

ORIGINAL RESEARCH

Rural nursing unit managers: education and support for the role

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ABSTRACT

Introduction: Nursing unit managers (NUMs) occupy the often unenviable position of first-line management in many health services in Australia. As such, their role is complex and multifaceted requiring an intertwining of their clinical and managerial responsibilities. While there is an abundance of studies that explore and describe the various management roles in many professions and industries, little is known about the experiences of nurses as managers, particularly in rural settings. This article focuses on the education and support needs of rural nursing unit managers.

Methods: A qualitative study design was used to explore the stories of a number of nursing unit managers in rural New South Wales, Australia. Data was collected using semi-structured individual interviews. Data was analysed using a voice-relational method as a framework for more clearly hearing the voices of participants. This method of data analysis is particularly useful for hearing from those who do not usually have a 'strong' voice, for gaining an understanding of the context of the interviews, and for acknowledging the role of the researcher in the research process. All NUMs employed in a single regional health authority in rural Australia were invited to participate.

Results: Out of 42 NUMs in the region, 20 agreed to be interviewed. Nursing unit managers were asked to reflect on their experiences prior to and during the early days within the position. In summary, all the NUMs: believed they were promoted because of their clinical expertise; felt unprepared for the managerial and administrative aspects of their role; continued to identify as nurses rather than as managers; found the role isolated them from their former peer group. Those employed in small facilities had limited opportunities for education and peer support.

Conclusions: Based on the NUMs' experiences and suggestions, the following information would have helped them to cope with the demands of their new role: information and discussions about the role expectations of first-line manager, from both an



employee and employer perspective; human resource and financial management skill development; leadership skills; negotiation and conflict resolution; a clear and realistic role description.

Keywords: education and support, rural nursing unit managers, voice-centred relational data analysis.

Introduction, background and context of the study

In Australia, as in many other countries, Nursing Unit Managers (NUMs) have replaced the senior nurse or charge nurse, and with the change in title came a change in the level of responsibility¹. In Australia today, a NUM is responsible for the day-to-day management of a ward or clinical unit. This includes managing human, physical and financial resources; interpreting policies; maintaining standards; and providing nursing leadership^{2,3}. It has been recognised that nurse managers in rural settings have even broader roles than those in metropolitan areas⁴. Furthermore, they work in an environment where they are isolated from peers, educational opportunities and often have to cope with limited resources⁴.

The role of NUM continues to evolve and expand, with many being responsible for a heavy burden of administrative tasks with no clerical help. These tasks may include: adhering to budgets, conducting annual staff performance reviews, reporting on workplace health and safety and quality assurance issues, meeting the workplace educational needs of staff and dealing with conflicts involving staff or patients. The role generally also requires the incumbent to deliver clinical nursing care, or to act as a senior clinical resource person for ward staff⁵. This is particularly the case in rural healthcare settings, where the NUM is often the senior, most experienced nurse⁶. There is little consensus within or between healthcare organizations about the scope of the role of NUM.

In a review of the literature regarding the role of nurse managers, Oroviogioicoechea⁷ indicates that there is an urgent need to develop effective strategies for selecting,

educating and supporting nurses who take on this multifaceted role. According to both Oroviogioicoechea⁷ and Duffield et al², the dual clinical and management aspects of the role can lead to personal conflict and role confusion for many NUMs, linked to a lack of educational preparation for their new role. Similarly, Duffield and Franks⁸ note that there has been little research into what the role of a first-line nurse manager is, or what it should be. This causes difficulty when developing effective education and on-going support programs for NUMs.

In this study, I was interested in exploring the NUMs' stories about the education and support they received in their role. In particular I was interested in hearing about the skills they felt they needed to function effectively, how they gained those skills, whether they felt they were suitably prepared to take on the role, and finally, the level of on-going support available to them.

Methods

Setting and sampling

Semi-structured individual interviews were conducted with 20 NUMs employed by a regional health authority in northern New South Wales, Australia. The area of interest provided health services for just over 175 000 people and covered 98 000 km². In this area, there were 20 public hospitals and community health centres, employing over 3000 staff, of which 42 were NUMs⁹. Each NUM was sent a written invitation to participate and the researcher interviewed those who responded positively. Sixteen of the interviews were conducted face-to-face and four by telephone. All interviews except one were audiotaped. In the



one exception the participant did not consent to audiotaping so the researcher wrote notes instead.

Each NUM was asked two opening questions and then if necessary a number of prompting questions:

1. Opening question 1: Thank you for agreeing to talk with me, first can you tell me why you agreed to be interviewed?
2. Opening question 2: Please tell me what it is like to be a NUM.

Examples of prompting questions: 'What was it like for you when you first took up the position of NUM?', 'How did you gain the skills you need to perform effectively in the role of NUM?'

The majority of the interviews were performed in the NUMs' offices, or other workspace during normal working hours, with four interviews conducted over the telephone, as the participants' choice. Each interview lasted approximately 35-45 min and the audiotapes were later transcribed for analysis.

Data analysis

Data analysis was conducted using a voice-centred relational model adapted from the work of Gilligan¹⁰ by Mauthner and Doucet¹¹. This method of data analysis has its roots in educational psychology and feminism, and it is particularly well suited to research that seeks to hear those who do not have a strong voice. It allows the researcher to hear the participants and understand their stories within a context. This method was chosen because although it is very time consuming, it allows the researcher to shift the focus of the analysis from the story to the storyteller, to attempt to hear what it is like to be a NUM, to understand that the story cannot be separated from the context. The entire working world of the NUM is embedded in each individual's story. The relationships, the environment, and the organisational culture of the health care facility are all factors that influence

the experiences described by the participants. Additionally, this method also allows the responses of the researcher to the stories to become part of the research. As a nurse researching nurses, I cannot be unbiased. I found that I empathised with the participants, at times their stories touched me, angered me or cause me to laugh because I was part of the context from which their stories arose.

After transcribing each interview, I listened to each tape 4 times and with each listening, I attempted to hear different elements of the NUMs' stories. The first reading/listening of each interview was uninterrupted, in that I listened to the full interview while reading the transcript before considering each NUM's story. After each tape finished I reflected on the whole story. I thought about what the participant told me about being a NUM. I thought about the plot, the characters, the tensions and the consequences and summarised the main points on an index card. According to Doucet and Mauthner¹² this first reading is common to many other methods of narrative analysis used to interpret interview transcripts, in that plots, themes and events are considered. However, the second stage of the first reading using a voice-centred relational approach requires the researcher to reflect on his/her responses to the interview¹³. So, immediately following the first reading of each transcript, I noted in a journal my own reaction to the speaker and the story for each interview. I asked myself what I thought of the speaker, how I reacted to the story and whether I identified with the speaker.

Brown and Gilligan¹⁴ indicated that this second reading allows the researcher to identify the voice of the participant and allows participants to speak of themselves before we, the researchers, speak of them. Mauthner¹³ added that in this reading it is important to hear when the speaker shifts the focus from 'I' to 'we' or 'you', because this shift indicates not only how a participant perceives themselves, but also how they think others perceive them. The second reading was focused on the way that each NUM spoke about themselves, I listened for sentences containing the words 'I', 'me' and 'my' in order to gain insight into the identity and role of the NUM from each participant's perspective, as well



as listening for reference to 'you' or 'they' which may indicate what the NUM thinks others think of her/him.

During the third reading, I listened for information about the working relationships of each NUM. I considered how they described their interactions with others, and listened for the basis of those interactions, such as, who had the power, who had the voice. I found this reading the most difficult, because I had to consciously set aside my own roles and relationships as a nurse in order to hear what the participants said about theirs. Brown and Gilligan¹⁴ described the third and fourth reading as focused on relationships. In these two readings the researcher is encouraged to identify how the speaker 'experiences themselves in the relational landscape of human life'.

The final reading focused on the context of the NUMs' stories, I looked for the political, societal, cultural and organisational aspects of their lives that impacted on their role. Mauthner and Doucet¹¹ indicated that this reading is focused on 'placing people within cultural contexts and social structures'. The reading helped me to understand how the organisational context of health care was embedded in their relationships and the professional identity of each NUM.

I looked for aspects of the stories that related to every NUM. Some aspects of their experiences were heard in their collective voice, while other aspects were common to a few, or were even unique. I reflected on my responses to their stories, their relationships and their contexts, and during this time I decided how I would present and interpret their stories in order to give them a voice. This method of data analysis is fundamentally different from that employed in many qualitative studies, such as thematic analysis, which identifies themes that cut across individual stories, and narrative analysis, which focuses on structure and content, coding discourse in an effort to more clearly understand the language. In voice-relational data analysis the researcher undertakes a detailed and time-consuming reflection on each participant's story and reaction to that story, in order to keep

the respondent's voice and story alive, and to make explicit the researcher's role in the interpretation of the data.

Ethical considerations

The University of New England Human Research Ethics Committee and the New England Area Health Service Ethics Committee granted ethical approval for this project. Following the granting of ethical approval the New England Area Health (NEAH) Service nursing department provided me with a list of the names of all NUM employed by the service, so that individual written invitations could be sent. A further ethical consideration was that many of the NUMs in NEAH work in small facilities. In order to protect their identity, the present study only identified them as working in NEAH. Finally, the gender of the NUMs is not provided because there were only a small number of male NUMs in NEAH, and any indication of gender could lead to identification of individuals.

Limitations

The aim of this project was not to generate findings that could be generalised to other groups of NUMs, but to hear the stories of these NUMs, from the context in which they worked. Many other major influences on the role of the NUM have not been mentioned in this paper. For example, it is acknowledged that factors such as gender issues, issues of power, the traditional image of the nurse, rivalries between nurses and other healthcare professionals, and organisational policies and structures all make up the societal and organisational context in which the NUMs work. A further limitation was that four of the interviews were conducted by telephone, preventing me from observing the participant in their normal working environment. However, had I decided not to conduct telephone interviews I would not have had the opportunity to hear these four NUMs' stories.



Results

Learning to be a NUM

The collective voices of the NUMs told of feeling overwhelmed by their new role, they talked about being under-prepared and unsupported in the role, not only when they first took on the role, but also subsequently.

Below are examples of some of the comments that illustrate how the NUMs described their first impressions of the role:

- 'It was sink or swim'.
- 'I had to fly by the seat of my pants'.
- 'I was thrown in at the deep end!'
- 'I arrived one day and I was NUM'.

The feelings that these comments elicited in me were that these NUMs were 'adrift' with little guidance about what to expect in their new role. I felt angry about the lack of support provided for them when they made the transition from registered nurse to NUM. I also felt concerned that the lack of preparation these NUMs described might set them up for failure.

Education and training

The majority of the NUMs did not have any managerial qualifications, despite the fact that possession of a qualification in health management or willingness to pursue such study was listed as essential criteria for the position⁹. The few participants who did have or who were working towards a management qualification had sought opportunities for study independently.

According to the NUMs interviewed, it remained largely up to the individual to seek out suitable sources of management education. The NUMs also indicated a certain unwillingness to identify with the role of 'manager', preferring to perceive their role as primarily that of a nurse. This was true even for those participants who no longer carried a clinical workload. Some of the NUMs' comments regarding education for the

managerial aspects of their role highlight their lack of preparation and educational opportunity:

- 'I got my education from other NUMs'.
- 'I wanted a stronger handle on how to run the job, nothing was on offer so I went looking for a suitable course'.
- 'I AM studying a higher qualification, but not in management.... I do that by trial and error!'

In my opinion, the NUMs tended to devalue and discount the administrative and managerial aspects of their job, preferring to talk about their nursing role. This may have been related to the context of health care in Australia, in which nurses have fought hard to develop a professional identity. Currently a 3-year bachelor degree program is the minimum requirement in Australia to gain nursing registration. Many nurses then go on to postgraduate study in speciality areas, requiring personal sacrifice and further years of study. It is often these highly skilled nurses who are encouraged to seek promotion to NUM positions². This is important information that assists the reader to gain some understanding of the context of the NUMs stories about educational preparation, and an understanding of why NUMs might identify themselves more as nurses, and devalue the managerial aspects of the role.

When listening to the NUMs, I found that few had any desire to seek out further educational opportunities in management studies. I felt this was hardly surprising when it was considered that the NUMs interviewed were expert nurses, most of them over 45 years old, who invested a great deal of time and energy in achieving their level of nursing skill, but despite this found they were only novice managers.

A number of the NUMs described being surprised that the clinical expertise that had assisted them in gaining the job was not really any help in dealing with the managerial aspects of the job. Thus, rather than focusing their energies on addressing their lack of preparation for management and administrative tasks, they relegated that aspect of their role to second place and continued to spend more of their time



involved in the clinical issues of the ward. I felt their frustration as it dawned on many newer NUMs that the job was much more complex than they had anticipated.

Support structures

All the NUMs voiced concerns about the lack of support they received since taking on the role. Collectively they described how difficult and isolating it was to be a first-line manager. This was exacerbated in facilities where there was only one NUM. Most of the participants volunteered information about who supported them and how they developed support structures that helped them cope with the day-to-day challenges of their role:

- 'I discuss difficult things with other NUMs'.
- 'Peer support is REALLY important to me'.
- 'In the role of NUM everyone 'dumps' on you, and you can only talk about it to other NUMs'.

I talk about issues to other NUMs, because you can't debrief to your staff, it's hard though because some of them used to be my best mates'.

Peer group support was mentioned by all the NUMs as the way they learned, grew and coped with the job. When interviewing NUMs from smaller facilities where there were only a few other NUMs or, in some cases, no other NUM positions, I heard how difficult it was for them to gain a sense of being part of a peer group, and how, at times, these NUMs felt alone. This was compounded by the context in which many rurally based NUMs work. For example, in small towns, the NUM had usually been promoted from being one of the nursing staff on the ward where, in many cases, all nursing staff had worked together for many years. This meant that the NUM and the nurses were all part of the same small community and, in many cases, were all part of the same social circle, possibly with friends or relatives in common. For this reason it was difficult for the NUM to maintain a professional distance. I felt that this compounded the sense of isolation felt by newly appointed NUMs, particularly those in small rural healthcare facilities.

A brief summary of findings that impact on education and support for the role of NUM

In the course of the interviews, the NUMs talked about the many challenges and issues that they faced, particularly in relation to education and support. In summary, all the NUMs:

- believed they were promoted because of their clinical expertise.
- felt unprepared for the managerial and administrative aspects of their role.
- continued to identify as nurses rather than as managers.
- found the role isolated them from their former peer group.
- employed in small facilities had limited opportunities for education and peer support.

Discussion

Based on the NUMs' experiences and suggestions, the following information would have helped them to cope with the demands of their new role:

- Information and discussions about the role expectations of first-line manager, from both an employee and employer perspective.
- Human resource and financial management skill development.
- Leadership skills.
- Negotiation and conflict resolution.
- A clear and realistic role description.

A workshop program for new and prospective NUMs would provide a means of developing peer support, particularly if presentations from more experienced NUMs were included. This type of preparation would allow for a sharing of experiences, which was something that all NUMs wanted. Additionally, informal workshops would increase the potential for developing peer support networks or even facilitate the development of more formal mentorship



programs. While it is recognised that NUMs from small rural facilities may find it difficult to be released for work to attend such workshops, their attendance, at least at some workshops, would put them into contact with their peer group and other relevant support people.

To follow up the workshops, on-line information, video conferencing or distance education packages could be used in tandem with phone and email communications to provide rural NUMs with vital information and support networks. Because one of the issues identified in this study was that the NUMs tended to devalue the managerial aspects of their role, the workshops could include information that would create awareness that, as a NUM, these nurses were actually assuming a 'second career'. Many other professions acknowledge the challenges of assuming a managerial role, but some professionals tend to wear the hat 'that fits best'¹⁵.

In addition, as well as initially developing training sessions for new and prospective NUMs, on-going workshops addressing specific learning needs identified by NUMs could be offered at regular intervals to build on the earlier knowledge gained, and to provide an opportunity for peers to meet and share experiences.

Conclusion

Because the findings discussed in this article also reflect the responses of the researcher, I will conclude with a brief comment on the responses to the opening question asked of all participants: 'Why did you agree to talk to me?' It was surprising to discover that many of the NUMs indicated that it was a way to be heard, a way to have a voice. As one NUM explained.:

'Talking to you is a way to have a voice, nurse unit managers don't have much of a voice, so it's an opportunity to have someone listen!

This comment validated the use of a voice-centred, relational approach to data analysis because this approach allowed the NUMs voices to be heard. Other findings from this study

illuminated the way in which the NUM role is constructed, and linked the lack of voice described by the NUMs to the organizational culture of health care. In order to assist NUMs perform their role more effectively, the role of NUM needs to be more valued, recognized and supported as a managerial role, rather than being seen as 'just a nursing position'.

Finally, while I believe that enhancing the provision of education and support for NUMs is vitally important, further research is needed to address many of the other challenges faced by the NUMs.

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