The working world of nursing unit managers: responsibility without power

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Abstract

This paper seeks to explore the responsibility and power of the role of nursing unit managers (NUMs) in rural New South Wales using Kanter's theory of organisational power as a framework. Using in-depth individual interviews with twenty NUMs, data were analysed from four perspectives to gain a deep understanding of the NUMs' working world. The findings show that the NUMs' role is substantive, encompassing both clinical and managerial functions. Overall, the findings indicate that the participants lacked power commensurate with their role responsibilities.

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THERE IS A GREAT DEAL of nursing literature that describes the role of nurses within the health care system. However, little is known about how nurses who hold management positions negotiate their role. This study aimed to explore the working lives of nursing unit managers (NUMs) employed in the public health care system in rural New South Wales. It was anticipated that by exploring the working world of this specific group of nurses, more could be learnt about how they fare within the system. Such insights could contribute to enhancing the job satisfaction of this group, which in turn could allow them to more fully support the nursing workforce and meet the goals of the organisation.

In Australia, as in many other countries, NUMs have replaced the senior nurses or charge nurses of the 1980s, and with the change in title came a

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What is known about the topic?
Nursing unit managers (NUMs) occupy a first-line management position in many health care services in Australia and worldwide. The role has evolved into a multifaceted one, in which the scope and authority of the position are poorly understood. Little is known about how nurses who hold management positions feel about their multifaceted role in Australia's public health care system.

What does this paper add?
This paper reports on a qualitative study that explored the working world of twenty nursing unit managers (NUMs) employed in the public health care system in northern New South Wales. The study revealed that the participants experienced a complex role that encompassed both clinical and managerial functions, yet they did not have sufficient power to allow them to achieve all that was expected of them. Suggestions are made regarding how to reduce the NUMs' stress levels and enhance the effectiveness of the role.

What are the implications for practitioners?
The study suggests that the role of nursing unit manager has considerable responsibility, but insufficient power. The implications of this for the health care industry are that stakeholders need to develop a more realistic role description that clearly identifies the scope and power of the NUM position. More attention needs to be paid to supporting potential and existing NUMs to function effectively as first-line managers.

change in the level of responsibility.[1] There are three levels of NUM recognised by the NSW Public Hospital Nurses (State) Award. NUMs at Level One are in charge of a ward or unit of 20 to 50 beds. NUMs at Level Two have responsibility for wards or units of 50 to 75 beds, while Level Three NUMs have responsibility for wards or units of more than 75 beds. In NSW, nursing unit managers are the first line of management in the nursing career structure and their job encompasses managing the human, physical and financial resources of a ward, interpreting policies,

maintaining standards, and providing nursing leadership,[1,2] all within tight budgetary constraints.[3]

Herein lies a major dilemma for nursing unit managers, in that they are expected to combine a demanding professional nursing role with administrative, financial and human resource management in a workplace that is dogged by limited resources and nursing staff shortages.[4-6] Another difficulty is that management is commonly perceived as a role concerned with resource manipulation, objectivity and control,[7-9] yet the nursing profession values caring and compassion above these traits.[4,10] A lack of research about the NUM's role has meant that little is known about how NUMs actually experience their day-to-day working lives, nor is there much known about the power, or lack of it, inherent within the role.

Nursing still carries an entrenched image, and a traditional role, based on a set of cultural and organisational assumptions that have made it difficult for nurses to be accepted as equal players in the health care arena.[11-15] For example, an editorial in the *British Medical Journal*[16] stated:

> Doctors and nurses are divided by gender, background, philosophy, training, regulation, money, status, power, and — dare I say it? — intelligence (doctors are usually top of the class, nurses in the middle).[16]

Daiski[14] argues that nurses continue to be cast into subservient roles because they have come to accept the existing power relations in health care as normal. Similarly, Kane and Thomas[12] warn that "the oppressive nature of nursing must be transformed before nurses can be empowered". Des Jardin[15] asserts that a nursing image based on traditional gendered assumptions "suffocates or represses" nurses, which in turn limits their ability to fight for greater power. Spence Laschinger[17] links nurses' lack of power to the hierarchical organisational culture of health care. However, others describe how the image of nurses is both created and maintained by the socially constructed nature of public and organisational perceptions about the identity and power of certain roles.[18] Diers[11] and Sullivan[9] both describe the image of nurses as one-dimensional and inaccurate, suggesting that this image both reflects and reinforces perceptions that nursing is a low status job with limited power and influence. How the image and traditional role of nurses impacts on these NUMs' ability to be effective managers remains to be seen.

Thus, while NUMs clearly face the challenge of a nurse's traditional powerless role they are also disadvantaged as first-line managers. Based on a number of studies described by Kanter,[19] first-line managers of both genders are functionally powerless because they are frequently responsible for results without "the resources to get them". According to Kanter,[19] first-line managers often have limited access to organisational power, which means that their positions are organisationally invisible and generally unrewarded. Within this framework power is not a feature of the individual, but of the role they occupy.

Kanter[19] contends that as women workers commonly only reach this first level of management, these issues are particularly relevant to female first-line managers, and remain relevant today. Thus, in an effort to make sense of the findings of this study, Kanter's[19] theory of organisational power was chosen as the theoretical framework. It was considered relevant because it is aligned with feminine understandings of power, which is power on behalf of others, rather than over others,[20,21] and because it specifically considers how women fare in workplaces, by considering how powerful and respected roles are negotiated in peoples' working lives. Kanter[19] argues that organisational power is accessed via four structural determinants: opportunity, support, resources and information. These determinants emerged during data analysis and the findings were analysed using Kanter's[19] theory.

Purpose

The broad purpose of this study was to explore the working world of NUMs. In particular, the study sought to gain insight into the responsibilities and power of the participants' roles, and to do this two specific aims were developed.

- Explore what it is like to be a nursing unit manager in the context of the NSW public health care system.
- Gain insight into the participants' perceptions of the preparation and support they received for the role of NUM.

Only the first of these specific aims is discussed in this paper. In addition, as the word "power" carries negative connotations for many nurses,[20] it was not used in the interview questions. However, the interview questions were broad enough to capture the participants' perceptions of their level of responsibility and power.

Methods

A feminist methodology was utilised in this study to explore the construct of power within the working world of nursing unit managers, as according to Speedy[22] a greater awareness of oppression can contribute to positive change.

> Nursing work in all its forms (including clinical practice, education and research), mostly undertaken by women, is affected severely by gender because of its construction and the context in which nursing is carried out. Becoming aware of such systematic oppression is the first step in changing paternalistic structures and systems that operate to disadvantage nurses, their patients and the overall healthcare system.[22] (p.145)

According to Roberts and Taylor,[23] feminist methodologies are concerned with exposing issues of power and domination and also raising awareness of a need for political action to change the status quo, making a feminist methodology ideal for this study. Because a feminist methodology seeks to unpack taken-for-granted ideas about people within historic, social and cultural contexts, and presents new ideas that challenge traditional views,[24] this approach was used to expose the links between the experiences of NUMs, who are predominantly women, their organisational contexts, and the roles that they perform.[12,13,25]

The study was conducted between 2003 and 2005 in the New England area of NSW. This area employs just over 3000 health care staff in the public health system, and at the time of the study, there were 42 NUM positions. After gaining ethical approval to commence the study from both the University of New England and the New England Area Health Human Research Ethics Committees, all 42 NUMs were invited to participate and 20 responded. Individual in-depth interviews of 45–60 minutes duration were conducted with the participants during their working day. The participants were all asked "Can you tell me what it is like to be a NUM?" Following this, prompting questions were used to explore particular aspects of their stories. In relation to the NUMs' level of responsibility and power, prompting questions were asked about the part they played in the organisation, how they felt about their work relationships and whether they felt that their opinions were heard.

Once each interview audiotape was transcribed, data were analysed by reading each transcript four times. The data analysis framework developed by Brown and Gilligan[26] allowed the researcher to consider the data from four perspectives. The focus of each of these perspectives was (1) the story as a whole, (2) who was speaking, (3) the participant's work relationships, and (4) the health care context. By analysing the data in this way and then comparing the four perspectives, particular attention could be paid to the NUMs' perceptions of their level of responsibility and power. The findings were then compared with Kanter's[19] structures of organisational power, which are opportunity, support, resources and information. Pseudonyms have been used for all participants to protect their identity.

Participants

Of the twenty participants, 16 were more than 40 years old, four were between 20 and 30 years, and none were under 30 years of age. Twelve participants had been nursing for more than 20 years, while the other eight had been nurses from 5 years to 20 years. Eleven participants had been NUMs for less than 5 years, while six had held the position for 6–10 years, and three for more than

11 years. Participants were asked to identify their highest level of nursing and management qualification. Sixteen had a nursing certificate as their highest nursing qualification, while two held a diploma and two a Bachelor degree. Only three held any management qualifications: two of these were Technical and Further Education-based qualifications, while one was a postgraduate health management qualification. Fourteen of the participants were NUM, Level 1, three were Level 2 NUMs, and three were Level 3s. It needs to be noted that while the educational profile and associated findings are vitally important they are not discussed in this paper.

Findings

In this section the findings that specifically relate to the participants' perceptions of their level of responsibility and power are presented. According to Kanter,[19] organisational power is evident in the level of access workers have to four determinants of power, which are support, information, resources and opportunities. Thus, in this study the NUMs' stories were examined from four perspectives to ascertain the participants' access to these determinants. By considering the NUMs' stories from four perspectives, the commonalities in the stories emerged as threads that illuminated their level of responsibility and power within all aspects of their working lives.

Without prompting, all participants responded to the question — Can you tell me what it is like to be a NUM? — by describing the responsibilities of their role and their perceptions of the organisational information and resources available to them. Of particular note, are the participants' feelings of being ill-prepared and overwhelmed by the sheer scope of the role and of having limited access to sufficient information and resources, in particular, time, staff and money. In addition, they all alluded to the tension or conflict they experienced when trying to blend the dual aspects of their role, and this was particularly evident in the stories of Level 1 NUMs, who retain a clinical presence as part of their workload. To illustrate these findings several

quotes have been selected from Level 1 NUMs as examples of the perceptions of the majority.

> The role involves a clinical and administrative load, in that I work clinically at least 4 days a week and one day is defined as a management day. However, every shift that I am on duty I am functioning at an administrative level, either in damage control or organising anything that comes through the door. I feel there is a tendency for hospitals to spend a whole lot of time and a whole lot of money looking after equipment, but my personal opinion is that they don't tend to look after their staff in quite the same way. I feel like I am dancing as fast as I can, trying to do all the clinical and all the management jobs, there is just never enough time or money. No one even tells me if I'm doing a reasonable job of it. [Ali]

Billie also described a dual role fraught with competing demands. This participant provided a more detailed account of the role responsibilities of being a NUM.

> Staff management, day-to-day staff issues, budget control, monitoring expenses and cost of equipment, and casual staff, how many of those we need, general management of day-to-day functions, quality assurance, performance appraisals, liaising with administration then passing the information back to staff about developments within the hospital. Oh God! and then you're a general staff manager and an administration manager. I also have the experience clinically, so I step in if necessary and help if the need arises. I'm aware that as a nursing unit manager, I am representing two factions — administration and staff — and you can't be seen to be behaving in too much of a one-sided manner. But, there are key things that nurses have been trained to do, encouraged to do, you know, all the extra things, like talk to patients, educate them, but there is so little time because of budgetary constraints and my other responsibilities. (Billie)

Charlie also discussed the overwhelming nature of the role and identified a similar tension

between the clinical and managerial aspects of the role.

> The role is huge, just huge and I find the paperwork, the amount of paperwork, more than I imagined actually, 'cause no one told me what to expect and I can't believe how much paperwork there is to do . . . I don't get any help with it at all. There is also performance management, like with staffing and budgeting. Also sometimes, I have a problem with my clinical compassion, you know. I think that sometimes as a manager all I'm supposed to care about is the dollar. Yet, what I'm trained or programmed to do is care for the needs of the patients. [Charlie]

These quotes illustrate the feelings of all participants about the sheer scope of their role. Each of them described the work expected of them and then went on to describe a lack of information and resources and the tensions this created for them between the managerial and clinical aspects of their role. For example, Charlie highlighted the nature of this tension when discussing her feelings of compassion and how they do not really fit with her image of what a manager should do. All the participants said it was very difficult to find enough time, staff and financial assistance to be both a nurse and a manager. Both Charlie's description of clinical compassion and Billie's desire to talk to patients suggests that it was not easy for these NUMs to distance themselves from their role as clinicians. Interestingly, three of the Level 3 NUMs in the study, who by definition are more removed from bedside care, also described a similar tension created by their desire to continue to provide clinical care.

> I don't have a clinical load, but if it's really busy I go in and give them [the nursing staff] a hand. But it's [the NUM role] supposed to be non-clinical, which means it's purely management. I've got rosters, budgets, skill mixes, I've got quality activities, I've got statistics to do, in between going to all those dreadful bloody meetings that we have to go to, where you seem to hear the same sort of information over and over, never anything new. It's also budgets, looking at the way

staff does the stores, whether they're over ordering, it's looking at new equipment, looking at fundraising, trying to raise money so that we can get stuff we can't get out of our budget. The thing is that I feel much more comfortable when I am doing hands-on nursing, I really miss it. [Frankie]

Frankie's role was clearly more management-orientated than that of the Level 1 NUMs: this did not prevent the participant from missing patient care and having limited time to assist with bedside care. One of the other Level 3 NUMs also felt there was a conflict within the role that was not just related to a lack of time to provide clinical care, but actually encompassed a tension between her role as an NUM and the core values she held as a nurse.

> I have found it very hard, personally, to stand up for what nurses want and believe, and at the same time do what administration wants. I try to hold the profession [of nursing] in respect, but all the time admin devalues it. I find I can never fulfil the role [of NUM] as they would like me to, I feel like no one cares if NUMs burn out. [Billie]

Another of the participants described the process of promotion from a Level 1 to a Level 3 NUM as being quite difficult, because, as well as feeling unprepared for the job, it also meant giving up the clinical component of the Level 1 role.

> I went from being the NUM of [name of one clinical area] with about 0.5 managerial time each week, to a full-time nurse manager, with little clinical input. I have gone from being a clinical person to a manager basically overnight, and I must say without much in-service on how to do that. It has been really hard to let go of my clinical role. [Jaz]

The finding that these first-line nurse managers experienced tensions between the dual aspects of the role is consistent with the literature that discusses the difficulties of being a clinician–manager.[4,5,27] However, in addition, this study also identified that the NUMs also felt uninformed, time pressured and under-resourced in their efforts to perform all aspects

of their role appropriately. Many of the participants also felt they did not have the opportunity to contribute to organisational decision making.

I feel like I'm kept in the dark about a lot of things that affect my staff and my ward ... there is just not enough communication about changes between senior management and NUMs ... I find that the job's just getting so big, or mine is, and for the other NUMs too, the expectations of us are unrealistic, it's frustrating, and there is nothing we can do, we can't make decisions about most of the stuff that goes on. I lie awake at night worrying about the lack of resources, budgetary constraints and you don't get enough sleep, you come to work feeling absolutely unable to cope for the day. [Kim]

Oma, another participant, also described a role defined by multiple responsibilities as well as a lack of power to control such things as the budget, for which she was responsible.

I am responsible for many different facets of the operation at the coalface. I am responsible for day-to-day management of the unit in terms of resource allocation, in terms of, you know like human resource allocation, ensuring that the skill mixes are correct on the ward, ensuring that the staffing levels are adequate to meet the activity on the ward. I'm also responsible for the ward's budget, to a degree anyway. I mean some things are beyond my control but each month I have to do a budget report anyway. [Oma]

Willow also outlines the expansive nature of her role and, like a number of the other participants, commented on having to attend numerous meetings that did not seem to equate to a meaningful role in the decision-making processes of the organisation.

Well I've been a NUM for quite a few years now and the role just keeps getting bigger and bigger. There was a time when matron did all the rosters, and the hospital administrator ordered all the supplies, all the charge nurse did was concentrate on looking after the nursing staff and the patients, but not

anymore. Now I have to look after the rosters, the budgets, the supplies, and file millions of reports, well it feels like millions, and attend lots of pointless meetings, where no one listens to me anyway! There is so much bullshit going on in hospitals today, we don't have any fun anymore. I work hard, I try to look after my staff and my patients, and I try not to go over budget 'cause that makes them mad ...

Them? [Interviewer]

Yeah, the powers that be, the people upstairs, those with the power to decide, you know ... Like I have to keep within a budget that I have no say in and I have to be responsible for everything that happens on my ward even when I have no control of how or why some things happen, its madness and its very frustrating. [Willow]

Hali discusses the frustration she feels when decisions she made as the NUM were overturned by senior management.

I would say the main area that there's frustration is staffing, I think if you're saying to them [senior management], I need seven nurses on this shift, that's it, not negotiable, that's what you need. Yet, they just go ahead and change it without finding out why that many nurses are needed. [Hali]

As Kanter[19] indicates, a lack of power is generally inherent in the role of first-line managers. This can be seen in the excerpts from the NUMs' stories in which the common thread was a lack of access to the structural determinants of power. A collective picture of the organisational role described by these NUMs suggests a role heavy with responsibility, but lacking access to information, support, resources and opportunity.

Discussion

The organisational role that the NUMs described consisted of trying to balance and sometimes juggle their substantive clinical and managerial duties, while lacking access to the structural determinants of power described by Kanter.[19]

The finding that nursing unit managers experienced responsibility without power is significant, as few studies have explored the personal experiences of NUMs. The participants' obvious desire to continue to care for patients and staff while dealing with an onerous administrative load caused them to feel overwhelmed. This was exacerbated by the challenges of staff shortages, financial constraints and a lack of time, information and equipment. By considering these findings within the framework of Kanter's[19] theory of organisational power and by analysing the participants stories from four perspectives,[26] their perceptions about themselves, their work and the context of health care clearly illustrated the lack of organisational power embedded within their role.

This is consistent with much of the existing literature about the roles of nurses — for example, Speedy and Jackson[20] made the observation that despite the fact that nurses make up the bulk of the health care workforce: "this dominance does not translate into significant organisational power." The literature also indicates that nurses are not adequately represented on the decision-making or financial committees of health care organisations.[11,18] So, while there is a significant amount of literature about the power of nurses generally,[9,10,12-14] little research has been conducted into the roles of nurses in management positions, making the findings of this study significant.

This study also found that the NUMs experienced conflicts within their role, and these conflicts were evident on two levels. The first type of conflict existed because, as nurses, the participants were concerned with caring for patients and staff. This clashed with their perceptions of their role as managers, which they felt was more aligned with the traditional managerial image discussed in the literature that focuses on objectivity, administrative duties and resource manipulation.[7,8] On another level, tension was also evident in the incompatibility that existed between the NUMs' level of responsibility and their authority to garner sufficient staff, information, time, and resources. In particular, a majority of the NUMs felt frustrated with their lack of input into the decision-making processes of the organisation. They described this lack of influence in terms of having limited opportunities to contribute to, or influence, organisational decisions that affected their ward and staff. In most cases the examples used by the NUMs to describe this lack of input related to not being heard at meetings and also having their decisions overturned by senior management. Another aspect of the NUMs' feelings about lacking an organisational voice revolved around the perceived lack of respect for their nursing values.

The findings indicated that many of the conflicts and frustrations experienced by these NUMs stemmed from a lack of access to the structures of organisational power. In turn, this caused the NUMs to feel overwhelmed by their responsibilities, and frustrated within the organisation. According to Clare et al,[18] nurses are the backbone of health care, yet they remain "at the bottom of the pile" when it comes to the health care system because nurses lack the professional status, power and "credibility of medicine". Kanter[19] also describes organisational power as being closely linked to the "overall state of the system", in that formal power is invested in certain ranks and is maintained by the system and the incumbents' credibility as a leader.[19] If this is the case, then it is the researcher's belief that these participants do not have a level of power commensurate with their role responsibilities.

According to Kanter's[19] theory, first-line managers often find themselves in powerless positions, because they lack access to adequate opportunities and lines of information, support and resources to get the job done effectively, and this was certainly true for the NUMs who participated in this study. The findings indicate that the NUMs in this study lack organisational power commensurate with their role responsibilities because they do not have adequate access to organisational opportunities, time, staff, information and resources. While only one of the NUMs mentioned power explicitly, saying that power resides "upstairs", all the stories demonstrated that organisational power is not embedded within the role.

As Kanter[19] suggests, happy and successful managers need to know they are heard and respected. They need to know that they have access to the structural determinants of power in order to initiate change, to take risks, and still have the backing of the organisation. This recipe for successful, powerful managers was not evident in these NUMs' stories.

Implications

In this study, the most significant finding was that these NUMs lacked power commensurate with their role responsibilities. However, as discussed earlier, the literature indicates that powerlessness is evident in many traditional nursing roles[20] and according to Kanter[19] it is also a feature of first-line management positions generally. Thus, it is unlikely that these participants are the only NUMs to have responsibility without power. With this in mind, potential and existing NUMs need to clearly understand the challenges of having a first-line nursing management role, and this is best achieved by being aware of nature of the role.

One implication of this study relates to how disempowerment impacts negatively on nurses. To empower these NUMS, macro changes are needed in the prevailing health care organisational culture, because, as argued by Buresh and Gordon[10] and Diers,[11] nurses will become more powerful when they start to believe that they have an obligation and a right to be influential in health care contexts. By becoming more aware of power issues, rejecting the dysfunctional, disempowered elements of their nursing role, and if the culture of health care valued the professional expertise and values of nurses to a greater degree, NUMs such as those who participated in this study and who feel disempowered would be more likely to demand greater access to the structures of organisational power.

As part of a new, more powerful vision of the NUM's role, a revised job description, based on critical review and reconceptualisation, could be the first step needed to more clearly embed an appropriate level of organisational power into the new role. This can be achieved by formalising the access that NUMs have to the decision-making processes of the organisation. This strategy alone will contribute to the NUMs' ability to gain more information, staff, time and resources.

In order to implement such significant cultural changes to the health care workplace, new policies would be needed to guide practice. As with any new policies, strategies for communicating the policy changes to all staff members need to be included, and this should incorporate mechanisms for evaluating the workplace responses to the changes, as the current NUM position is entrenched in the system, and according to the findings of this study, is a reflection of the powerlessness of nurse roles generally.[20] In addition to new policy formulation, health care organisations would also need to actively encourage a culture of open communication between all levels and professions of health care workers if policy changes are to have any chance of success. It needs to be noted that resistance to changes in the balance of organisational power in any organisation is likely to be strong, as those with greater power may oppose such changes. However, changes such as these are possible, evidenced by the recent development of more empowered roles for some nurses, for example, nurse practitioners. Thus, by formalising organisational power within the NUM role and by supporting potential and existing NUMs to participate in the decision-making processes of the organisation this first-line management role will have more potential to evolve into a more powerful one. The benefits of this would be twofold: first, greater job satisfaction for the NUMs and their staff; and second, the NUMs could more easily contribute to, and meet, organisational goals.

Based on the findings of this qualitative study, a larger study is currently underway in NSW that explores the perceptions of more senior nurse managers regarding the level of responsibility and power inherent in their roles.

Competing interests

The author declares that she has no competing interests.

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