff to become

involved and to get everything going." She emphasized the need to have highly motivated staff in order to get the work of the unit done.

In summary, the subjects used both formal and informal means to set direction for the nursing unit. Unit philosophy, goals and objectives, as well as written standards and protocols, represented the formal approach. Talking with staff, going on rounds, and acting as a role model were some of the informal ways to set direction. The head nurse was also involved in creating an environment where people were motivated through activities such as listening to staff, using their ideas, being flexible with shift changes, and encouraging participation.

Liaison

The liaison role seemed to be fairly straightforward for the subjects. They readily described the types of people they liaised with routinely and discussed the reasons for these liaisons.

Most subjects described themselves as doing a great deal of liaison everyday, talking to many different people in order to coordinate the operation of the nursing unit. They liaised regularly with several categories of people outside the nursing unit, as shown in Table 16. One subject, who described the head nurse as the core of the wheel, said, "I see the nurse as the person who's coordinating all the other spokes that are coming in to affect that core. I see myself as sort of enabling the staff nurse to coordinate that." In contrast, another head nurse felt that nursing was too involved in coordination of care:

> I think nursing takes on a lot of things at every level, that is, the staff nurse, the head nurses, and the directors. I think [the Vice-President] is trying to change that, but it's a real mind set. It's really hard to change....I spend 11- and 12-hour days here, and why should I be working. I was going to say I don't mind, but I do mind, and especially when it's not nursing-related; I'm following up for

another discipline and it drives me crazy.

Table 16: People with Whom Head Nurses Liaise Regularly

Description	Number	%
Other disciplines (excluding physicians)	16	80
Other hospital departments	11	55
Other nurses (CNS, DON, ostomy nurse)	8	60
Physicians	7	35
Other Head Nurses	6	30
Families	3	15

One subject was trying to make changes in her liaison role:

> [This hospital] is a huge community and I have to liaise with a lot of people. Now I like to see the staff try that initial liaison and if that doesn't work then to bring it to me and then I can follow up with them.

The main reason for being a liaison was for "communicating information about patients." Even contact with non-nursing departments was, indirectly, for the purpose of affecting patient care, for example, discussions about laundry service, renovation plans, and delivery of supplies.

In summary, the liaison role was one in which the subjects spent a great deal of time. They liaised with a variety of people outside the nursing unit in order to coordinate the services necessary for supporting patient care. The similarity of answers indicates some degree of consistency within the activities of the role.

The Roles in General

At the end of the interview, the subjects were asked two questions about the roles in general and were given an opportunity to make additional comments about their head nurse position. The purpose of these questions was to allow the subjects to prioritize roles as well as to provide an unstructured format in which the subjects could describe their work. The responses are presented in three sections: roles identified as most important; roles not covered in the framework; and finally, general impressions about the head nurse position.

Although most of the subjects indicated that all of the roles were important, 10 identified one or more specific roles which to them were most significant. Of the 10 subjects who answered about specific roles, nine (90%) felt that the leader role was important. The remaining responses were spread over the range of the roles, with resource allocator second and entrepreneur third, as can be seen in Table 17.

By summarizing the responses within the three groups of roles, it can be seen that the interpersonal roles were identified 12 times (26%), the decisional roles, nine times (34%), and the informational roles, five times (19%). These totals reflect the trend of the 10 subjects who did not select individual roles in response to the question, but rather indicated a group of roles: five (50%) identified the group containing interpersonal roles; four (40%) identified the decisional roles; and one (10%) the informational roles. Several subjects acknowledged that the importance of the roles varied with the time and situation; on some occasions, one role was particularly significant whereas, at other times, a different role might be. Only two of the subjects said that all roles

were equally important.

Table 17: Roles Most Important to the Head Nurse Position

Role	Number	%
Leader	9	90
Resource Allocator	4	40
Entrepreneur	3	30
Disseminator	2	20
Spokesman	2	20
Liaison	2	20
Monitor	1	10
Disturbance Handler	1	10
Negotiator	1	10
Figurehead	1	10

When asked if there was a role not covered by Mintzberg's description, ten (50%) said they had nothing to add. Some others, however, suggested that supporting staff in a "nurturing" or "mothering" role was necessary, that "hands-on nursing care" was still important, that the ability to "organize" was missing, and finally, that "research" was not mentioned. In general, however, the subjects found Mintzberg's framework of the 10 managerial roles to be comprehensive and useful for describing their positions as head nurses.

As a last point, most of the subjects claimed that, while they found the head nurse position to be frustrating, at the same time it was "challenging" and "interesting." Four said it was a powerful position,

pivotal to the operation of the nursing division. Thus, it appeared to be a position worthy of the effort required to carry it out effectively.

Summary

In this chapter, the data obtained from the interviews with 20 head nurse subjects have been presented. The study sample represented people with a variety of educational backgrounds and a wide range of experience. As well, their areas of clinical responsibility corresponded to the type of service on the unit. Despite the variations in numbers of staff reporting to them, clinical specialty of the unit, educational background, and range of experience, the subjects were able to describe their behaviours and decisions within the 10 managerial roles used as the basis for the interview. Some of the roles, such as the monitor, disseminator, resource allocator, disturbance handler, leader, and liaison, were described in terms of very consistent themes. Other roles, such as spokesman, entrepreneur, negotiator, and figurehead, generated a variety of responses. In general, all of the roles were described as important, with the leader and resource allocator identified most frequently as the most significant individual roles. Some subjects identified a role grouping as most important rather than identifying an individual role. Ranked in importance, these were the interpersonal, decisional, and informational role groupings. A discussion of these findings will be presented in the following chapter.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter presents the discussion of findings set forth in the preceding chapter. It is divided into five main sections: The first section presents the subjects' responses to the specific managerial roles in relation to the framework upon which the study was based; the second section discusses the utility of Mintzberg's framework as a tool for describing the work of head nurses; the third section presents a comparison with the only other study of head nurses using Mintzberg's framework; the fourth presents general themes about head nurses' roles and, finally, the fifth section discusses two individual roles that were particularly significant to the subjects.

The Specific Roles

The way in which the subjects interpreted Mintzberg's (1973) roles provides a description of the head nurse's work and gives an indication of how familiar the subjects were with the roles. In general, they were able to describe their work within the context of all 10 managerial roles. Each of the roles will be explored individually in order to review the subjects' descriptions in relation to those of Mintzberg.

Monitor

The monitor role was exemplified by informal measures, which included observing the patient care delivered by staff, talking to nursing and allied staff, and listening to report. Although formal measures, such as quality assurance activities, were mentioned by a few of the subjects, the

informal measures dominated both internal and external monitoring.

The subjects' description of the monitor role was consistent with Mintzberg's (1973) description of the monitor as the receiver and collector of information in order to understand the organization. He argues that the manager pieces together informal information in order to get a picture of the operation, in part because s/he can expect little help from formal systems based on historical, aggregated data. The subjects in the current study used mainly informal measures to piece together their pictures of the nursing unit.

Disseminator

In the disseminator role, most subjects agreed that the head nurse deals with a great deal of information on a regular basis. The prime concern was how to disseminate the incoming information appropriately to the nursing staff. A variety of means was used to do this job depending upon the urgency or importance of the information. The head nurse's responsibility was described as having to triage the information and to choose the best channel for communicating it. The subjects sorted information based on the level of applicability to patient care and wrote relevant information in the communication book or posted it accordingly.

The subjects' descriptions of the disseminator role were also consistent with Mintzberg's (1973) findings that managers transmit specialized information into the organization, placing value on the information by the method they choose for transmission. Thus, the disseminator role comprises an important part of the head nurse's position because it allows for the transmission of information into the nursing unit.

Spokesman

The spokesman role was reported by some of the subjects to be carried out by service on committees, attendance at conferences, and at any time they were talking to people outside of the nursing unit either within or beyond the hospital. Only a few recognized the importance of representing the unit to the rest of the hospital or to outside agencies, and they did not consider this role to be a major part of their job.

According to Mintzberg, the spokesman role is one by which information about the manager's organization is disseminated to the outside. In the current study, most of the subjects did this task, but not all recognized its importance. They also confused it with the liaison role when they described the number and variety of contacts outside of the unit. It may be that the strong orientation towards the staff and the internal operation of the unit led them to perceive contacts with people outside the unit as being of less significance.

Entrepreneur and Disturbance Handler

There was considerable overlap between the descriptions of the entrepreneur and disturbance handler role. In describing the entrepreneur role, the subjects used many examples of changes which they had implemented based on ideas imposed on them from outside. Few ideas were identified that could be termed innovative for patient care delivery or staffing utilization on individual units. Although most of the subjects dealt with many changes, they were reacting to them rather than initiating them. The entrepreneurial behaviours they described were similar to those commonly related to the disturbance handler role, such as dealing with interpersonal conflicts, conflicts over performance expectations,

conflicts over the allocation of resources, and conflicts over role expectations. The types of people with whom the subjects dealt were fairly consistent, representing the staff, physicians, other disciplines or departments, families, and patients.

Although the subjects were familiar with the role of entrepreneur, they did not use it in the same manner as Mintzberg's (1973) entrepreneur role which might be described at one end of a continuum, initiating or designing "controlled" change. At the other end, the disturbance handler role deals with imbalances within the organization by resolving conflicts some of which may arise from unplanned or uncontrolled change. The subjects in the current study described the latter role when describing changes with which they had been involved. The head nurse endeavours to maintain balance through managing conflicts or disturbances as they present themselves, just as Mintzberg's managers took charge when the organization was threatened with a major disturbance. Mintzberg suggests that people in lower levels of the hierarchy place the greatest emphasis on the disturbance handler role because it is involved with the day-to-day maintenance of the workflow. Perhaps this is why the head nurse, as a first line manager, seems to be involved in less entrepreneurial maneuvering than the managers described by Mintzberg.

Resource Allocator

The role of resource allocator was described consistently by all but two of the subjects. The high degree of convergence in the responses indicates familiarity with the role and suggests that it is very important to the position of head nurse. However, the subjects expressed frustration with lack of control over resource utilization. They cited

lack of knowledge about ways to use resources creatively and lack of perceived power as reasons for this frustration, even though many described the position of head nurse as pivotal to the nursing organization.

Mintzberg (1973) argues that managers oversee allocation of resources and thereby maintain control of strategy-making processes by setting organizational priorities, designing work systems, and authorizing all major decisions before implementation. The subjects in the current study recognized their role in resource allocation but were not confident in their ability to carry it out. They had some input into budget planning but had little control over major decisions regarding how those resources would be allocated. For example, a decision to change medical treatment of a particular patient condition could have significant impact on nursing care requirements but if the head nurse was unable to adjust baseline staffing allocation to accommodate this change, budget overruns could occur. Mintzberg (1973) also suggests that the manager's time is a valuable resource and emphasizes the importance of scheduling time for the activities which are highly valued in the organization. The subjects in the current study described resource allocation as applying only to staffing, equipment, and supplies. They did not talk about their own time but rather were conscious of their budgetary responsibilities. Only one subject identified the "organizer" role as lacking from Mintzberg's framework, suggesting recognition of the need to allocate time effectively. With the decentralization practices of the past several years (Kirsch, 1988; Maguire, 1986; Sullivan & Decker, 1985), it may be that financial allocation of resources has become the reference point for

nursing managers, with little emphasis on the need to think about how to use themselves or their time as a resource.

Negotiator

The negotiator role was difficult for the subjects to describe. Some of the subjects said they spent much of their work day actively negotiating with other people and described behaviours similar to those of the liaison role. A few of the subjects confused this role with formal labour negotiations with which they had little experience.

Mintzberg (1973) described managers in the negotiator role as being compelled to enter negotiations on behalf of the organization. The inability of some of the subjects in the current study to relate to this role could have been based on lack of familiarity with the term and possibly their naivety about organizational politics. In the organizational climate of today's health care facilities, the ability to negotiate for the necessary portion of the health care dollars is becoming increasingly critical (Evans, 1984; Finkler, 1984; Kirsch, 1988; Pfeffer, 1978). Thus, it may be that the head nurse needs to develop confidence in the role of negotiator in order to advocate for resources to provide effective patient care on the nursing unit.

Figurehead

The figurehead role was one of the most poorly described and much probing was needed to encourage any responses to the questions. For example, one subject said she did not want to be considered as a figurehead because "what she did mattered." Her concept of figurehead was a person who "looked good but did nothing." The subjects in the current study identified the head nurse as the person to whom people looked for

solving problems and dealing with complaints. Despite these descriptions, symbolic activities were absent from the subjects' conceptualizations of the head nurse role. When asked, some subjects offered reasons for the absence whereas others had no ideas. Some of the reasons suggested were that the head nurse position is changing and evolving from a very traditional role to one which allows individual styles and interpretations. Others suggested that the increased participation of the staff in both clinical and administrative decision-making may have enabled and/or forced head nurses to share more of their power with the staff. Many of the subjects were very comfortable with this new definition of their role and indeed found it to be much more satisfactory than when they made all of the decisions.

According to Mintzberg (1973), the manager as figurehead represents the organization in all matters of formality and, because of the position, must be involved in certain social and ceremonial activities. Also, the manager must be available to certain parties who demand to deal with her/him because of the authority or status of the position. After much probing the subjects were able to identify the head nurse as the person who solves problems and deals with complaints. However, their understanding of the figurehead role was limited. It may be that the changing role of the head nurses within a decentralized organizational structure and a system of primary nursing care has made the staff, physician, patients, and families less dependent upon the head nurse for direction and control. As well, the role of figurehead may be more relevant at more senior levels of nursing management such as the director or vice-president of nursing.

Leader

The role of leader was another with which the subjects were familiar and was the one many selected as most important. The leader role involved setting the directions for the unit through acting as a role model, establishing the standards, philosophy, and objectives of the unit and, an aspect of the leader role that the subjects were particularly passionate in describing, creating the environment in which people were motivated. The head nurses felt strongly that they needed to know their staff well and had to be flexible in the unit operation in order to encourage the ideas of the staff to come forth.

The subjects' description of the leader role was consistent with Mintzberg's description of the leader role as being most important and permeating all other activities. The ability to set and communicate directions for the work group has been established as an important part of leadership (Bass, 1985; Pfeffer, 1978; Sergiovanni, 1984; Szilagyi & Schweiger, 1984). Studies of job satisfaction in relation to leadership style support the assertions of the subjects in this study that group consideration and participation are significant (Campbell, 1986; Duxbury, Armstrong, Drew, & Henley, 1984; Fretwell, 1983a, 1983b; Pryer & Distefano, 1971) and that flexibility is an important way of encouraging or fostering motivation (Klein & Posey, 1986; Pinder, 1984). Thus, most of the subjects had knowledge of the leader role and attempted to use it to their advantage.

Liaison

Finally, the subjects shared common views about the liaison role. They talked about their association with a variety of outside contacts,

mainly for the purpose of improving or coordinating patient care.

According to Mintzberg (1973), in the liaison role the manager interacts with peers both inside and outside of the organization in order to gain favours and information, dealing with a web of relationships. This function is similar also to Kotter's (1982) description of network building, the development of cooperative relationships among the people who will help the manager carry out the agendas s/he sets. The descriptions given by the subjects in the current study are consistent with those set forth by these authors.

In summary, of the 10 managerial roles described by Mintzberg (1973), seven emerged as familiar to the subjects and thus provided the largest amount of descriptive material. These were the roles of monitor, disseminator, entrepreneur, disturbance handler, resource allocator, leader, and liaison. The question should be asked as to why these roles came forth as being more familiar to the subjects than the others. One answer is that these roles are "people oriented," that is requiring a high degree of one-to-one or group discussion. The subjects spent large amounts of their time talking to other people in order to carry out their work and, therefore, these roles took up a good portion of their time. A second possibility is that many of the subjects had gained knowledge of these particular roles through management development programs. The roles are similar to the skill sets most often presented in such programs. A third possibility is that the language used by Mintzberg to describe the roles was more familiar to the subjects so that they were more able to relate it to situations within their own work. Finally, it may be that not all of the 10 managerial roles apply to every level of manager. There

may be greater emphasis upon some roles at the first line manager level than at other levels of management in the nursing organization.

The subjects found the three remaining roles of spokesman, negotiator, and figurehead more difficult to describe and discuss. The reasons given for the difficulty provide some interesting insights into the head nurse role. The less familiar roles were less time-consuming for the subjects, were not clearly distinguished from other roles, or were described by Mintzberg in language unfamiliar to the subjects. Thus, head nurses were able to describe activities in relation to Mintzberg's 10 roles although some were clearly more familiar to them than others.

Utility of Mintzberg's Framework

Because Mintzberg's framework is commonly used to describe the work of managers, analysis of its application to head nurses will facilitate an understanding of the degree to which their role is in fact one of manager. The majority of Mintzberg's roles were familiar to the subjects and they were able to describe behaviours consistent with them. Those roles with which they were less familiar pose a potential area of development.

As has been noted, most of Mintzberg's roles were familiar to the subjects. It was only in the entrepreneur role that the subjects did not enact the behaviours as Mintzberg described. This discrepancy could well be due to the nature of the daily workflow at the level of the head nurse as first line manager. The less familiar roles may have been those not developed to their fullest potential by the head nurses. Thus, it would be reasonable to speculate that further knowledge of the behaviours and activities within each of the managerial roles could enhance the ability

of head nurses to enact these roles within their organizations.

According to the head nurses in this sample, the managerial roles cannot easily be viewed in isolation. They overlap with one another, with the emphasis on a particular role changing dependent upon the requirements of the situation and the skills of the manager. Although the subjects in the study were asked to describe the roles individually, their responses demonstrated the overlapping among roles. For example, several roles were described in similar terms: the entrepreneur and disturbance handler; the liaison and negotiator; the spokesman and liaison. Mintzberg was able to identify and describe the roles individually although he said they formed "a gestalt--an integrated whole," with all being necessary to the manager's position (1973, p.58). This suggests that the skill with which the roles are integrated may be improved with increased understanding of the individual roles. Thus, it seems likely that Mintzberg's 10 roles are useful in describing the work of head nurses, but that head nurses may not yet conceptualize the roles as distinct. Further, it may be that the knowledge gained by viewing the head nurse position through Mintzberg's framework could enhance head nurses' understanding of the roles and, in so doing, increase their potential to use them more effectively. The framework may, therefore, help to identify areas where development of knowledge could further enhance the degree to which the head nurse position is one of manager.

Comparison with the Jones and Jones Study

The findings in the current study were generally inconsistent with those of Jones and Jones (1979), who also used Mintzberg's framework to

study the work of head nurses using an entirely different methodological approach and toward a different purpose. While both studies considered all 10 roles, the findings of activities comprising each role were markedly different. A comparison of the findings in relation to each role will illustrate the discrepancies.

The only role for which the description was consistent between the two studies was that of liaison. In both sets of findings, formal meetings of head nurses and other organizational committees provided the contacts for the head nurses, whereas membership in professional associations, and attending conferences and seminars were the external sources of contacts.

In the descriptions of all other roles, inconsistencies were noted. As in the current study's findings about the monitor role, Jones and Jones (1979) observed head nurses receiving report at the beginning of the work shift, making rounds, gathering information from patients and/or family, and checking charts. However, unlike the findings of the current study, Jones and Jones also noted that head nurses accepted verbal laboratory reports over the phone, checked emergency carts and unit medical supplies, and checked laboratory reports for pertinent information. Because the current study subjects did not report these activities, one might assume that they were not particularly significant in the subjects' perceptions of the monitor role. Alternately, it may be that the activities in question did not come to mind during the interviews, but might have with prompting by the interviewer. However, even among a multitude of minor activities which provided them with information about the unit's progress, the activities identified in the Jones and Jones study were not mentioned.

In today's nursing organizations, the unit clerk does many clerical duties and members of the nursing staff now assume many of the activities which were formerly thought to be in the domain of head nurses only (Gillies, 1982; Maguire, 1986; Sullivan & Decker, 1985). Thus, the role may no longer include some of the activities that it did 10 years ago.

The Jones and Jones (1979) study identified specific activities in the disseminator role which included passing on information in reports to the oncoming shift, implementing physicians' orders by passing them on to the staff, calling attention to new memos and procedures, and sharing with staff information obtained from going on rounds with physicians. It may be that these activities were not identified in the current study since they reflect the more traditional role of the head nurse, which most of the subjects did not perceive themselves as carrying out.

As in the current study, Jones and Jones (1979) found overlap between the entrepreneur and disturbance handler roles. However, even though their data suggest considerable similarity in the activities between the two roles, Jones and Jones did not address this overlap. They described head nurses in the entrepreneur role as mediating between the unit services and hospital operations, identifying unit weaknesses and designing plans to remedy them, deciding when to notify the physician, developing nursing care plans, and assisting staff to make decisions regarding patient care. For the disturbance handler role, Jones and Jones found that non-routine or crisis situations were numerous, using the examples of having to respond to a doctor, coordinating external disaster or fire drills, starting difficult intravenous therapy, adjusting shift assignments because of sudden staff illness, resolving intershift

conflicts, responding to telephone calls at the desk, and assisting in treatment for unscheduled procedures. The activities associated with the entrepreneur and disturbance handler roles were different from Mintzberg's (1973) findings and from those in the current study. In comparison with Mintzberg's description, the Jones and Jones study identified entrepreneurial activities which are more aptly categorized within the disturbance handler role. The subjects in the current study described themselves in the disturbance handler role as having the communication skills to resolve interpersonal, performance, resource allocation, and role conflicts.

Jones and Jones (1979) found that head nurses in the resource allocator role made patient assignments, coordinated meal breaks, and provided patient care in selected situations. Although the subjects in the current study reported that staffing allocation was part of their role as resource allocator, they had more knowledge about the budget implications of their decisions regarding staffing requirements and the utilization of equipment and supplies. Jones and Jones did identify one of the most important resources to be utilized as the head nurse's own time, consistent with Mintzberg's description, whereas only one of the current study's subjects did so.

The findings about the role of leader were not consistent with the descriptions in the current study. Jones and Jones (1979) identified activities in the leader role as orienting new personnel and students, conducting employee evaluations, demonstrating clinical expertise when warranted, maintaining and coordinating schedules, conducting ward conferences, and ensuring that students are supervised in medicine

preparation. The subjects in the current study described themselves as setting directions for their units through activities such as discussing philosophy, goals, and objectives, talking with staff, and acting as a role model. In addition, they were committed to creating an environment in which staff could be motivated and encouraged staff participation in a variety of activities. These behaviours describe a level of operation different from that of the subjects in the Jones and Jones study. The behaviours of the current study's subjects suggest an understanding of the concept of leadership which goes beyond supervision activities. It may be that the subjects in the current study have more impact on the direction of their units than the head nurses in Jones and Jones' study. It may also be that the methodological differences between the two studies created an avenue for new information with the descriptive method of the current study providing a different view of the head nurse role through the perceptions of the incumbents rather than through those of an observer.

Jones and Jones (1979) described the spokesman role as including such activities as communicating with physicians during rounds, answering questions for patients and/or family members, sending requisitions to other patient service departments, responding to questions from other departments, and communicating information to nursing administration. If the subjects in the current study carried out these activities, they did not equate them with the spokesman role. In addition, the subjects tended to encourage their staff to do more of these activities, thus promoting the autonomous practice of the staff nurse. Thus, the activities which Jones and Jones described as representative of the spokesman role may be

more aptly categorized within the liaison role. The changing role of the head nurse to that of a manager who coordinates the overall patient care of a variety of people (Maguire, 1986) may account for this discrepancy.

The Jones and Jones (1979) study identified negotiator activities as follows: "soothing" physicians, patients, and/or family about things they were unhappy with; working out intershift and interdepartmental disturbances; working out needs for additional staff; and lobbying for new equipment. Although the subjects in the current study would agree that they negotiated for staff and equipment and decreased conflict on the unit, they were generally loath to talk about "soothing" physicians. All had a sense of themselves as colleagues of the medical staff, perhaps due to the increasing professionalism among nurses, the increased level of education amongst the head nurses themselves, and the emphasis upon the managerial activities of the head nurse position.

In the figurehead role, Jones and Jones (1979) identified duties of a ceremonial nature carried out by the head nurse. These included representing the unit at head nurse and other meetings, attending hospital parties, and acting as "hostess" to people of importance who were touring the head nurse's own unit. They concluded that, "Some of these activities seemed unimportant to several subjects in the study; however, when the figurehead role is ignored, the smooth functioning of the unit is disrupted" (p.49). These findings are partially similar to those of the current study in that the subjects were aware of the importance of representing their units on committees, and attending social events. However, Jones and Jones did not identify the head nurse as the person to whom people go to solve problems or handle complaints. Interestingly, the

findings of both studies fall short of Mintzberg's (1973) description of using the figurehead role as an avenue for gaining or disseminating information and networking with other people.

In summary, many of the findings of the current study are inconsistent with those of Jones and Jones (1979). There are two possible explanations for extent of the discrepancy. First, Jones and Jones observed rather than interviewed the head nurses so were unable to determine individual perceptions. Thus, the study may have been biased by the ability of the individual observers to categorize activities within a designated framework. Alternately, a bias may have been introduced in the present study by use of the interviewer technique. Also, the observable behaviours are not necessarily what the head nurses themselves perceive to be the important aspects of each role. It may be that an action does not always signify the actual intent of the head nurse. Second, there have been several changes in nursing over the last decade which may have had significant impact on the head nurse position. The head nurse role has evolved to one which has far more managerial responsibility than it did 10 years ago when team rather than primary nursing was the system of patient care delivery (Harrison, 1981; Maguire, 1986; Rotkovitch, 1983). In addition, the decentralization of responsibilities such as preparing budget submissions, monitoring utilization of resources, and hiring staff has accorded the head nurse a different focus in the nursing organizational structure (Gillies, 1982; Kirsch, 1988; Strasen, 1987). A 10-year difference in the timing of the study has apparently made a significant difference in many activities of head nurses, according to the head nurses' perceptions of those activities.

General Themes in Head Nurse Roles

Four general themes emerging from the findings of the study require further development. First, many of the activities of head nurses are unstructured and informal. Second, the emphasis on individual managerial roles varies with the situational requirements and skills of the manager. Third, the ability of the head nurse to "see the whole picture" or have a systems orientation may be unrealistic for a first line manager. Finally, participative management and power-sharing are important both to the development of nursing staff and to the potential job satisfaction of the head nurse. These themes will be developed in the following sections.

The Unstructured and Informal Nature of Head Nurse Activities

That management activities are unstructured and informal was clearly recognized by the subjects in this study. For example, information which enabled the subjects to monitor unit progress was gathered informally through observation, patient rounds, talking to people, and checking charts. Dissemination of information often took the form of conversations, quick summaries at report time, and notes in the communication book. The methods for leading a unit were also informal, including role modelling, talking to staff, giving feedback, and listening. A large portion of the leadership role involved talking with other people: giving directions, giving feedback, asking for information, or resolving conflicts.

Other researchers have made similar observations. Mintzberg (1973) found that managers use a variety of ad hoc stimuli as valid sources of information. He describes the manager role as characterized by brevity, fragmentation, and superficiality in tasks which cannot be delegated

because of the nature of the work. Kotter (1982) found that the conversations of managers are generally short and disjointed, but effective nonetheless, if agendas are used to guide opportunities and networks are developed so that these quick conversations are meaningful. The work of successful managers is less systematic, less reflective, less well-organized, more informal, and more reactive than one would expect. Kotter's findings establish that the manager spends the majority of time working with other people.

The subjects' perceptions of how they carried out the head nurse role were similar to those of Kotter and Mintzberg. However, because of the lack of prior nursing research in this area, little acknowledgement has been given to the informal and unstructured nature of the position.

Variations in Emphasis Among Managerial Roles

The emphasis upon individual managerial roles varies between head nurses. In some situations one role is emphasized, while in other situations, it is a different role or combination of roles. For example, the head nurse who moves to a new unit spends much time in the liaison role while s/he develops the contacts necessary to facilitate the unit's operation. The role of leader is significant when directions in standards of nursing are being discussed and, as well, when staff morale is identified as a problem area. It is then that the head nurse must work closely with staff to determine what changes in the environment are necessary to increase their level of motivation.

Other research supports the concept of variation in emphasis between managerial roles. Mintzberg (1973) suggests that managers in new jobs spend considerable time in the monitor and liaison roles in order to

develop contacts, build their information systems, and bring themselves to the level of knowledge necessary for effective strategy-making. Similarly, the disturbance handler role is emphasized following periods of intense innovation, thus suggesting that a period of change is followed by a period of stabilization. Like Mintzberg, Kotter (1982) found that, in the first few months of a position, the manager develops a rough agenda, typically containing a very loosely connected and incomplete set of objectives, along with a few specific strategies and plans. Over time, as more information is gathered, new managers incrementally make the agendas more complete and tightly connected.

The subjects in the current study described all roles as being important with variations in emphasis occurring depending upon the situation. Mintzberg (1973) argues that the role must fit the situation since management is a dynamic job with constantly changing emphasis. Whitely's (1985) idea of the job being what the manager makes it also supports this idea of changing emphasis. Stewart's (1976, 1982) concept of demands, constraints, and choices can also be applied to the head nurse role. If head nurses know the demands of the job and the constraints within which decisions can be made, they should be able to make choices. In the current study, however, few of the subjects had this last perspective. Of particular significance is that in the area of change and resource allocation, the subjects perceived themselves to have little control but were only able to react to the impact of decisions made by other people. The reasons for this perception can be speculated upon. If people perceive themselves to have very little power, they do not see opportunities to use it (Pfeffer, 1981; Sayles, 1979). In addition, the

day-to-day operations of the nursing units may have been so all-encompassing to some of the subjects that they could not see opportunities for creative changes.

"Seeing the Whole Picture"

The head nurse's focus of attention is the nursing unit, encompassing the staff and patients there rather than the organization as a whole. In order to manage at this level, it is important that s/he have the technical skills related to patient care delivery and the human relations skills to deal with personnel management (Katz, 1974). In the current study, many examples were given of the need for technical proficiency in order to set and monitor standards of patient care, to evaluate staff, and to resolve conflicts. As well, interpersonal examples for conflict management, information sharing, and motivation were considered. The ability to look at the organization as a whole, understanding how variations in function depend on one another, and how changes in one part affect the other parts is an integral part of the role of a senior nursing administrator who is responsible for a number of units or an entire Nursing Department. Although the head nurse coordinates and integrates the activities of the nursing unit for which he or she is responsible, it may be unrealistic to assume that the external perspective is a significant requirement.

Mintzberg (1973) suggests that a manager is driven to focus on current and tangible problems even though more complex problems require reflection and a far-sighted perspective. Most of the subjects in the current study were so busy with daily operational concerns that they found it hard to adopt a thoughtful, planned, and long-range perspective. If

this perspective is necessary, ways must be found to deal more effectively with the day-to-day operations.

The Participative Nature of Managerial Work

A strong theme in the subjects' responses was the commitment to staff involvement in decision-making, planning, and direction setting for the nursing unit. For example, staff were encouraged to resolve their own conflicts, to take advantage of educational opportunities, and to act autonomously in dealing with patient concerns. The subjects listened to staff and emphasized the importance of using their ideas.

Other researchers have reported similar findings, particularly in relation to staff job satisfaction. In a study of first line supervisors, Klein and Posey (1986) found that outstanding supervisors understood team development, shared skills and knowledge (i.e., shared power), and viewed ambiguity and the lack of structure as a challenge rather than as a source of frustration. The outstanding supervisors were described as people who were competent, caring, committed, and able to set direction and motivate employees.

Some authors describe management in the future as encompassing participative management, as well as the use of autonomous work groups, of complex information systems, and of first line managers who have increased technical proficiency and excellent human relations skills (Kerr, Hill, & Broedling, 1986). Motivation, leadership, and productivity are linked with employee participation in unit operation (Levey & Loomba, 1984). Employees are seldom motivated to learn and improve if they are not involved in decisions about their work (Pinder, 1984). Those who decentralize their authority to the staff through participative management

find time for other aspects of the position (Szilagyi & Schweiger, 1984).

The subjects in this study were committed to staff involvement in the unit operation and employed a variety of methods in order to achieve staff participation. These methods and commitment are consistent with the trend noted in the current literature regarding the importance of participative management.

In summary, the general themes in head nurse roles provide further insight into an important management postion in nursing organizations. The unstructured and informal nature of head nurse activities, the variations in emphasis between managerial roles, the focus of the head nurse on the unit rather than on the whole organization, and the commitment of head nurses to participative management were significant findings.

Roles with Particular Significance

Two of the roles had particular significance for the head nurse position: leader and resource allocator. Identified by the subjects as being most important, these roles have the greatest capacity to take nursing organizations forward into the future.

Leader

The subjects described this role as being particularly important because of its direction-setting and motivational components. Mintzberg (1973) suggests that the role of leader is one which encompasses many of the other roles. It, more than the others, defines the relationship of the manager with the workers. Mintzberg argues that the leader role permeates all activities and is clearly among the most significant of all

the roles.

Speculation about why this role was selected suggests two possible explanations: first, the availability of leadership literature in nursing and, second, the possibility that management is in fact a subset of leadership. Much of the nursing literature addressing administration and management uses the term "leadership." For example, leadership requirements have been explained by definition of terms and description of styles (Gillies, 1982; Leininger, 1974; Sullivan & Decker, 1985; Zorn, 1977). As well, leadership style has been studied in relation to staff job satisfaction and the nursing unit environment (Campbell, 1986; Duxbury, Armstrong, Drew, & Henley, 1984; Fretwell, 1983a, 1983b; Pryer & Distefano, 1971). Further, leadership has been described as the essential element which will change the way nursing is practiced in the future (Baumgart & Larsen, 1988; O'Connor, 1983; Sample, 1987). Thus, the exposure of students and practicing nurses has been specifically oriented to leadership information rather than management theory.

Exposure to leadership literature within nursing may not be the only reason for the head nurses' familiarity with the term. It may be that management is perceived as a subset of the larger concept of leadership as suggested by many writers (Immegart, 1988; Murphy, Hallinger, & Mitman, 1983; Sergiovanni, 1984). If this were the case, it would be difficult to distinguish between the two without specific questions to elicit the difference. For example, the orientation of managers is to the present, operational issues of an organization whereas the orientation of leaders is towards the future development (Bass, 1985; Sergiovanni, 1984; Zaleznik, 1981). In the current study, many of the subjects were

conscious of the need to look to the future as well as manage the present and thus straddled both leadership and management as related concepts.

Resource Allocator

The second role of particular significance to the head nurses was the role of resource allocator. The subjects recognized that the head nurse is responsible for allocating the human, supply, and equipment resources to facilitate the delivery of patient care. Their concern over lack of control of budget allocation and utilization was a significant finding.

In the nursing management literature, a consistent theme is that nurse managers need to have a solid understanding of the budget process. It is generally agreed that active participation by the nurse manager in preparing and controlling budget is essential in providing cost effective health care (Finkler, 1984; Gillies, 1982; Hoffman, 1984; Strasen, 1987; Sullivan & Decker, 1985). Once the budget has been prepared, the control of expenditures is best monitored by the nurse managers closest to the actual expenditures.

In a time of scarce financial resources and strong competition for the health care dollar within and between facilities, all management personnel must be able to manage resources effectively (Cleverly, 1982; Evans, 1984; Hoffman, 1984; Strasen, 1987). Nursing is not exempt from the problems facing the health care industry and must be in the forefront of developing new solutions to the current problems and those which will present themselves in the future. Head nurses, as first line managers in the hospital, are in an ideal position to develop and encourage new ideas for the structure and delivery of patient care.

The subjects in the current study appeared to feel bound by budget

parameters so that their decisions were often swayed by financial considerations rather than the goals and standards of patient care. Furthermore, the subjects were not aware of their own time as a valuable resource, a perspective produced, perhaps, by the recent emphasis on budget management. The head nurse could use the allocation of her/his time to indicate how the staff nurses should be spending their time. For example, if the head nurse allocates a large portion of the time to patients and staff, the value of these human relationships is emphasized. If, conversely, s/he spends all of the time on the budget, scheduling, and payroll, the staff and patient emphasis is significantly decreased. Thus, analysis of the findings in relationship to the two roles identified as most important reveals useful insights about the head nurses' perceptions of the roles relative to a changing health care scene.

Summary

In this chapter, findings of this study were discussed in relation to those of other similar studies. The subjects were able to describe their behaviours in all of the roles defined by Mintzberg (1973), although some were more familiar than others. The utility of Mintzberg's framework for studying the work of head nurses was supported. Comparison with an earlier study of head nurses by Jones and Jones (1979) showed that the nature of the head nurse position may have changed over the last 10 years.

Several themes emerged from the descriptions presented by the subjects. The nature of head nurse work is highly informal and unstructured. Furthermore, the emphasis on a role or a combination of roles may vary dependent upon the situation and the skills of the nurse

manager. In addition, the ability of the head nurse to "see the whole picture" or have a systems orientation may require further development. Finally, head nurses recognize the value of staff participation and have developed methods to motivate and support these valuable human resources.

Two roles were presented as having particular significance for head nurses and the nursing profession in general. The leader role enables the head nurse to set directions for nursing practice and to develop a motivated staff. The resource allocator role is crucial for effective utilization of resources in order to facilitate a high standard of patient care. As nursing organizations move into the future, the leader and resource allocator roles may become increasingly important.

This chapter has, therefore, located these findings within the context of knowledge relating to management in a changing health care system. The final chapter will present the summary and conclusions of the study, and the implications for nursing practice, education, and research.

CHAPTER SIX

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

This chapter begins with a summary of the study and the conclusions suggested by the findings. The implications which arise from the conclusions are then presented.

Summary and Conclusions

The head nurse position is important in the nursing organization of a hospital because it influences the standard of patient care delivered and the degree of job satisfaction for employees, yet little is known about the head nurse's role. Previous research has addressed the tasks carried out by head nurses and has assessed staff job satisfaction in relation to the head nurse's leadership style. This study explored the perceptions of head nurses about their roles.

An exploratory, descriptive research design was used for collection and analysis of data. Twenty subjects who were head nurses at a large tertiary care hospital in the British Columbia Lower Mainland were interviewed by means of a semi-structured guide based on Mintzberg's (1973) framework of 10 managerial roles. The procedure of content analysis was used to analyze the data. Four major areas were addressed: subjects' responses to the specific managerial roles; the utility of Mintzberg's framework; a comparison to another study using the same framework; and finally, the general themes in head nurse roles.

Conclusions which can be drawn from analysis of the data include the following:

1. The work of head nurses involves many informal and unstructured activities.
2. The specific tasks associated with the various roles of head nurses may have changed significantly in the last decade.
3. Mintzberg's framework is one useful way of understanding the roles head nurses fulfill. The 10 roles do reflect an understanding of the position from the perspective of those who fill it.
4. Some of Mintzberg's 10 roles are less meaningful to head nurses than others. These include the spokesman, negotiator, and figurehead roles.
5. The activities which head nurses describe reflect considerable overlap among certain of Mintzberg's roles when applied to head nurses. The roles which share similar tasks are: the entrepreneur and disturbance handler; the liaison and negotiator; the spokesman and liaison.
6. There is variation in emphasis among roles depending on the skill of the head nurse manager and the situational requirements.
7. Head nurses understand their management role in relation to the nursing unit more easily than they understand it in relation to the organization as a whole.
8. Head nurses favour a highly participative management strategy encouraging staff involvement in many ways.
9. Head nurses view the leader role as important and are familiar with the idea of leadership as a role requirement.
10. Head nurses also view the resource allocator as an important role. Financial resource allocation represents a significant challenge to

the head nurses in this study because of a perceived lack of control of resource utilization.

11. Head nurses describe conflict resolution and budget management as two areas in which more knowledge and skills are required.

Implications for Nursing Practice, Education, and Research

The findings of the study have implications for nursing practice, education, and research. Each of these is addressed separately in the following sections.

Nursing Practice

The study's findings emphasized that one of the most important aspects of the head nurse position relates to the presence of the head nurse on the nursing unit to guide, coach, and direct the practice of the staff nurses. They also revealed that much of the work of head nurses is done informally, from evaluation of a staff member's performance to setting an example for conflict resolution. These findings suggest, therefore, that head nurses need time to spend with the patients and nursing staff rather than be involved entirely with monitoring the budget and attending meetings. Thus, the demands upon the head nurse's time may need to be controlled by limiting the number of meetings s/he is required to attend and ensuring that budget preparation and monitoring involves head nurses in decision-making but not in extensive calculations. Another avenue for freeing up the head nurses time to spend with patients and staff is to provide clerical support for head nurses so they have assistance with staffing activities, maintenance of statistics, and routine contacts with other departments.

The findings also suggest that, in contrast to other managers, head nurses may have a greater focus on the nursing unit than on the organization as a whole. It may be that this unit focus is an inherent attribute of the head nurse position. Because head nurses seem to maintain an advocacy role for the patients and staff of their nursing unit, the loss of this focus could be detrimental to the function of that unit. This implies that head nurses should not be asked to diffuse their advocacy role by supervising more than one unit. Rather, nursing organizations may need to assign a nursing manager above the level of head nurse to coordinate the activities of a number of units. In contrast, if the nursing unit focus is not a desireable attribute, it may be that far more sophisticated preparation would be required if first line managers are to view their area of responsibility as part of the larger picture. Nursing organizations may, in this case, need to develop a broader perspective for each of the head nurses through activities in which head nurses work with other units on projects, committees, or possibly in program management groupings.

The commitment which head nurses have towards staff participation in the unit operation is also emphasized in the findings. Head nurses seem to perceive that opportunities for staff nurses to participate in planning and decision-making are necessary in order to foster job satisfaction for the nurses and ensure the effective functioning of a unit. In order to facilitate this involvement, it would appear that the head nurse must be able to articulate the unit's goals and objectives clearly, to promote an effective working team, and to create an environment in which staff are motivated. Therefore, the structure of nursing organizations which

support staff participation are likely to be flat, with decentralized decision-making and units of a sufficiently small size that the head nurse can work individually with staff to develop their skills and abilities. As well, recognition of staff contributions could be enhanced through verbal and written acknowledgements.

According to the findings of this study, head nurses recognize the importance of the role of leader. Through this role, head nurses exemplify the desired standards by role modelling appropriate behaviours and articulating the directions for their nursing unit within the overall umbrella of the nursing organization philosophy, goals, and objectives. If the role of leader is so important, it behooves the head nurse to foster leadership among other nurses by encouraging staff to take on activities such as being "in charge," coordinating projects, and chairing staff meetings.

The study also found that the resource allocator role is a significant one in the view of head nurses. The head nurses perceive that they can control expenditures more effectively if they are involved in preparing budgets which accurately reflect the needs of the patients on the unit and receive timely and accurate reports with which to monitor resource utilization. Thus, to be effective in the resource allocator role, head nurses should likely have the authority to manipulate resources within the allocated budget. For example, in order to reduce the patient workload demands which would incur staff overtime, the possibility of restricting patient admissions or closing beds should be within the scope of the head nurse's decision-making.

Nursing Education

The need for management knowledge in order to carry out the activities of head nurses was apparent from the responses of the subjects in the study. Despite the range of educational preparation of the subjects, from an RN diploma to a Master of Science in Nursing or related discipline, many had little theoretical knowledge about some of the management roles. Therefore, educational programs which prepare nurses may need to increase the amount of management material provided beyond that of managing patient care to include human and financial resources management. Further, nurses who enter into management positions will likely require additional preparation through attending workshops or short courses and reviewing relevant management journals.

From the findings, there were three topics which highlighted specific areas of educational development. First was the emphasis which head nurses place on handling of conflicts or disturbances among the staff who work on the nursing unit. Because of the need to mediate between staff conflicts and to facilitate resolution of disturbances, head nurses require knowledge of conflict resolution strategies and proficiency in demonstrating these strategies to staff members. Such knowledge and skills could easily be included in workshops and self-directed reading modules. Second, with the current decentralization in nursing organizations, head nurses are in the position to manage increasingly large budgets. Until recently, many head nurses, through lack of knowledge, time, or skill, have tended to relinquish the right to make decisions to someone else. Clearly, there is a need for preparation in developing and monitoring budgets, manipulating resources within financial

constraints, and justifying resource utilization.

A third area of educational development related to the finding that the spokesman, negotiator, and figurehead roles were not seen as particularly significant to the head nurse position. It may be that these are not as important for head nurses as for more senior nursing managers in the organization, or that head nurses are unable to isolate behaviours within these roles from those within other roles. On the other hand, it may be that better educational preparation in relation to these roles could improve their usefulness to head nurses. For example, a clearer understanding of the purpose of the spokesman role and development of confidence in the skills relevant to the role could provide the head nurse opportunities for disseminating information about the nursing unit to other parts of the hospital or to the community. Similarly, an improved understanding of the negotiator role would increase the power of the head nurse to advocate for resource allocation for the nursing unit. As well, head nurses would benefit from a greater appreciation for the scope within the figurehead role to network with others and achieve recognition for the nursing unit.

The more general finding that head nurses assume managerial roles raises several implications for the preparation of future nursing managers. As described by the subjects in this study, there is a basic skill set which allows the head nurse to carry out such functions as assigning staff to patients or projects, coordinating the unit payroll process, and conducting interviews for employment or performance appraisal. These skills could be learned through management training and development programs, reading, and observation. However, the varied

managerial roles of the head nurse and the impact on patient care delivery and staff satisfaction are not so easily learned. The integration of these two aspects of the head nurse position might be addressed in specific undergraduate or graduate administration courses which both explore the skills and roles from a theoretical perspective and provide practical experience. It may be that practica in which students of nursing management work with head nurses or other nursing managers would be particularly useful.

The question must be asked as to whether it is realistic to expect a person newly in the head nurse position to function at the level of someone who has had years of management experience. It is more likely that just as clinical knowledge in nursing is learned from integrating theory and practice at several levels (Benner, 1984), so must management knowledge be learned. Roles are determined by sets of behaviours (Biddle, 1979) which are best learned through exposure of the head nurse to role models who actively use the roles (Dunne, Ehrlich, & Mitchell, 1988). With the flattened organizational structures that have developed over the past few years, head nurses may not always have the benefit of effective role models. To address this need to learn from role models, head nurses could be conscious of the need to provide management experience for staff nurses through "in-charge" positions, projects, committee work, and budget preparation. As well, new head nurses could be "buddied" with experienced head nurses in order to learn the appropriate behaviours of the head nurse position.

Nursing Research

The setting for this study was a large, tertiary-care agency in the

British Columbia Lower Mainland. Because this limits the generalizability of the findings, it would be useful to replicate the study in other settings to determine whether different sizes and types of institutions and different organizational structures have an impact upon how head nurses perceive their roles.

Further, because the current study does not consider the perceptions of head nurses in relation to the perceptions of nursing staff or of the head nurse's immediate superior, it would be valuable to develop the findings by designing quantitative studies of staff job satisfaction, of the impact of the head nurses' roles on staff satisfaction, and of impressions of head nurses' immediate superiors as to the effectiveness of their performance and the manner in which the roles are carried out. Another aspect of the head nurse position to explore is whether or not the managerial roles shift based upon the incumbent's experience or educational preparation, the type of nursing unit supervised, and the number of staff for which s/he is responsible.

Finally, it would be useful to explore the degree to which the behaviours within each of Mintzberg's (1973) 10 managerial roles vary with the level of the manager in the nursing organization. For example, would the behaviours of the head nurse in the leader or resource roles vary from that of the director of vice-president of nursing? Furthermore, do the ways in which roles are enacted have a critical bearing on the overall performance of a manager at different levels and are certain types of roles vested with more potential for power? Since it is speculated that three of the most significant managerial roles with power potential are those of leader, resource allocator, and entrepreneur, future research

could consider which of these roles is most critical in building power in the organization and if the type of role which is most critical varies among the different levels in the nursing hierarchy.

The findings of this descriptive study have demonstrated that head nurses perceive themselves to be managers and that they carry out many of the managerial roles which have been identified in other research. The Mintzberg framework provides a comprehensive framework which allows an important nursing management position to be explored in more detail. The potential for more effective management through increased understanding of the head nurse's roles has been emphasized by the rich descriptions provided by the subjects in this study. The varied roles of the head nurse make that position a complex one. The nursing profession could benefit from recognition both of its importance and of the need for educational support for first line managers. Further research is needed about the roles that are most critical for developing the potential for power in an organization and about the impact of the head nurse's roles on staff satisfaction and effective job performance.

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Appendix B

Summary for the Subjects

MINTZBERG'S FRAMEWORK OF MANAGERIAL ROLES

The framework used by Mintzberg to describe the nature of managerial work has been used as the basis for study of the head nurse position. He identified the ten common roles played by managers in all settings in the following way:

Informational Roles

- monitor - the manager seeks and receives a wide variety of information to develop an understanding of the organization and the environment and thus acts as the "nerve center" of internal and external information of the organization.
- disseminator - the manager transmits information from outsiders and from other subordinates to members of the organization. This information may be interpreted and integrated with the values of the organization.
- spokesman - the manager transmits information to outsiders on the organization's plans, policies, actions, results, etc. and serves as the expert on organization's industry.

Decisional Roles

- entrepreneur - the manager searches the organization and its environment for opportunities, and initiates changes to improve the organization.
- disturbance handler - the manager is responsible for corrective action when the organization faces important but unexpected disturbances.
- resource allocator - the manager is responsible for the allocation of organizational resources of all kinds including staff, equipment and supplies.
- negotiator - the manager is responsible for representing the organization at major negotiations.

Interpersonal Roles

- figurehead - the manager, by virtue of position, is obliged to perform a number of routine duties of a legal or social nature.
- leader - the manager is responsible for staffing activities and fostering an environment which motivates subordinates .
- liaison - the manager maintains a network of outside contacts and informers who provide information and favors.

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Appendix C

Interview Guide

Section 1: Demographics

1. For how many years have you been nursing?

2. For how many years have you been a head nurse?

3. What is your educational background?

4. Have you had any formal management training?

5. What type of nursing unit are you currently responsible for?

Section 2: Management Roles

You have reviewed the summary of Mintzberg's ten managerial roles. I would like to explore with you how these are applicable in your head nurse position.

INFORMATIONAL ROLES:
After reading the summary sheet, do you feel that the informational roles apply to your position as head nurse?

1. (Monitor)
   How do you monitor the activities of your unit?
   How do you monitor the progress of your unit within the larger nursing organization?

2. (Disseminator)
   Does your position require you to deal with a great deal of information? How do you disseminate this from people above to people below you (and vice versa)?

3. (Spokesman)
   How do you represent your unit to other parts of the organization? Can you give me some examples of when you do this?

DECISIONAL ROLES:
After reading the summary sheet, do you feel that the decisional roles apply to your position as head nurse?

4. (Entrepreneur)
   Are you involved with initiation and implementation of change on your unit? Can you describe some of the changes which you are involved with?

5. (Disturbance Handler)
   Do you deal with conflicts or disturbances between people?
   Can you describe some situations which you deal with?

6. (Resource allocator)
   Are you responsible for allocation of resources?
   What does this mean to you?
   What factors influence your actions?

7. (Negotiatior)
   Are negotiations with other people a component of your role?
   When does this occur?
   How do you do this?

INTERPERSONAL ROLES:
After reading the summary sheet, do you feel that the interpersonal roles apply to your position as head nurse?

8. (Figurehead)
   How do you represent your nursing unit in the kinds of situations described by Mintzberg?
   What are some of the symbolic activities which you carry out as a head nurse?

9. (Leader)
   Are you responsible for setting the direction and purpose of an organization?
   How do you do this for your nursing unit?
   How do you create an environment in which people are motivated?

10. (Liaison)
    What types of individuals or groups outside of your nursing unit staff do you liaise with on a regular basis?
    For what purpose do you do this?

General Questions:

Which role(s) do you feel are most important and why?

Is there another role which has not been covered?

Do you have anything else you would like to add?

Appendix D

Consent Form

UNIVERSITY OF BRITISH COLUMBIA
FACULTY OF NURSING

Consent to Participate in the Study

THIS IS TO CERTIFY THAT I, _____
(print name)
HEREBY agree to participate as a volunteer in the research study entitled "Head Nurses' Perceptions of Their Roles" conducted by Elaine Baxter.

I agree to be interviewed, and to have the interview tape recorded. I understand that, at the completion of the research, the tapes will be erased and that my name will not be associated with any published or unpublished material.

I understand that I am free to refuse to answer any questions during the interview. I also understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

I have received a copy of the letter of information and the consent form.

Signature: _____ _____
Participant Researcher

_____ _____
Date Date

Phone No.: _____
Participant