vices have senior officers to report to – and the senior medical member a committee to report back to. These constraints should be considered seriously.

Apart from these proposals, perhaps what the district management team should be looking for from units is collective views and proposals, not concerted management action already taken.

There is much collective work to be done at unit level. If the work of the existing divisional nursing officers is compared with the new directors of nursing services, what differences emerge? This will depend on what services are delegated to units.

If all personnel services are to be devolved to units, then workable policies have to be formulated conforming to district policy. If the works' organisation is essentially at unit level, much more collective discussion will have to take place.

The evaluation of all services operated at unit level will need to be undertaken by the director of nursing services and unit administrator with the presence of a senior medical member. Regular reviews will be made of the unit's budgets and spending and of developing new services and revitalising others.

Effects on the new person at unit level will result in more work in group situations and analysis of services across the unit. How this will match with the individual responsibilities of accountable officers I do not know. Already the existing divisional nursing officer has a right to monitor all those services that are offered at ward level, such as catering, domestic and linen services. Whether she does so is a different matter.

Differing views of what a satisfactory service is could be challenged in this new world of "units".

While an administrator may be very pleased that the laundry services performed first class for 49 weekends last year, the nurse judges the performance of the service on three weekends when some patients had no sheets or bottoms to their pyjamas. Administrators may find this unfair, but nurses judge the service from the patients' point of view. However, in most areas individual officers are accountable to a more senior officer. A most effective mechanism, I believe, for no change.

If a nurse spends less time managing her service, what happens to that service? Remember the director will be able to use her budget on nurses of her choice. No longer can the response to a request for more nurses on the intensive care unit be "the district will not give the money".

Management costs reductions will give her fewer subordinates to do different work. Those who are to be involved in the management costs exercise, should remember that in nursing the 37½-hour week reduced management hours by over 6 per cent. In Newcastle, the loss is calculated at three whole-time equivalent staff. Therefore, we have had our cut.

Now there is an urgent need to review the structure of the ward team at patient level. The ward structure of sister, staff nurse, learners and auxiliaries, supplemented by enrolled nurses, has remained unchanged for many years □

An art and a science

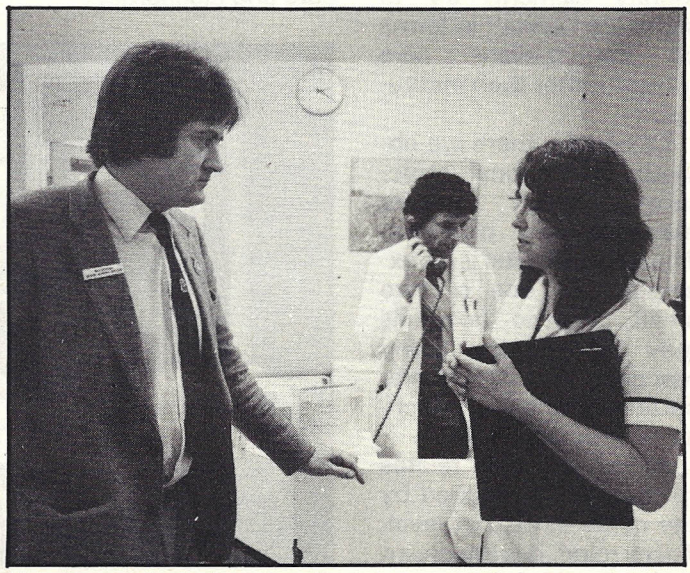
ANTHONY CARR says a successful nurse manager combines art and science in the application of her job. Science in this sense means effective management systems and art is the initiative and flair needed for carrying them out.

IS NURSE management a science or an art? I suppose this question could be asked about many work activities and it is a continuing debating point for general management in industry.

Because nursing patients is often seen by practising nurses to be more of an art than a science, nursing management is also something that one does only one or more layers removed from the patient scene. I am sure many nurses will challenge my view on the art or science approach to nursing. Nurse educationalists are continually striving to bring a scientific basis to their nursing theory, but sadly large numbers of nurses remain isolated from the larger body of knowledge found outside their hospital and in professional bodies and journals.

From a background of work experience which includes trades union activity, management education, and for the last 12 years senior nursing management, I have concluded that nursing management is both a science and an art.

I see the application of effective systems of management for manpower planning, personal development, organisational structures, and the working out of authority and responsibility within the organisation as a



Listening to other's views is an important part of the manager's job.

science. The art is putting the scientific parts into action.

Application of the principle of good sound management is the science, while the style in which it is put into practice is the art. To my mind both are important. A senior manager can survive for some time on good personal style alone.

Lack of application

There comes a time, however, when lack of application of management systems and principles produces an instability in the organisation. Eventually, the personality which once was so attractive becomes an irritant because style (art) alone does not produce proper organisational life.

On the other hand, a systems dominated organisation is lifeless. Everything is judged by the rule book.

What is needed, of course, is a well functioning body. The skeleton, flesh and organs providing the basis (the science) while the working out of the body in terms of personality, initiative, and so on, is the art.

Nurse managers often have personal conflicting views on whether they are managers first and nurses second or vice versa. Perhaps it all depends on what the problem or project is, but in terms of managing nursing staff I do not have a problem. The nurse manager is first a manager.

There are many definitions of the word ''manager''. Of all those I have read over the years, the one I identify with most is Reddin's definition which is: ''A manager is a person occupying a position in a formal organisation who is responsible for the work of at least one other person and who has formal authority over the person.'' He goes on to place the manager in context to the organisation by saying: ''Persons whose work he is responsible for are his subordinates. A person he works with, who is neither his supervisor, nor a subordinate, is a co-worker. The person responsible for the manager's work is his supervisor.'' So, he continues, ''the difference between being a manager, subordinate, co-worker, and supervisor, is essentially based on where the power lies, or who has the responsiblity and authority.''

The laundry may be working well, but the patients' well-being is the most important criterion.

There is a reason for quoting at length from this writer. I find some nurses in management confused about their role. When they are asked as a point of clarification what responsibility they carry, the answer is unclear. It is then pointless to continue the conversation by determining what authority they have. The answer is always the same. They do not think they have any authority worth talking about.

Different job

I do think that one of the problems facing nurse managers is their previous nursing experience. Somehow many nurse managers sincerely believe that they are contributing to the nursing care of patients much more directly than they are in reality. Recently when a nurse manager was approached by a treasurer about an incorrectly completed form which resulted in a payment delay to a more junior nurse, the response was that form filling was not essentially a nursing duty. She was right in saying it was not a nursing duty, but wrong in assuming it was not a nurse manager's responsiblity.

Must be qualified

Because I believe it essential for managers in nursing to be qualified nurses I do not consider it necessary for them to continue to practise bedside nursing. This does not mean they do not contribute to the care of people. It means their job is now different.

I have heard of many well-meaning senior nurses reviewing the duties of existing nursing officers and senior nursing officers in preparation for NHS reorganisation. It is an opportunity to rethink the whole range of work being undertaken at middle management level. But the question I have to ask is why is middle management there at all? Is it not to support the nurses actually nursing the patients or visiting clients? Are their areas of responsibility so clearly defined that no work needs to be done there?

One test on a nursing organisation's effectiveness is to review job descriptions from ward sister up. Notice if each person has some responsibility for standards of patient care and how that responsibility is defined. It can be virtually the same sentence repeated ''up the line''.

From my understanding, only one person can be given the responsiblity for maintaining standards of patient care. That is the one who issues the actual work to the nurses.

Accountability

If a failure of care happens on a ward, the ward sister is essentially ''called to account''. In essence the nursing officer, unless clinically in charge, does not take responsiblity for standards of care, but for monitoring standards of care.

Less than a total review of the position of the ward or departmental sister or senior nurse in charge of clinical practice will fail to identify the position of middle managers in the new structures.

As an exercise, in Newcastle a working group of middle managers, ward sisters and their divisional nursing officers reviewed the responsibilities of ward sisters in two ways. First, those responsibilities which cover the 24-hour situation and more specific responsibilities while being on duty. The results of those discussions are shown below.

It must be emphasised that these comments relate to the thinking and style of management of a local situation. Nevertheless, the information could

be used to review many other districts' ward sister levels.

Responsibility

Each day personally responsible for:

- keeping up-to-date and professionally aware of changes in the nursing profession affecting the patients treatment, staff education, and applying such knowledge continually in the working situation;
- establishing and maintaining a leadership role in the ward/department for each patient;
- provide known monitoring systems for plans of care which will recognise the need to take into account the physical, psychological, emotional and spiritual needs of all patients;
- provide adequate nursing policies and interpret them to staff;
- provide for ward/departmental management policies for the effective use of equipment and materials;
- providing, where relevant, policies for the effective teaching of: patients and carers, learners, unqualified staff, trained staff;
- providing through policies a safe environment for the treatment of patients and protection of staff;
- satisfactory management and supervisory arrangements covering non-nursing staff working in the ward/department situation;
- providing a safe handover system from day to night, night to day, and between shifts taking into account the special arrangements which may be necessary when the nursing process is in operation;
- ensure essential equipment and resources are ordered and available for staff and patients, reporting to a higher authority if these resources are unavailable;
- maintain adequate records: for use of nurses to record treatment of patients and for ordering other supplies as necessary;
- meeting the aims and objectives contained in modules of experience for learners; and
- recognise and develop potential in all staff, identifying those staff to higher authority where appropriate.

During the shift

While on duty personally responsible for:

- being satisfied that resources (staff and material) under the sister's control are used in the most effective way;
- providing for effective control of patient care plans through understandable delegation of work to other nursing staff;
- awareness of situations that require medical opinion and help and take necessary action;
- ensuring that all staff, including learners, are properly supervised (no one carries out procedures not previously taught and found proficient without supervision);
- taking part in the selection of staff up to and including staff nurse for his or her ward, unless a rota type system is used for certain types of staff;
- developing effective communications systems among all grades of staff, patients, medical and non-medical staff. In addition, effective liaison should extend to nurses in the teaching department and nurses in the community;
- providing adequate supervision personally and through proper delegation within the available manpower and be satisfied that patients are cared for in the most effective and compassionate way so that medical and nursing treatment is given when required;
- making sure that patients and near relatives are kept informed – and involved in the patient's care plan – according to any of the patient's wishes;
- personal accountability of the staff performance under his/her control, reporting to a higher authority if individual performance continues to be unsatisfactory after informal counselling;
- provision, through the duty roster, of proper cover throughout the day shifts ensuring fairness to all staff;
- maintenance of care standards and individual care plans throughout the shift which is the sister's major responsibility;
- for operating instructions contained in policy statements ANO(P)37 entitled "Nursing responsibilities in hospital for a) reduction of services, b) closure of wards and/or departments", should staffing, resources, or other aspects of the ward/department become such that to continue to offer care would become harmful to patients.

Discussion

Some important issues, however, must be discussed. Can a person managing others be held responsible for staff they did not take part in selecting? I find it difficult to accept that a senior manager can impose staff on a junior manager and then insist on making that junior responsible.

I have said very little about the word "authority". This is defined in the *Chambers Twentieth Century Dictionary* as "legal power or right; power derived from the office held; having the power of sanction".

No authority can be given to any person until their responsibilities are clearly defined and understood by the person and their subordinates. Otherwise subordinates will think the ward sister has tried to take on power she does not have.

However, once authority has been designated it is important that all staff see that senior management upholds that authority.

Unsure of role

Because organisations are often confused in this area of responsibility and authority, the staff and managers are unsure of their role.

This in turn means decisions are only made at a high level in the organisation. It is often at a level that has the most formal information and the least informal information about a particular situation.

The senior manager knows what action to take according to policy, but is unaware of the reaction of more junior staff in terms of fairness and possible abuse of the more junior nurse manager.

Senior nurse managers must be sensitive to their staff's needs in that nurses of all grades need to feel secure in exerting their legitimate authority. A person having authority to take certain action or make decisions needs to know that when exercising those powers senior staff will back them up.

Where mistakes happen, as they will, it is up to the more senior staff to help their colleagues; advise and offer them constructive help not criticism □