NURSING UNIT MANAGERS’ LEARNING FACILITATION PRACTICES: A PHILOSOPHICAL HERMENEUTIC STUDY

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Certificate of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

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Publications arising from this research

Journal articles


Conference presentations


Abstract

The aim of this research was to more deeply understand how Nursing Unit Managers (NUMs) facilitate learning in clinical workplaces. In particular, an understanding of the nature of NUMs’ actions to facilitate qualified nurses’ learning in their clinical units was sought. This understanding is important in contemporary healthcare contexts as nursing knowledge and skill development underpins the delivery of safe, quality care to patients. While a review of the academic literature revealed a learning facilitation dimension of NUMs’ roles, few studies explored the nature of this facilitation, the influence of contextual factors, or of NUMs’ individual perspectives on their learning facilitation practices. This research sought a more nuanced understanding of NUMs’ learning facilitation practices, and how they were enacted within ordinary work routines.

A philosophical hermeneutic approach was chosen to frame this research. Philosophical hermeneutics, which enables deeper understanding of individual perspectives within a socially constructed environment, provided an appropriate framework for exploration of the diverse perspectives around learning facilitation held by research participants. Thirteen NUMs working in two public hospitals in a metropolitan location participated in the research. Text, as the source of understanding in philosophical hermeneutics was constructed from participant interviews and a period of observation of NUM learning facilitation in the clinical workplace. Consistent with a philosophical hermeneutic approach, interpretation was iterative and ongoing and occurred during all phases of the research including before, during and after each fieldwork interview as well as before, during and after each period of observation and shaped questions asked within subsequent fieldwork encounters.

Through iterative and deep exploration of texts, the unique and specialised ways that NUMs influenced learning in clinical workplaces were revealed. NUMs’ learning facilitation practices were found to be complex, fluid, embodied and embedded in their every-day work routines. NUMs’ learning facilitation practices were deployed through engagement with staff individually, within teams, and through artefacts, and were shaped by NUMs’ inherent qualities and knowledge including their identities, conceptions of staff learning, knowledge of staff performance, and motivations.
Further, power was revealed as a central and uniquely enacted driver of NUMs’ learning facilitation practices.

The key contribution of this research is new knowledge of NUMs’ learning facilitation practices including the nature of those practices and the way that power, together with NUMs’ inherent qualities and a complex network of contextual factors arising from the external, organisational and unit environments, combine to shape those learning facilitation practices. This knowledge is meaningfully drawn together in a Living Systems Model of NUMs’ Learning Facilitation Practices. This model allows simultaneous consideration of the nature of NUMs’ learning facilitation practices and the way that contextual factors, NUMs’ inherent qualities and values and NUMs’ use of power come together to influence facilitation of nurse learning in clinical workplaces.

Given current concerns about safety and quality in healthcare, this research has contributed important new understanding around NUMs’ learning facilitation practices and has opened up possibilities to improve patient safety and care through enhancement of nurse learning. By making knowledge of NUMs’ practices explicit, there is potential for NUMs to learn more about their own practice, and for programs of nursing management education to enrich student understanding of their roles in influencing staff performance.
Glossary

Nursing Unit Manager (NUM)

A Registered Nurse who manages nursing staff, and coordinates patient care activities and operational processes associated with the unit’s work.

Registered Nurse (RN)

A nurse who has a professional qualification in nursing and is registered as a Registered Nurse with the Australian Health Practitioner Regulating Agency.

Enrolled Nurse (EN)

A nurse who has undertaken training in nursing and is registered as an Enrolled Nurse with the Australian Health Practitioner Regulating Agency.

Assistant in Nursing (AIN)

An employee who undertakes nursing duties but does not have registration as a Registered or Enrolled Nurse.

Clinical Nurse Educator (CNE)

A Registered Nurse who provides education to nurses within the ward/unit.

Clinical Nurse Specialist (CNS)

A Registered Nurse who has relevant specialised training and experience and contributes to professional development and clinical practice in a unit or ward beyond what is expected of Registered Nurses.

Clinical Nurse Consultant (CNC)

A Registered Nurse who has a high level of tertiary education and extensive experience in a clinical area, and relevant specialised training in a unit or ward. CNCs are involved in teaching, research and professional practice development, and serve as a resource to other staff in a clinical specialisation.
**Team leader**

A Registered Nurse who is allocated responsibilities by the NUM for organising the clinical care in a unit or ward for the shift they are rostered to work.

**Clinical unit**

A ward or department in a hospital that provides care to a group of patients, and forms the work context for staff employed to provide such care.

**Skills pathway**

A list of goals, based on clinical skills including those that are specific to a clinical area, that guides incremental learning and development of nursing staff working in the unit.

**Mentor**

An experienced Registered Nurse who provides constructive career development guidance to an experienced nurse.

**Preceptor**

A Registered Nurse who has undertaken a short hospital-based training course and works for a defined period of time to orientate a new staff member to the clinical workplace.
Chapter 1: Introduction

1.1 Research overview

This thesis presents findings of research that aimed to deepen understanding of Nursing Unit Managers’ (NUMs’) learning facilitation practices in clinical workplaces. A qualitative research methodology, underpinned by philosophical hermeneutics, was used to explore NUMs’ perceptions of how they facilitate learning for nursing staff within their clinical contexts. Texts for interpretation were constructed from interviews with NUMs in two hospital sites, and from field notes taken during periods of observation. Interviews were used to seek the participants’ perspectives on their roles, the context of their work, their perspectives on staff learning, and their approach to influencing staff performance and learning. Periods of observation during routine nursing meetings explicated the participants’ interactions with staff and how they facilitated learning through these interactions. Drawing on these texts, deeper understanding, consistent with a philosophical hermeneutic tradition, was reached through processes of question and answer, hermeneutic spiral and fusion of horizons. NUMs’ learning facilitation practices were found to be complex, nuanced, and contextual, reflecting individual identity, conceptions of staff learning, knowledge of staff performance, and motivations. These findings were coalesced and represented in a Living Systems Model of NUMs’ Learning Facilitation Practices, as a key outcome of this research.

1.1.1 Rationale for this research

This research recognises the centrality of NUMs’ influence on the performance of safe, quality clinical work within hospital contexts. Safety in healthcare has become a global concern and, despite efforts to enhance the safety and quality of healthcare, patients continue to experience adverse events (Slawomirski, Auraaen, & Klazinga, 2017). Many of these events occur in hospitals as major providers of healthcare (Australian Institute of Health & Welfare [AIHW], 2016). NUMs, who have a primary role in managing nursing staff performance in hospital workplaces, have a significant role to play in influencing the quality of patient care through learning facilitation.
Despite NUMs’ central responsibility for assuring patient safety and high-quality patient care through staff development, their learning facilitation roles have received limited attention in academic literature and policy documents that describe the nature of their work. Currently little is known about how NUMs facilitate learning in their units. The limited references to learning facilitation roles in NUMs’ job descriptions, as well as the presence in hospitals of formalised educational services including centralised training departments and appointment of Clinical Nurse Educators, probably occludes this aspect of their practice. However, NUMs’ known proximity to clinical work suggests that they have opportunities to influence learning that have previously been understated. This research sought to explore NUMs’ work in influencing learning, and the contextual and personal factors that influence their learning facilitation actions and decisions. It sought to expose an aspect of NUMs’ work that should be recognised for its contribution to the enhancement of patient care.

At the point of care delivery in hospital units are nurses, most of whom are Registered Nurses (RNs), although smaller numbers of Enrolled Nurses (ENs) and Assistants in Nursing (AINs) are employed in some units. The educational needs of qualified nurses employed in public hospitals is dependent on their level of experience and the nature of the unit they are working in (Gohery & Meaney, 2013). There are few, if any, situations where an RN, as the most highly qualified category of nurse, would commence work in a specialised clinical unit with the scope of knowledge and skills to be able to perform competently (Ashley, Brown, Halcomb & Peters, 2017). There are four key reasons why this is the case.

Firstly, most work units in large hospitals are specialised, for example coronary care, renal dialysis, ophthalmology and surgical. Nurses who are new to a particular specialty are required to develop a particular range of speciality specific knowledge and skills that will enable them to work safely and effectively within that specialty area. These skills are often termed ‘advanced practice skills’ as they surpass those learnt within an undergraduate or pre service nursing education program. For example, nurses working in renal dialysis need to learn how to care for patients receiving complex dialysis, including technical aspects of their treatment. These
skills are not generic and the unit must create opportunities for new staff to develop these competencies (Lima, Jordan, Kinney, Hamilton, & Newell, 2016).

Secondly, nursing work in recent times has been challenged by ‘case mix instability’ (Chiarella & Roydhouse, 2011) where high-acuity patients with unknown diagnoses are moved from the emergency department to wards and units for assessment and initial care, to free up beds in the emergency department. This places enormous pressure on nurses to develop broader knowledge bases and to acquire a much wider set of skills to enable safe and effective work with these patients, not to mention the pressure placed on them in terms of workload and stress. In these circumstances NUMs have responsibility for upskilling staff, sometimes at short notice.

Thirdly, developments in technology and clinical treatments are continual and require nursing and other health professionals to adapt and incorporate new knowledge and skills into their practice. Hospitals are required to ensure staff are competent and able to implement evidence-based best practice. Enabling nursing staff to acquire knowledge and skills required to adopt change is an essential and ongoing responsibility that often falls to NUMs (Lima et al., 2016).

Finally, and most importantly, hospitals have a responsibility to uphold and promote safe care. RNs in particular are responsible for clinical decision making and practice that carries potential risk for patients. Their ongoing need for learning means that educational experiences are required that ensure competence and safe practice (Lima et al., 2016).

RNs, ENs and AINs working in the acute care sector have complex and ongoing learning needs (Gohery & Meaney, 2013). NUMs, as nursing leaders in their units are responsible for ensuring these learning needs are met, however, in contemporary literature, there is little attention paid to how NUMs facilitate this learning. A comprehensive approach to understanding NUMs’ learning facilitation practices and approaches that seek to safeguard patient safety in contemporary dynamic and high-pressure hospital contexts is required. Deeper understanding of NUMs’ learning facilitation practices provides a focus for professional development and curriculum design in nursing management education.
1.1.2 Research aims and questions

The aim of this research was to gain a deeper understanding of NUMs’ learning facilitation practices in clinical workplaces. I was particularly interested in developing understanding of how contextual factors alongside NUMs’ perspectives on staff performance shape their learning facilitation practices. I sought to extend contemporary understandings that described NUMs’ learning facilitation work as formal, tangible tasks, and reveal the more nuanced nature of NUMs’ learning facilitation practices including tacit but powerful learning facilitation strategies.

To achieve my research aim, I developed the following research question:

How do Nursing Unit Managers facilitate learning in clinical workplaces?

To achieve this understanding, and guide my research, I developed four sub-questions:

1. What contextual factors influence Nursing Unit Managers’ learning facilitation practices?
2. How do Nursing Unit Managers perceive their role in facilitating learning in the clinical workplace?
3. How do Nursing Unit Managers’ perspectives on staff learning shape their learning facilitation practices?
4. What activities do Nursing Unit Managers undertake to facilitate staff learning?

1.1.3 Research context and scope

This research is located in the context of current nursing unit management work in the acute healthcare sector, the broader practices of management and workplace learning, and a wider understanding of professional practice. Drawing on a broad range of research areas, this research focuses on contextual factors that shape NUMs’ learning facilitation practices. The emphasis of this research was to develop an understanding of how NUMs facilitate staff learning in acute hospital contexts by accessing knowledge of education, management and practice theorists and the knowledge and experiences of those currently involved in NUM work. The focus of
this research was to better understand NUMs’ learning facilitation practices, and not to judge or critique these practices.

Although NUM work occurs across a broad range of settings, the focus of this research was restricted to a metropolitan acute care setting. I chose an acute care setting as NUMs’ work in this context is considered to be more complex and fast paced, their interactions with staff more frequent, and matters of safety and risks to patients more intense than those occurring in other healthcare contexts (Needleman, 2013). Furthermore, as most nurses work in the public hospital sector (AIHW, 2015), I considered research within this context to have wide application. To capture the variation that was sought, I chose to conduct this research in two large metropolitan hospitals that host a broad range of clinical specialisations.

The focus of this research was purposefully limited to NUMs’ facilitation of learning for Registered and Enrolled Nurses and Assistants in Nursing in their workplaces. The influence of NUMs’ learning facilitation practices on other staff including medical, allied health and administrative staff was not included, as their interactions with these groups of staff are less frequent, and NUMs’ responsibilities for their performance less direct. NUMs’ work in facilitating patient education was also excluded owing to the highly clinical nature of this practice and the less direct involvement of NUMs.

Finally, as this research aimed to better understand learning facilitation practices within management work, leadership qualities were not included. This was an important distinction that underpinned the scope of this research. My exploration was focused on the participants’ accounts of their learning facilitation work as it was carried out within the ordinary routines of their day, and within their formalised management role. Leadership however, as a reflection of individual behaviours and qualities rather than a formalised position, does not define the scope of NUMs’ work. While leadership is well recognised in contemporary literature as an important component of management practice, and for its capacity to influence performance (Maddern, Lambert, & Dwyer, 2016), the focus of my research was not bound by leadership ideology. However, I acknowledge that there is potential for future research to interpret research findings from a leadership perspective.
1.1.4 Overview of the research approach

An interpretive paradigm was used to guide the design of this research for two key reasons. Firstly, an interpretive paradigm gives voice to the different perspectives of multiple participants (Bailey, 2007). This approach was well suited to my exploration of the diverse perspectives, experiences and clinical contexts that characterised my participant group. Secondly, management work in healthcare is challenging to quantify and, as a social practice, knowledge of its dimensions is best achieved through interpretation of individual experience (Denzin & Lincoln, 2018).

Philosophical hermeneutics, an interpretive approach that enables exploration of human experience, was chosen to guide the design of this research. Within the hermeneutic tradition, language, as represented in text, is considered an avenue for understanding human experience. Language is not only the means by which humans communicate; it is also the means by which humans shape and acquire meaning (Crotty, 1998, p. 88). Interpreting language in the form of text makes understanding of human experience possible.

Philosophical hermeneutics, a distinct branch of hermeneutics, espouses declaration of the interpreter’s pre-understandings as central to understanding. Pre-understandings are a condition for understanding, as they prompt the interpreter to ask questions in the search for meaning (Gadamer, 1975/1989). Within the philosophical hermeneutic tradition, three processes enable the interpreter to gain meaning from text. Firstly, a ‘fusion of horizons’ occurs when the interpreter’s pre-understandings are extended in response to the meaning of the text (Gadamer, 1975/1989). Secondly, questions and answers lead to understanding as the interpreter recognises the dissonance between the text and their own pre-understandings and seeks deeper understanding by asking questions of the text (Gadamer, 1975/1989). Thirdly, a hermeneutic spiral is formed as answers to questions prompt more questions of the text, and this to-and-fro movement leads to deeper understanding, and an appreciation of the relationship between each text and the whole (Paterson & Higgs, 2005). In my research, I was able to develop deeper understanding by drawing on my pre-understandings of nursing management work. A to-and-fro
process, guided by questions and answers, consistent with the hermeneutic spiral, guided my interaction with texts arising from initial and follow-up interviews and field notes from periods of observation. A fusion of horizons emerged as I recognised my initial horizons had been extended and I had found meaning in the text I had chosen to interpret.

Texts in this research were created from interviews and field notes. Thirteen NUMs participated in the research. Interviews were conducted with all participants across the two hospitals, and twelve participants were interviewed a second time. Ten participants consented to the researcher attending a staff meeting for the purpose of observation. Field notes were made following each encounter and complemented text derived from interview transcripts. Interpretation of text and generation of questions followed each fieldwork encounter. Interpretation was a constant and iterative process that occurred during and after each fieldwork encounter.

1.2 Contextualising this research in contemporary NUM practice

Hospitals located in metropolitan areas are complex, highly specialised organisations that employ a diverse range of health professionals, often with competing interests (Swerissen & Willis, 2017). Furthermore, hospitals are challenged by the increasing prevalence of chronic disease, increasing demands to enhance quality and safety of patient care, ever-changing technology, and matters of access, efficiency, and increases in consumer expectations (Palmer & Short, 2014). In Australia, most NUMs are employed in the acute care public hospital sector (AIHW, 2016), including those who participated in this research. NUMs have a central position in the complex and rapidly changing health sector, where they seek to balance the interests of multiple stakeholders including patients, staff and other health professionals against organisational needs for efficiency and effectiveness.

NUMs’ work in managing their clinical units in this complex and dynamic environment is largely determined by formal policies, procedures and established routines. Much of their work involves planning, organising and administering the operational processes of the unit, and their presence in the clinical area is often limited. Their work, as a social practice, is enacted with and through people
including the nurses for whom they are responsible: Registered Nurses (RNs)\(^1\), Enrolled Nurses (ENs)\(^2\), Assistants in Nursing (AINs)\(^3\), Clinical Nurse Educators (CNEs)\(^4\) and Clinical Nurse Specialists (CNSs)\(^5\) as well as other health professionals, senior nurse managers and administrative staff working throughout the hospital. This network of professional relationships forms the social context in which NUMs’ work is enacted.

Within this complex, dynamic and highly networked context, a number of significant constraints impact on NUMs’ practice. NUMs have limited access to opportunities for their own professional development (Gaskin, Ockerby, Smith, Russell, & O’Connell, 2012), despite often having minimal preparation for their management roles. NUMs are challenged by staff retention issues, a system-wide issue that creates constant demands on NUMs who must ensure that sufficient skilled staff are available to provide care (Duffield, Roche, Blay, & Stasa, 2011). They are challenged by the changing scope of practice for nurses, especially with the introduction of AINs to the hospital sector (Roche, Friedman, Duffield, Twigg, & Cook, 2017). Finally, workplace tensions associated with historical power relationships (Paliadelis, 2008) present an ongoing challenge to NUMs who are responsible for ensuring effective interprofessional relationships in their units.

While much of NUMs’ work in this complex and dynamic environment is determined by formal policies, their discretionary decision making and use of personally constructed approaches to unit management enables them to influence the

\(^1\) Registered Nurses (RNs) are nurses who successfully complete a three-year university degree in nursing and are registered with the Australian Health Practitioner Regulating Agency (AHPRA) (Nursing & Midwifery Board of Australia, 2016b).

\(^2\) Enrolled Nurses (ENs) are nurses who complete a Diploma in nursing and are registered as Enrolled Nurse with AHPRA. ENs work under the guidance of RNs (NSW Health, 2015).

\(^3\) Assistants in Nursing (AINs) are nurses who complete a certificate in nursing. AINs attend basic nursing duties and work under the guidance of RNs (NSW Health, 2009).

\(^4\) Clinical Nurse Educators (CNEs) are RNs who oversee skills development of RNs, ENs and AINs at the unit level (Industrial Relations Commission of New South Wales, 2017).

\(^5\) Clinical Nurse Specialists (CNS) are RNs who have been awarded advanced status based on specialised skill and knowledge. CNS are expected to mentor and act as a resource for other nurses on specialised aspects of care (Industrial Relations Commission of New South Wales, 2017).
process of care delivery in unique and individual ways. Part of this involves shaping the performance of staff by facilitating staff learning within the routines of unit work. This research seeks to understand how NUMs influence learning in this complex environment and how contextual factors shape their learning facilitation values, choices and practices.

1.3 The structure of this thesis

This thesis is presented in nine chapters. Following this introductory chapter, Chapter 2 details the background and context of NUMs’ work. In Chapter 3 I review the literature that framed this study, and introduce a new theoretical framework that was developed to facilitate the interpretation of the research texts and better understand NUMs’ learning facilitation practices. The philosophical hermeneutic research methodology and methods are presented in Chapter 4. The findings from the experiential studies are reported in Chapters 5, 6 and 7. Each chapter has a specific but related focus, with Chapter 5 providing details of the context of NUMs’ work, Chapter 6 presenting the participants’ perspectives on staff learning, and sources of knowledge that influence their learning facilitation work and Chapter 7 presenting the participants’ learning facilitation practices. In Chapter 8 these findings are coalesced and presented as a Living Systems Model of NUMs’ Learning Facilitation Practices. Chapter 9 presents a critique of the research, a detailed discussion of professional, practice and future research implications, and concludes this thesis.
Chapter 2: The landscape of contemporary nursing management

In this chapter I present an overview of the global, national and organisational contexts of nursing and nursing management. I examine current challenges arising from these contexts, in general and with particular reference to the acute care (public hospital) sector in Australia, which is the context of my research. I explore the nature of nursing management work and identify how contextual factors influence what Nursing Unit Managers (NUMs) do. This discussion is underpinned by the premise that management work is embedded in the context in which it is performed, and better understanding of management work requires critical appraisal of its contextual dimensions.

2.1 Contextualising contemporary nursing and nurse management work

Nurses form a significant proportion of the global healthcare workforce (World Health Organization [WHO], 2010). Nursing work broadly supports the health of individuals across their life span and provides important and sometimes independent support to community healthcare. In this section I first discuss the context of nursing and nursing management in the global environment, and then in Australia. I apply a particular focus to the nature of public hospitals as the context in which this research was undertaken.

2.1.1 Global position of nursing and nursing management

Nurses are the largest group of health workers worldwide (WHO, 2016). Their contribution to healthcare has been well recognised across a broad range of contexts including hospitals; community, public health, primary health care and health promotion; schools; aged care; occupational health; as well as policy development; management; and education and research (WHO, 2010). For example, nurse midwives around the world have successfully led the WHO’s ‘Baby Friendly Hospital Initiative’ which advances infant health through promotion of breastfeeding in hospitals and communities (Hawkins, Stern, Baum, & Gillman, 2015); mental
health nurses have been recognised internationally as vital for leadership of future integrated mental healthcare services (Soltis-Jarrett, Shea, Ragaisis, Shell, & Newton, 2017); and the substantial role of nursing research into the prevention and management of non-communicable diseases (cardiovascular disease, cancer, chronic respiratory diseases and diabetes) has been a focal point in plans to reduce the global impact of this growing health challenge (WHO, 2012).

The capacity of nurses to enhance healthcare across a diverse range of contexts and communities worldwide has gained nursing a prominent place in the strategic plans of international healthcare agencies. The International Council of Nurses (ICN), which represents the interests of approximately 16 million nurses worldwide, works with the World Health Organization (WHO), the International Labour Organization (ILO) and the World Bank to advance nursing’s contribution to healthcare and policy development across the globe (ICN, 2018). Recently, the WHO (2016) recognised the enormous potential of the nursing profession in efforts to achieve ‘universal health’, especially in relation to primary healthcare and healthcare leadership. The WHO (2016) has also recognised the prominence of nursing in policy development globally and at all levels of the healthcare sector.

This worldwide recognition of nursing is partly due to the diverse and inherently fluid nature of nursing practice. The diversity, adaptability and scope of nursing practice within the global context is encapsulated in the ICN definition of nursing:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (ICN, 2002, para. 3)

Nursing work involves care of people at vulnerable and significant times of their lives, for example as they experience ill health, loss or disability, or adapt to significant life events such as the birth of a child. Nursing work is carried out in multiple settings. Nurses are often the first point of contact for healthcare, and are often in a position to shape the outcomes of that care (Patterson, 2017). Furthermore, epidemiological, social, political, technological and economic factors that impact on population health, for example the AIDS epidemic, adoption of electronic medical
records and changes to regulation of the profession, have also elicited responses from the nursing profession. These responses include ongoing development of nursing knowledge and skills through research and education; restructuring nursing roles, scopes of practice and models of care; and involvement in policy and advocacy for patient rights (All Party Parliamentary Group on Global Health, 2016). Nurses have a demonstrated and strong propensity to adapt to uncertainty, while adhering to the shared values, skills and knowledge that define nursing work (All Party Parliamentary Group on Global Health, 2016).

Recognition and support for the role of nursing in leadership, education and policy development and a focus on enhancing nursing capacity positions nursing as an important resource for achieving health objectives worldwide (WHO, 2016). Nursing managers have an important role to play in leading nurses to meet these challenges. Further, globally, nursing management has been identified as playing a central role in the safety and quality of healthcare and in the creation of enabling workplaces that foster learning and aid staff retention (ICN, 2010). The centrality of nursing management to the provision of safe and high-quality healthcare underscores the importance of this research which aims to better understand nursing management work and its influence on staff performance as the basis for achieving quality in health care.

2.1.2 Australian healthcare system as a context for nursing work

In Australia, nursing and the work of NUMs are practised within a healthcare system that aims to enhance the health of the Australian population by providing quality, affordable, sustainable and equitable healthcare that is carried out in hospitals, as well as primary and community healthcare settings (Productivity Commission, 2015a). In this system, health services, including hospital and primary healthcare services, are delivered by both public and private sectors, and are regulated by federal, state and territory, and local governments. Federal government responsibilities include developing national health policies, regulating private health and national insurance (Medicare), and funding national health insurance pharmaceutical benefits, and medical research (AIHW, 2018a; Productivity Commission, 2015b). State and territory governments are responsible for preventive and public healthcare services, public hospitals, licensing of private hospitals,
ambulance services and complaints management (AIHW, 2018a) and generally exert a more direct influence on health service operations than other levels of government. Local governments are responsible for community environmental health services such as water and waste disposal, and community planning for health and wellness (Willis & Parry, 2012). Responsibilities that are shared between the three levels of government include establishing and monitoring standards of quality and safety, regulating health professional education and practice, and providing focused funding for specific services (AIHW, 2018a).

The complex relationship between these three tiers of governmental regulation and support for the Australian healthcare system is located in an equally complex socio-political environment characterised by multiple stakeholders, often with competing interests (Krassnitzer & Willis, 2016). Purposeful collaboration between stakeholders and the development of shared strategic directions have been identified as essential to achieving population health objectives, as well as ongoing sustainability of the healthcare system (Duckett & Willcox, 2015). In recognition of this, the Council of Australian Governments (COAG) developed a National Health Reform Agreement (COAG, 2011) that clarifies areas of responsibility and accountability across the healthcare system, and in particular in relation to hospitals. This agreement is of particular relevance to my research, as it provides the foundation for a number of policies and strategies that shape hospital environments, and influences priorities and perspectives that define and impact on my research participants’ work.

Nationally, in addressing the health needs of the Australian population, the federal government has also declared its allegiance to the World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD) in working to improve the healthcare of other nations and also in responding to the recommendations advanced by those organisations (Lin, Smith, & Fawkes, 2014). Governments have communicated their priorities in various policy documents and plans. At the state level, in a recent document called *NSW State Health Plan: Towards 2021* (Health System Planning and Investment, 2014), the NSW Ministry of Health articulated its aims to promote health and to deliver world-class, integrated care. The plan aimed to address increasing chronic illness, increasing needs for health promotion and primary healthcare, and equity issues, and reflects global
priorities. The document includes recommendations for changing the scope of practice of nursing in the hospital sector to better meet healthcare needs, for example by redistributing nursing work to ensure registered nurses (RNs) work to their full capacity and less skilled technical work is completed by nurses who have less comprehensive education (Assistants in Nursing). These recommendations are relevant to my research because they have significant implications for NUMs whose responsibility for staffing in their units takes on greater complexity with the addition of different levels of staff and changes to the scope of their practice.

2.1.3 Australian hospitals as a context for nursing work

Hospitals are the key providers of institutional healthcare in Australia and consume around 40% of healthcare expenditure (Duckett & Willcox, 2015). Funding, structural arrangements, access, and accountability and performance standards in relation to hospital care are outlined in the National Health Reform Agreement (COAG, 2011), which clarifies areas of responsibility and accountability across the healthcare system, and in particular in relation to hospitals. The majority of admissions to public hospitals are for treatment or curative purposes (AIHW, 2018a). However public hospitals also provide a range of services to non-admitted patients including accident and emergency care; outpatients; and non-acute patients including mental health, rehabilitation, long stay and public health, as well as research and teaching (Productivity Commission, 2015b).

A key feature of public hospitals, the context of this research, is their highly regulated, highly specialised and pluralistic nature. Public hospitals are regulated by legislation including the Health Care (Appropriation) Act 1998 (Cth), and National Health Care Agreements (Parliament of Australia, 2003) and an extensive range of state legislation that regulates many hospital activities, including professional registration and employment, workplace health and safety, standards of care, and patient rights. Policy responses to regulatory mandates exert a key influence on the work of NUMs, who are often responsible for policy enactment at the unit level.

Public hospitals are also highly specialised organisations. Hospitals in metropolitan areas, including those in which this research was conducted, offer a wide range of specialised clinical services, whereas those in smaller rural communities are more
generalised. Smaller hospitals service much smaller populations, and trends toward centralisation of health services in metropolitan areas have reduced resources available to rural hospitals to offer specialised care (Weinhold & Gurtner, 2014). Rural hospitals now often limit their services to first aid and referrals. All hospitals in Australia are classified according to the number of patients admitted and the range of specialised services offered. In this research, one research site was classified as a principal referral hospital and the other as a major hospital (AIHW, 2015). These classifications signal the substantial capacity and highly specialised nature of these hospitals. This high degree of specialisation was evident in the nature of the units in which the participants in this research worked: highly specialised units that were characterised by a high turnover of patients, large numbers of staff and complex inter-professional team arrangements, demanding a high degree of coordination and cooperation. These specialised environments influenced the nature of the clinical practices, relationships, routines, knowledge and skills required by nurses to carry out their work. Centralised education programs were provided by the hospitals in which this research was conducted to support generic staff skill development. However, the need for specialised skill development was largely conducted by individual units. The need for specialised learning influenced the work of NUMs in this research who needed to ensure the currency of their own knowledge of the clinical area, as well as that of staff assigned to their units. This task involved seeking continual evidence of competence and addressing any shortfalls.

Public hospitals are also pluralistic entities: their workforce consists of many different professions, each with their own values and objectives (Kerridge, Lowe, & Stewart, 2013). Professions safeguard their interests through professional associations, regulatory bodies and educational qualifications that determine the scope of knowledge that underpins specific professional practices (Willis, Reynolds, & Keleher, 2012). Power differentials, role blurring, potential ‘turf wars’ and a raft of competing interests amidst a complex and intense working environment can pose challenges to the integrity of the organisation and the achievement of patient care. These tensions are well known in hospitals (Kim et al., 2017) and, in this research, added to the complex nature of the contexts in which the participants performed their work.
2.2 Australian healthcare system: contemporary challenges

The Australian healthcare system is confronted by many challenges. In this section, I discuss six key challenges that significantly shape health service responses in the acute care sector: chronic disease, maintaining quality and safety, technology, patient access to hospital care, efficiency, and increases in consumer expectations.

2.2.1 Chronic disease

While the status of population health in Australia is positive in terms of life expectancy, years free of disability, falling rates of premature death, and reduction in the burden of disease (AIHW, 2016), an increasing life span has been accompanied by an increase in chronic disease including diabetes, cancer and heart disease as well as multiple morbidities (AIHW, 2016). Policy responses to the challenge of chronic illness include reduction of risk, coordinated care and an emphasis on self-management, with a greater emphasis on out-of-hospital care, including primary and community care (Duckett & Willcox, 2015).

The increase in chronic disease has implications for nursing and NUMs’ work. In Australian hospitals, including those in which this research was conducted, nurses encounter an increasing number of older people admitted with complex combinations of chronic conditions, with higher levels of acuity, in need of more technically advanced care, and who stay in hospital for relatively short periods of time (Duckett & Willcox, 2015). This impacts on the skill sets of nurses, workloads and workflow processes, and models of care, all of which are coordinated by NUMs (Needleman, 2013). In response to this complexity, nurses and NUMs play an active role in interdisciplinary care where health professionals from a range of disciplines work together to manage patients’ healthcare problems (Chang & Johnson, 2014). NUMs seek to secure successful patient transitions back to their communities with appropriate support systems in place to maximise patient independence and prevent readmission (Leggat, 2012).

2.2.2 Focus on safety and quality

Achieving safety and quality in healthcare is a global concern. Across the world, approximately 1 in 10 patients receive an iatrogenic or unintended negative
consequence from healthcare (Slawomirski et al., 2017). For users of healthcare services, a 1 in 10 chance of an unintended negative consequence is of great concern. It is estimated that many of these ‘adverse events’ can be prevented, fuelling concerns about healthcare quality worldwide (Slawomirski et al., 2017). Adverse events are costly to patients, and to the healthcare system.

In Australia, the statistics are slightly lower, with approximately 6.7 patients per 100 hospitalisations experiencing adverse events, the most common being abnormal reactions to procedures, treatments or medications (AIHW, 2018a). Examples of adverse events include administration of wrong medication, or unanticipated but preventable reaction to a surgical procedure, which can lead to injury or death (Duckett, Jorm, Danks & Moran, 2018). Errors and adverse events in healthcare generally result from an interplay between a range of factors including the complex nature of care, systems and processes, as well as human relationships and behaviours and other contextual factors (Yates, Lewis, & Iedema, 2012).

In response to concerns about adverse events and several significant reports about healthcare quality, for example the Final report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals (Garling, 2008), safety and quality have emerged as key drivers of Australian healthcare delivery. Safety refers to “issues related to the unintended consequences of healthcare leading to a focus on adverse events” (Duckett & Willcox, 2015, p. 255) and quality relates to “intended outcomes of care … including timeliness and acceptability as well as overall care outcomes” (p. 255). The management of safety and quality have become central to healthcare work (Yates et al., 2012). This focus has particular relevance to NUMs who are at the front line of service provision, and who are directly responsible for ensuring policies and procedures are embedded into practice; standards of care are maintained, measured and revised; and that their unit’s culture supports quality and safety. As managers at the point of care delivery, NUMs are responsible for maintaining these standards of care 24 hours a day, which means ensuring the staff who are in charge during their absence are capable of maintaining standards and making appropriate decisions. Consequently, NUMs are responsible for translating organisational policies on patient care into practice (Baker et al., 2012) and, in turn, representing the quality and safety interests of their unit to the wider organisation. NUMs’ position at the point of care delivery also enables them to shape a positive
workplace culture by moving from punitive cultures of blame to open, collaborative learning cultures considered vital for quality patient care (Daly, Speedy, & Jackson, 2014). At the individual hospital level NUMs are required to ensure systems and standards for measuring quality are in place and that adverse events and incidents are reported and acted on in a way that enables learning and minimises recurrence (Healy & Sampford, 2011).

Safety and quality of healthcare has become a focal point in healthcare, and has particular significance in the public hospital sector where the risks of injury to patients are high (AIHW, 2018a). Achieving safe, quality care, by working to prevent adverse events and by ensuring the outcomes of care are consistent with the intentions of that care, underpins nursing and nursing management work.

2.2.3 Rapid technological advances

Over the past 30 years, a proliferation of medical technology in healthcare has improved diagnosis and treatment, and has decreased patients’ length of stay in hospital (Palmer & Short, 2014). Technology refers to the entire range of activities involving personnel, processes, and procedures and equipment that are involved in new approaches to treatment or diagnosis (Palmer & Short, 2014). Viewed this way, technology encompasses not only equipment and procedures, but the systems, skills and other human factors that influence its use.

Alongside potential health outcome benefits, advances in technology can also increase the complexity of care and risk of harm to patients, either directly during the process of care, or indirectly, by producing incorrect information (Healy & Sampford, 2011). For example, invasive surgery carries a high risk of harm, and diagnostic procedures such as pathology tests can produce incorrect results.

Technological advancements have significant implications for hospitals as sites where technology and technological change is most concentrated and for the work of health professionals, including nurses, who need to use technology and adapt their practice in response to its changing demands. This in turn has the potential to influence the work of NUMs who are key to embedding technological change in their clinical units, and to ensuring that staff are competent in its use. Ongoing
technological change also significantly shapes NUMs’ need for enhancement of their own knowledge and skills.

2.2.4 Community public hospital access

Community access to public hospitals is a major challenge for the healthcare system (Krassnitzer & Willis, 2017). Insufficient capacity for hospitals to treat patients in a timely manner means that patients are experiencing extended periods of pain and/or disability and sometimes death (Productivity Commission, 2015b). Of particular significance to the functioning of public hospitals on a day-to-day basis is access to emergency departments. Access block, where hospital occupancy becomes so high that patients cannot be admitted through the emergency department, causing a backflow to ambulances waiting to discharge patients, has been associated with poor patient outcomes including mortality (Forero et al., 2010).

In response to critical access block issues, recent policy directives including the National Emergency Access Target (NEAT) (COAG, 2011) have stipulated a four-hour maximum waiting time in accident and emergency departments. Strategies to achieve this target include reorganising accident and emergency care procedures and processes, and streaming patients to units of the hospital for assessment rather than keeping them in the emergency department. This has affected the roles of hospital units and nursing staff who have had to adapt and develop their skills to manage and assess more acute patients (Duffield, Diers, Aisbett, & Roche, 2009). In some hospitals, Medical Assessment Units have been opened specifically to cater for this group of patients (Slatyer et al., 2013). However, many patients are moved from emergency departments directly to hospital units and wards for initial assessment. In response to these changes, in some areas, nurses’ scope of practice has been increased to enable initiation of diagnostic tests (Crawford et al., 2014).

In this context, NUMs are responsible for ensuring staff are adequately prepared to provide competent and safe care for patients whose diagnosis may not be known, to manage the challenges of a high throughput of patients, and to ensure adequate numbers of staff with the required skill mix are receiving adequate support and supervision. This role also extends to ensuring staff are competent in a wide range of skills, and that opportunities for staff to learn are available when they are needed.
2.2.5 Focus on efficiency

Healthcare in Australia is considered to be of a high standard in relation to world standards (AIHW, 2018a). However, as costs rise there are ongoing concerns about efficiency, that is, achieving best outcomes in relation to costs/inputs across the system (Duckett & Willcox, 2015). Responses to costliness recently have focused on quality rather than cost cutting, with a recognition that poor-quality care is expensive, and high-quality care is integral to efficiency (Productivity Commission, 2015a).

In a recent report the Productivity Commission (2015a) developed a broad range of recommendations to achieve efficiencies in healthcare. Included were health technology assessments to ensure a solid evidence base for the purchase of all new technology; updating out of date clinical guidelines; including financial incentives for providers who provide cost-efficient care; investment in preventive health; revising health professionals’ scopes of practice; as well as reviewing regulations around pharmaceuticals, health insurance and regulations that constrain practice and prevent adaptations to the changing healthcare needs of the population. These recommendations have implications for nursing as the largest health profession, and for NUMs whose presence across the healthcare system has an influence on the efficiencies associated with providing care. NUMs are in a position to enact recommendations for greater efficiency at the point of service provision.

Implications of the Productivity Commission’s efficiency measures for NUMs’ work include openness to variations in staff scopes of practice, managing quality and safety in recognition of the costliness of error, removing outdated practices, and promoting models of care that embrace health promotion.

2.2.6 Managing consumer expectations

Consumers of healthcare include all people who utilise health services. In the past, consumers have accepted a position of being passive recipients of healthcare (Coulter, 2011). With improved access to information from the internet and higher

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6 In public hospitals consumers are also known as patients. While the term ‘patient’ has patronising and passive overtones, it was the term used by the participants in this research. For this reason, the term ‘patients’ rather than ‘consumers’ is used in other sections of this thesis.
levels of knowledge about healthcare, as well as increased awareness of rights, consumers today exert considerable influence on the provision of health services (Palmer & Short, 2014). Consumers’ increased knowledge and awareness has positively influenced healthcare practitioners’ accountability for the safety and effectiveness of the services they provide. Consumers’ knowledge and capacity to influence healthcare is aided by self-help organisations, consumer advocacy groups and government departments that manage complaints and advocate for quality healthcare (Duckett & Willcox, 2015). Consumers are also aware of the risks associated with healthcare and are able to identify variation that occurs between services. As a result, health services are required to make their performance more visible, for example through the MyHospitals website (AIHW, 2018b), and the performance of providers employed within their organisations. This has direct implications for the work of nurses, and of NUMs who are responsible for the standard of care that is delivered to patients.

The Australian healthcare system is challenged to find a balance between efficiency and effectiveness in the provision of healthcare. Meeting the needs of a population that is aging, experiencing more chronic conditions, and is better informed about healthcare, in a context characterised by ongoing demands for safe, efficient and effective care, amidst a stream of costly diagnostic and treatment technologies, demands constant adjustment. Adaptations to the manner in which healthcare is delivered has significant implications for all health professions, including NUMs whose role at the point of service delivery includes balancing inputs and outcomes to achieve desirable outcomes for patient care.

2.3 The nursing workforce

The nursing workforce in Australia forms more than half of the total professional healthcare workforce (AIHW, 2015) and their presence as key providers of healthcare is well established across the healthcare sector, including acute care, community health, mental health and long-term care, within both the public and private sectors.

There is a substantial number of nurses within the management structures of these services. In 2015, out of 307,104 employed RNs and midwives, 14,797 (4.82%)
worked in administration (management) roles, 277,667 (90.45%) worked in clinical roles, 9847 (3.21%) in education, 2700 (0.88%) in research and 2093 (0.68%) in other roles (see Figure 2.1). While the majority of nurses held clinical roles, a significant number, although a small percentage, held management roles. The average age of an RN is 44 years and the number of RNs aged 25–34 and 50–65 is increasing. The majority of RNs are employed in the public hospital sector in clinical roles and nurses also make up the largest portion of health professionals employed in public hospitals (AIHW, 2015). RNs also work in other areas including the private hospital and aged care sectors, community health, outpatients’ services and general practice (AIHW 2015).

![Figure 2.1. Registered Nurses and midwives’ principal role.](image)


Of those nurses working in administration roles, likely to be composed largely of NUMs, 75% worked in full-time roles, 88% are female and 75% are aged over 45 years (AIHW, 2015). These figures have remained static over the past four years. This data is consistent with the demographic details of my research participants.

Having provided a summary of Australian nursing profession demographic data as a frame, in the next section I provide a potted history of Australian nursing, and
nursing management in particular. I then identify contemporary challenges faced by NUMs in carrying out their work, including working within power structures, staff retention, scope of practice and educational preparation.

2.3.1 History of nursing

The nursing profession in Australia has played an important role in healthcare from the time of the first non-Indigenous settlement through to contemporary times. Across this time the nursing profession has undergone significant change in both scope of practice and education of new practitioners. These changes have largely been driven by advances in medical knowledge, technology and increasing societal expectations for safe and effective healthcare.

The first nurses in Australia were drawn from the convict population and worked under the supervision of surgeons from the First Fleet (Schulz, 1991). These nurses worked in establishments that housed destitute, aged and diseased individuals, where resources, standards and quality of care were of low priority. Efforts to manage these early nurses were coordinated through the Sydney Dispensary, which in 1845 became the Sydney Infirmary and Dispensary, and then Sydney Hospital in 1881 (Griffith, 1974). More wealthy members of the community received care in their own homes from doctors and carers who visited in a private capacity. With developments in science, by the middle of the 19th century medical care became more specialised, and treatment centres or hospitals began to emerge. Untrained nurses continued to work caring for patients under the control of the hospital matron (also untrained) and medical staff, and standards remained poor. Changes came about with the establishment of the first nurse training course at Sydney Hospital in 1868, by Lucy Osburn, one of Florence Nightingale’s students, alongside five other nurses (Stevens, 2003). Lucy Osburn became the first hospital superintendent and retained oversight of the clinical work of nurses (Stevens, 2003).

Once established, nurse education remained within the hospital system until 1993 when nurse education was transferred to universities. The basis for the transfer was acknowledgement of a lack of standardisation of programs and the subordination of students’ educational needs to service needs (Palmer & Short, 2014). The move has also been associated with better preparation of nurses to work in increasingly
complex healthcare environments (Parry & Grant, 2016). Further evidence of enhanced nurse education in the higher education system can be seen in the evolution of Nurse Practitioners, who are licensed to practice independently under the *Health Practitioner Regulation National Law* (NSW) in specific areas of need.

Contemporary nursing work in Australia is regulated by a number of regulatory bodies. All health professionals, including nurses, are regulated by the *Health Practitioner Regulation National Law* (NSW). The principles of this law are administered by the Australian Health Practitioner Regulation Agency (AHPRA) (2015) in conjunction with the relevant professional boards, and in the case of nursing the Nursing and Midwifery Board of Australia (2015). The board determines registration requirements and procedures, practice standards and accreditation standards for courses of study, and manages complaints in conjunction with the requirements of the *Health Care Complaints Act 1993* (NSW). Nurses in Australia are required to be registered with the aim to protect the public from harm. Through registration, AHPRA and the Nursing and Midwifery Board of Australia control entry to the nursing profession, standards of education and practice, and procedures for consumer complaints (AHPRA, 2018). Nursing work is strongly bound to regulatory requirements and health services, and managers have an obligation to ensure practice standards can be met.

Today Australian nurses work in a range of contexts, including hospitals, aged care facilities, community health settings, schools, industry, health departments and educational institutions. They work in a range of roles including clinical, management, education and research. The nursing workforce is further differentiated in relation to expertise and education as Registered Nurses (RNs), Clinical Nurse Specialists (CNSs), Clinical Nurse Consultants (CNCs), Enrolled Nurses (ENs), Assistants in Nursing (AINs) and Nursing Unit Managers (NUMs). Each of these categories of nurse will be discussed in the following sections.

### 2.3.2 Registered Nurses

Registered Nurses (RNs) are nurses who successfully complete a three-year university degree in nursing and are registered under the *Health Practitioner Regulation National Law* (NSW).
Regulation National Law (NSW). The board has outlined its definition of registered nurse practice:

Registered nurse practice is person centred and evidence based with preventative, curative, formative, supportive, restorative and palliative elements. RNs work in therapeutic and professional relationships with individuals as well as with families, groups and communities. These people may be healthy and with a range of abilities or have health issues related to physical or mental illness and/or health challenges. These challenges may be posed by physical, psychiatric, developmental or intellectual disabilities. (Nursing & Midwifery Board of Australia, 2016b, para. 1)

The board recognises the cultural and historical context of nursing in Australia and the professional accountabilities and responsibilities to engage in critical thinking, to develop professionally, to provide comprehensive care and to supervise others. Nursing work includes any work where nurses draw from their nursing knowledge, including education, management and research, as well as clinical work. Nurses are considered responsible for their autonomous work within healthcare systems and their work in conjunction with other health professionals (Nursing & Midwifery Board of Australia, 2016b).

Despite the development of practice dimensions and standards of practice, as outlined by the Nursing and Midwifery Board of Australia (2016b), there has been a lack of clarity in recent times over RNs’ scope of practice and this has led to blurring of roles and confusion in some areas. There is a need for nursing to better define its scope of practice while at the same time adapting to the changing needs of the healthcare environment (Birks, Davis, Smithson, & Cant, 2016). Some of the lack of clarity has emerged in relation to the introduction of other classifications of nurse (ENs and AINs). While the clinical work of RNs is more complex and carries greater responsibility for decision making and coordination than ENs or AINs, they are less specialised than CNSs and CNCs (Industrial Relations Commission of New South Wales, 2017).

2.3.3 Clinical Nurse Educators

Historically, under hospital nurse training models, Clinical Nurse Educators (CNEs) were employed to organise ongoing education for RNs and to organise and deliver the training of student nurses, as much clinical learning took place under the
supervision of the charge nurse (Duffield, Wood, Franks, & Brisley, 2001). When nursing education moved from hospitals to the tertiary sector, CNEs’ roles became less clearly defined. Today their role includes providing ongoing professional development for RNs, ENs and AINs and oversight to student nurses on placement from their universities (Sayers, Salamonson, DiGiacomo, & Davidson, 2015).

Under the NSW Public Health System Nurses’ and Midwives’ (State) Award 2017 (Industrial Relations Commission of New South Wales, 2017), CNEs are defined as appropriately qualified and experienced RNs who deliver education at the unit level, including supporting new staff through induction and preceptorship, supporting clinical education for all staff through both formal and informal approaches, supporting policy development and providing in-service education programs. CNEs are responsible to the NUM who is ultimately responsible for all nursing staff employed in the unit. CNEs participate in decision making in ward areas collaboratively with the NUM (Fairbrother, Rafferty, Woods, Tyler, & Howell, 2015). CNEs participate in clinical work for the purpose of providing educational support to staff but do not take on a clinical workload independently of that. CNEs engage in planning for staff education with NUMs and report as required on staff performance or underperformance issues and ongoing education needs.

2.3.4 Clinical Nurse Specialists

Clinical Nurse Specialists (CNS) are employed widely across the health sector. ‘Clinical Nurse Specialist’ is an individual classification that can be awarded to RNs who meet specific criteria in relation to experience and qualifications, in a specialist area. Re-classification is based on a formal application and review process initiated by the individual RN and in relation to standards determined by NSW Health (NSW Nurses Association, 2008). The classification was introduced to provide a clinical pathway for RNs that rewarded and recognised their specialised practice work and ultimately to encourage RNs to remain in nursing. CNSs are expected to contribute to practice and add to the clinical resource of the specialty area (Industrial Relations Commission of New South Wales, 2017). CNSs work as members of nursing teams and contribute to staff education and induction and the ongoing development of nursing practice in the unit. They are considered to be in an ideal position to facilitate evidence-based nursing practice when given appropriate time allowance.
(Malik, McKenna, & Plummer, 2015). As members of the nursing team, CNSs are responsible to NUMs. NUMs support RNs’ professional development to enable progression to a CNS role.

2.3.5 Clinical Nurse Consultants

Clinical Nurse Consultants (CNCs), unlike CNSs, have a specific, appointed role in a specialty area. CNCs are appointed on the basis of extensive experience and advanced qualifications (Industrial Relations Commission of New South Wales, 2017). CNCs are expected to engage in evidence-based practice and to provide a consulting role to patients, families and other health professionals on the care of patients who have complex care needs. They are also expected to engage in clinical leadership, practice and consultation, education, service planning and management (Dawson & Benson, 1997) although the emphasis given to these practice areas varies in different contexts (Baldwin et al., 2013). Unlike CNSs, CNCs have a designated educational role and are expected to positively influence the knowledge and skills of RNs (NSW Health, 2017). Relationship building with all members of the healthcare team is core to their role, and enables ongoing development of their own practice (Ramis, Wu, & Pearson, 2013). They may not be employed in every unit of a hospital or may be shared between several similar specialty areas. CNCs work closely with patients, families and clinicians and their work may traverse a number of health services (Baldwin et al., 2013), for example hospital and community care. Once appointed, CNCs work in a consulting capacity with NUMs, developing clinical standards and meeting educational needs of staff in relation to a particularly specialised aspect of practice.

2.3.6 Enrolled Nurses

Enrolled Nurses (ENs) are registered by the Nursing and Midwifery Board of Australia (Industrial Relations Commission of New South Wales, 2017). They study a Diploma of Nursing (Enrolled Nurse) over 12–18 months and work under the supervision of an RN although, unlike AINs, they have a specific scope of practice and are able to perform some complex nursing activities (NSW Health, 2015). ENs are employed throughout the acute care sector. In recent times the scope of practice of ENs has increased to include more complex activities such as medication
administration. The extension of their role has created some overlap with the role of RNs and as a result delineation of the two classifications has become less clear (Jacob, Barnett, Sellick, & McKenna, 2013).

The extended ENs’ role provides a greater skill set for NUMs to work with as they determine the appropriate skill mix for each shift, although it also increases the degree of oversight that ENs require as they undertake more complex work. This oversight, while ultimately the responsibility of NUMs, is provided by RNs and CNEs as part of their job roles and responsibilities (Nursing & Midwifery Board of Australia, 2016b).

2.3.7 Assistants in Nursing

An Assistant in Nursing (AIN) is defined as a nurse who is not an EN or an RN, who is engaged in nursing work in the public sector (Industrial Relations Commission of New South Wales, 2017). Traditionally, AINs have worked almost solely in nursing homes and aged and community care services. However, recently AINs have been introduced into public hospitals. This change has occurred largely in response to shortages of nursing staff, attributed to low RN retention rates, remaining shortages arising from the loss of student nurse labour from the transfer of nurse education to the tertiary sector, a desire for cost containment, and to free up RNs for more technical and specialised work (Kessler, Heron, & Dopson, 2012). Their entry to the acute care sector has posed challenges for NUMs and contributed to the complexity of nursing work.

To accommodate the role of AINs, models of care have had to change from primary nursing (where one RN provides total care for a group of patients) to team nursing, where several staff work together to meet the care needs of a group of patients. This model enables greater supervision of less skilled staff and allocation of tasks that are best suited to their abilities (Davidson & Hickson, 2014). Integrating AINs into hospital workplaces has significantly impacted NUMs’ work, particularly in ensuring effective team function, provision of quality patient care and support to team members. Furthermore, while AINs complete a formal training program (Certificate III in Health Services Assistance: NSW Health, 2014b), they are not registered and their scope of practice is dependent on the work allocated to them by RNs ( NSW
Health, 2010a) under the oversight of NUMs. Professional development of AINs is dependent on the environment in which they work (NSW Health, 2009) and is overseen by NUMs, who are responsible for their performance and overall effective participation in the work of the unit.

2.4 Nursing Unit Managers

NUMs are RNs who have moved into management roles. Generally, promotion to a NUM role is based on clinical experience, and many NUMs possess limited management skills or qualifications (McCallin & Frankson, 2010). However, as part of their prior clinical experience as senior RNs, it is likely that they have performed some team leadership work. NUM positions are generally filled via general recruitment processes, and promotion to the role from RN is not automatic. NUMs have 24-hour responsibility for the operations of their hospital units or departments (Duffield & Franks, 2002). In this section, I outline the history of NUMs’ position in management, and examine their roles and challenges in the current healthcare context.

2.4.1 An historical review of nurse management

Nurses have had a prominent role in the management of health services, and hospitals in particular, since the middle of the 19th century (Arndt & Bigelow, 2005). Prior to that time, hospitals were generally managed by an untrained ‘matron’ who managed domestic services and a ‘superintendent’ who managed financial matters (Stevens, 2003). These roles were later merged into a single role once nursing was established and became dominant in the hospital workforce. In Australia, the first hospital ‘lady superintendent’ was Lucy Osburn, a student of Florence Nightingale, who travelled from England to Australia in 1868 to take up her position at Sydney Hospital. Osburn assumed management of the nursing staff in the face of significant opposition from the medical profession, whose desire for control over nurses persisted for many decades. Her success in training a group of 16 nurses and advocating for improvements in the appalling hospital conditions established the authority and legitimacy of nursing as a skilled labour force, which would prove instrumental to the development of the public hospital system (Stevens, 2003). Osburn’s work established the role of nurses in management (as ‘matrons’) in
Australia, although this has been globally attributed to her tutor, Florence Nightingale (Wildman & Hewison, 2009).

Nightingale was an advocate for women as key providers and managers of patient care, and insisted that hospital matrons be women who had worked as ward nurses and demonstrated high-level capability. Her approach gave women a prominent place in the hospital hierarchy and in management (Wildman & Hewison, 2009). During the 20th century, the influence of economic rationalism and the adoption of managerialism has increasingly seen hospitals being managed as businesses. The matron’s role, which included management of nursing and related services such as laundry, food services and some allied health (Wildman & Hewison, 2009), evolved into a Director of Nursing role, concerned with strategic and other responsibilities and no longer solely responsible for nursing work (Duffield & Franks, 2002).

Similarly, business principles redefined the role of ward sisters, who were previously concerned with details of all ward activities and nursing work (Bradshaw, 2010), into ‘Nursing Unit Managers’, whose responsibilities continue to be focused on ‘ward work’ but whose role also includes a raft of administrative roles such as budgeting. Concerns have been raised about the potential of this change to negatively impact on patient care (Duffield & Franks, 2002).

Changes to structural arrangements also accompanied changes to traditional nursing management roles. During the latter part of the 20th century, with the rise of management in other industries, a range of administrative aspects of the matron’s role became separated from nursing concerns and evolved into general management roles (Arndt & Bigelow, 2005). A three-dimensional management structure that included nursing, medicine and general administration emerged and remains the dominant arrangement in many hospitals today (Duckett & Willcox, 2015). However, over the past 20 years, with increasing concerns over the costs of healthcare and adoption of business principles, a move toward costing episodes of care created a need for hospitals to merge clinical and management roles, ensuring resourcing decisions were made by managers who had clinical knowledge and credibility (Duckett & Willcox, 2015). Nurses are among a number of health professions who have moved into these clinical manager roles. As a result, the role of NUMs is no longer confined to managing clinical nursing care, but is
multidimensional and includes oversight of financial and physical resources and responsibility for other management tasks (McCallin & Frankson, 2010).

2.4.2 Nurses in management today

Nurses who manage units or wards in hospitals are classified under the NSW Public Health System Nurses’ and Midwives’ (State) Award 2017 (Industrial Relations Commission of New South Wales, 2017) as ‘Nursing Unit Managers’ (NUMs), a term that has replaced the traditional titles ‘ward sister’ and ‘charge nurse’. NUMs are RNs whose responsibilities include the coordination of patient services, unit management, and nursing staff management in a unit or groups of units within a healthcare organisation (Industrial Relations Commission of New South Wales, 2017). NUMs’ roles are classified from Grades 1 to 9. Their responsibilities at each level of appointment reflect the complexity of the role, the size of the hospital or work area, and the presence of reporting relationships. NUMs at Grade 1 manage nursing services in a hospital/department, but are responsible to an on-site more senior NUM at all times. At Grades 2–4 their roles involve managing several departments within the hospital, also under the oversight of a more senior NUM, and beyond that (Grades 5–8) they work more autonomously and their responsibilities encompass multiple hospitals, facilities and services, or Local Health Districts with a high degree of complexity. Grade 9 is reserved for Directors of Nursing of a district or of a major teaching hospital (Industrial Relations Commission of New South Wales, 2017).

The NUMs who participated in the experiential part of this research were graded as Grade 1. Their level of management responsibility is described in the award as ‘participatory’, although the NUMs who participated in my research generally managed their unit independently, with a reporting relationship with their senior nurse manager who provided oversight to a group of units. Core knowledge and skills expected of NUMs employed at Grade 1 are specified within the domains of leadership, communication, knowledge, performance management, planning and resource management (Industrial Relations Commission of New South Wales, 2017).
2.4.3 NUM roles

As discussed in Section 2.4.1, NUMs’ roles have changed over time from the traditional, clinically focused ward sister to a more business-oriented NUM (Bradshaw, 2010; Duffield & Franks, 2002). In contemporary healthcare contexts, NUMs oversee units that are complex and highly technical, where patient stays are typically short and involve a range of health professionals and other staff. NUM reporting lines include senior NUMs who manage a group of units or departments (Industrial Relations Commission of New South Wales, 2017), and often other divisional managers including financial and human resources managers. NUMs undertake a broad range of activities including rostering, budgeting, performance reviews, managing incident reports, addressing staff educational needs, and dealing with interpersonal and inter-professional relationships (Duffield, Moran, et al., 2001). NUMs also provide clinical oversight and advise on clinical care issues when needed. NUMs set the tone of the unit, seek to model appropriate behaviours, support a good culture and promote opportunities for staff to develop as leaders (McCallin & Frankson, 2010). They also act as a conduit for information and communication between the practices of their unit and the policies of the hospital (Baker et al., 2012).

At a time when instability in the nursing workforce is compounded by low retention rates, NUMs’ influence on the quality of the working context as a factor in retention has been recognised (Roche et al., 2016). NUMs can influence the work environment in various ways such as supporting professional and personal staff needs (Roche et al., 2016); managing complexity associated with the unpredictable nature of care (Duffield, Roche, Dimitrelis, Homer, & Buchan, 2015); maintaining a strong presence in their units; and engaging with staff and providing positive feedback (Duffield, Roche, Blay, & Stasa, 2011). In enhancing the quality of the working environment and staff satisfaction, NUMs not only influence staff retention, but establish a firm basis for nurses to provide quality care (Aiken et al., 2017).

2.5 Contemporary challenges to NUMs’ work

In working to achieve quality outcomes for patients and staff, NUMs face a complex network of challenges. Of significance to this research are those posed by traditional
power relationships, changing and sometimes ambiguous scopes of practice for nursing staff, staff retention, and limited preparation for the role. In this section I examine these factors as significant contemporary influences on NUMs’ work in public hospitals.

2.5.1 Power relationships

Challenges to nursing work and identity posed by power relationships have persisted since a nursing presence was established in hospitals in the mid-19th century (Stevens, 2003). Since then, despite the growth in nursing as a profession, with nursing now firmly anchored to a scholarly body of research, and nursing presence in policy making formally recognised (Nursing & Midwifery Board of Australia, 2016b), challenges to nursing’s autonomy and status still exist.

The journey toward professional status for nurses has not been easy. Challenges to their role and status have persisted over time and remain a contemporary issue. Nurses, despite being the largest group of health professionals in Australia (Health Workforce Australia, 2014), experience lower status and do not have the same level of power as other professions (Paliadelis, 2008). Tensions between nursing and other health professionals, such as allied health, have arisen from nurses’ concerns that these professionals have taken on roles that are traditionally the purview of nursing (Palmer & Short, 2014). Despite acknowledgment of nurses’ professional status through salaries, university education and more recently legislation, challenges arising from power relationships and perceived status persist.

The status of nursing as a profession has presented a particular threat to the medical profession since the early days of nursing in Australia. Nurse training at that time established lines of nursing authority that were outside medical control, and led to the medical profession working (unsuccessfully) to discredit the nursing profession (Stevens, 2003). From those early days, nurses have continued to work under the direction of other nurses for standards of nursing care, but also under the direction of the medical profession in providing clinical treatment. However, over time, nursing has developed its own identity, based on a body of knowledge developed through

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7 The *Health Practitioner Regulation National Law* (NSW) section 95 acknowledges nursing autonomy through nurse practitioner roles.
research that has informed standards of professional practice (Daly, Elliott, & Chang, 2014) independently of medicine.

Despite nursing’s professional status, the dominance of the medical profession has continued (Hart, 2015). Importantly, tensions arising from power relationships between health professionals within hospitals have a significant influence on patient care. For example, subordination of nurses to doctors has been associated with unsafe care, as nurses have remained silent about incorrect treatment interventions for fear of retribution (Healy & Dugdale, 2009).

While the current status of nursing as a profession is a far cry from the image of the ‘doctor’s handmaiden’ that has been prominent throughout history, issues of power and ‘turf wars’ arising from a complex interplay of factors have persisted. These factors add to the complexity of the context in which NUMs practice and seek to enhance staff performance and patient care.

2.5.2 Scope of practice

NUMs work in an environment of increasing complexity in terms of health professional roles and responsibilities. Changes to the scope of practice of many classifications of nurses has created a need to adjust models of care and workplace practices and processes, for which NUMs are responsible. ‘Scope of practice’ has been defined as “the activities that an individual healthcare practitioner is permitted to perform within a specific profession” (Klein, 2005, p. 1). Activities performed within a profession’s scope of practice can overlap or ‘blur’ with those of another, and this can be a source of conflict, confusion and complexity (Maddern, Lambert, & Dwyer, 2017). An example of this is ENs moving into the practice area of RNs (Jacob et al., 2013) and being permitted to administer medications and engage in more complex care. Such blurring has also been demonstrated between AINs and RNs (Kessler et al., 2012), and between CNSs and CNCs (Baldwin et al., 2013).

Role overlap is not limited to nursing, as the roles of other health professionals also overlap with those of nurses and doctors in many situations. A growing emphasis on inter-professional collaboration in response to the increased prevalence of chronic illness and complex care needs (NSW Health, 2014a) makes overlapping of professional scopes of practice and boundaries inevitable. The potential for conflict
between these overlapping roles has implications for NUMs, whose central position on hospital wards or units creates an opportunity to facilitate collaboration, shared understanding and a search for synergies. NUMs have an important role in clarifying roles and scopes of practice to ensure achievement of quality patient care outcomes.

2.5.3 Staff retention

Registered nursing shortages is looming as a worldwide problem as populations age, nurses from the ‘baby boomer’ period retire and the current decline in nursing retention rates continues (WHO, 2016). In Australia, it is predicted that there will be a shortfall of 123,000 nurses nationally by 2030 (Health Workforce Australia, 2014). From an operational level, staff shortages present an unrelenting tension for NUMs, whose responsibilities for maintaining high standards of care in a dynamic and changing environment already pose challenges.

Staff retention issues have a significant influence on NUMs’ work. Not only are they required to ensure safe levels of skilled staff in their units, but they also provide oversight to new staff and manage the impact of low levels of staffing on existing staff. Research cites a range of workplace strategies that aid retention, including involving staff in decision making; providing positive feedback on performance (Duffield et al., 2011); promoting initiatives for staff development and recognition, and actively supporting health, safety, quality and workloads (Tomey, 2009); and providing opportunities for learning (Laschinger, Finegan, & Wilk, 2009). NUMs, however, cannot achieve these aims alone, and require support from organisations and senior managers (Duffield et al., 2011) and the power to function effectively in implementing such strategies (Paliadelis, 2008).

The impact of staff attrition on clinical care has become a significant issue in Australian hospitals. Issues associated with staff retention, including ensuring appropriately skilled teams, managing the implications of low staffing levels, and gaining support to implement approaches that influence retention, pose a significant challenge to the work of NUMs in public hospitals.
2.5.4 Role preparation

Classifications of NUMs’ grades, consistent with their duties, are outlined in the Public Health System Nurses’ and Midwives’ (State) Award 2017 (Industrial Relations Commission of New South Wales, 2017). However, unlike CNSs and CNCs, the commission is largely silent on educational preparation to support NUM classifications. This omission perhaps reflects the reality of NUMs’ experiences of moving into management positions based on clinical experience, often with limited management knowledge, skills or abilities (McCallin & Frankson, 2010). Health services have responded to this shortcoming, in part, by providing education on topics such as budgeting and leadership; for example, NSW Health’s (2014a) ‘Take the Lead’ project is designed for work-based learning and offers some preparation for NUMs’ leadership roles. Universities offer post graduate courses in Health Services Management, that seek to support the transition of clinicians such as Registered Nurses into their management roles. However, RNs generally accept NUM positions without knowledge or experience of management, and learn ‘on the job’ to manage the activities of their units (Gaskin et al., 2012). These complex, dynamic, intense workplaces that are pressured by the competing interests of multiple health professionals seeking to provide high-quality patient care in an environment of diminishing resources and staff retention issues present significant challenges for NUMs.

It is no surprise that NUMs report feeling ill-prepared for their roles in managing time, staff, resources, change and conflict and experiencing difficulties in accessing support from the organisation, managing high expectations of others, coordinating multidisciplinary teams and working with information systems (Gaskin et al., 2012). The challenge of managing a complex workplace in a somewhat unsupported environment (Gaskin et al., 2012; Paliadelis, Cruickshank, & Sheridan, 2007), with limited skills and knowledge to perform the role, poses significant challenges for NUMs in public hospitals.
2.6 Conclusion

In this chapter I have portrayed the context in which nursing and nursing management in public hospitals is organised and practised. NUMs are members of the nursing profession, whose work is primarily concerned with the performance of nursing practice within the public hospital system in Australia. I have discussed nursing management, its historical roots in nursing, and its place in the global, national and local landscape of healthcare. I have also identified contemporary challenges to nursing and nursing management as it is carried out in the public hospital sector, including demands for safety and quality, managing scope of practice and dealing with issues of power that have their roots in tradition. These factors form a complex and dynamic context that shapes the work that NUMs perform, including their relationships with others, their team participation strategies and the choices they make. This portrayal provides a backdrop for deeper discussion of the relationship between NUMs and nursing staff, and how they facilitate learning in clinical workplaces.
Chapter 3: Theoretical framework for understanding NUMs’ educational work

In this chapter, I build on the broad contextual descriptions provided in Chapter 2 to position my research in established and emerging scholarship around Nursing Unit Managers’ (NUMs’) learning facilitation practices. In this way, I seek to better understand the learning facilitation dimensions of NUMs’ roles and to identify what is already known about their work in enabling learning in clinical workplaces. Literature focused on NUMs’ practice in influencing learning in clinical workplaces is explored and critiqued. While the roles of other staff (e.g. Clinical Nurse Educators (CNE) and Clinical Nurse Specialists (CNS) who provide direct education to staff are acknowledged, NUMs’ contribution to staff learning is specifically highlighted. This literature review contributed to my deepening understanding of the learning facilitation dimension of NUMs’ work and answered in part the research question: How do Nursing Unit Managers influence learning in clinical workplaces?

A theoretical framework that combined three discrete but relevant theoretical perspectives related to learning in workplaces was constructed and used to enhance my understanding of NUMs’ learning facilitation practices in clinical workplaces. The theoretical perspectives used to form the theoretical framework are management theory (Mintzberg, 2009), practice theory (Kemmis et al., 2014) and workplace learning theory (Eraut, 2012). Mintzberg’s ‘model of managing’ explicitly positions NUMs’ learning facilitation activities within the frame of their management roles; Kemmis et al.’s concept of ‘practice architectures’ enables identification of NUMs’ influence on the conditions that shape clinical practice and hence learning; and Eraut’s ‘Factors influencing learning at work: the two-triangle model’ elucidates the learning potential in NUMs’ seemingly routine activities. Together, these three theories coalesce to form a framework that enables deeper understanding of the nature of NUMs’ learning facilitation work within its structural, contextual and social dimensions.
3.1 Frame and scope of this chapter

The aim of my literature review was to situate my research within the body of academic literature that reports NUMs’ learning facilitation practices in clinical workplaces. Key findings indicate that NUMs are well situated to influence learning in the workplace in multiple and complex ways. However, much of the literature reviewed did not directly explore this aspect of NUMs’ practice. Rather, their learning facilitation practices were detailed as implications and recommendations of studies that investigated various aspects of nursing work. NUMS’ learning facilitation practices are presented within two key themes: Understanding and developing the learning context (Section 3.3.2); and Developing a community of professional practice (Section 3.3.3). Studies reviewed were generally limited in depth and scope and few reported NUMs’ perspectives on their learning facilitation practices. Furthermore, studies that explored the broader scope of NUMs’ roles gave scant attention to an educational dimension. NUMS’ perspectives on how they facilitate learning have not been explored in contemporary literature to any depth. This was somewhat surprising, given the importance of NUMs’ work in influencing the quality and safety of patient care, and their proximity to the context in which care is provided.

As described in Chapter 2, NUMs take final responsibility for the standard of care that is delivered to patients on their units. In the acute care sector in Australia, as the context of this research, multiple services, professions and technologies interact to provide healthcare to a diverse population that is aging, experiencing more chronic illness and that has high expectations of care (Australian Institute of Health & Welfare, 2018). This phenomenon is also reflected more generally in many Western countries around the world (World Health Organisation, 2017). Patient care in the acute sector is highly specialised, knowledge intense, complex, and technically charged with NUMs’ responsibility for the standard of care on their units greater than ever (Paliadelis, 2008). Within this complex and demanding environment, safety in healthcare has become a significant national and global issue with 10% of all contemporary healthcare encounters resulting in an adverse event (Organisation for Economic Co-operation and Development, 2010) with little improvement noted in the last 15 years (Slawomirski, Auraaen, & Klazinga, 2017). The provision of safe patient care is dependent on a complex network of political, regulatory, structural,
technological and human factors that occur at all levels of the healthcare system (Slawomirski, Auraen, & Klazinga). However, at the point of delivery of patient care in acute healthcare settings, the ability of nursing staff to provide safe patient care is also dependent on their skill and knowledge of the specialty area in which they work, and on their capability to adapt to changing demands. This places a critical onus on NUMs to ensure conditions on their unit are conducive to nursing staff learning. This chapter reports findings of a literature review that explored how NUMs facilitate nursing staff learning within the dynamic context of their workplaces.

Given the broad range of contexts of contemporary healthcare delivery, this review was purposefully focussed on facilitation of learning in the acute care hospital sector as this was the context of the experiential component of this research. The acute care hospital sector was chosen as it is the site where the majority of nursing work is performed (Australian Institute of Health & Welfare, 2015), where the interface between NUMs’ work and staff performance is most complex and intense, and where frequent interactions with staff were expected to be found. It did not include the aged care or community health sectors as management positions in these sectors are not always occupied by NUMs. Furthermore, in community healthcare, models of care are different, staff often work in isolation of the NUM with less frequent interactions between NUMs and staff.

The scope of this review was also deliberately focussed on NUMs’ work. Here I differentiated between nurse management work, and leadership. Nursing literature abounds with studies on leadership, and in particular in relation to safe practice, quality care and staff retention (Asamani, Naab, & Ofei, 2016; Azaare & Gross, 2011; Merrill, 2015b; Saleh et al., 2018). Leadership involves a set of behaviours including inspiring staff and teams to achieve their full potential, being innovative, challenging the status quo and developing a common vision (Curtis, de Vries, & Sheerin, 2011). Generally, in healthcare, leadership is considered an integral component of management work (Chambers, 2011; Maddern, Lambert & Dwyer, 2016). However, leadership and management are not the same, and while leadership behaviours can occur within management roles, they also occur in non-management roles. Therefore, as the focus of this research was NUMs’ learning facilitation
practices, literature that included leadership within NUMs’ roles was included and literature that referred to leadership that was not specific to NUMs’ roles was excluded.

This literature review involved searching for relevant literature using key search terms and appropriate databases. The review focused on literature directly relating to management, leadership and learning in nursing workplaces. Therefore, search strategies were confined to predominantly healthcare and nursing data bases including CINAHL database (Allied Health & Nursing), Proquest Health and Medical Complete, Ebsco Host (Health), Informit Health and Medicine and Health and Society databases, and Pub Med Central, where nursing literature is found. The search was guided by the following key search terms: nursing management; nurse unit management; nursing unit manager; nurse leadership; learning; education; teaching; professional development: performance; induction; orientation; mentoring; staff; roles. All search terms were used separately and in combination.

Key papers informed further searching from reference lists and citation histories. This snowballing technique enabled the identification of further appropriate literature. Key ideas and themes were identified through thematic analysis and considered in relation to the aim of the review. These themes included: NUMs’ learning facilitation roles embedded within their established practice (presented in Table 3.1: Summary of NUMs’ learning facilitation roles within their established practice) and two themes specific to NUMs’ learning facilitation work: understanding and developing the learning context; and developing a community of professional practice.

Identified gaps in the literature about NUMs’ learning facilitation practices justified the conduct of this research. Furthermore, themes identified within this review informed the development of a theoretical framework, presented in Section 3.4.: Toward a theoretical framework, that enables deeper understanding of NUMs’ learning facilitation practices.
3.2 NUMs’ learning facilitation practices in contemporary healthcare contexts

Healthcare facilities, and acute hospitals in particular, are high risk environments that seek to achieve safe, high quality patient care. Within these complex and dynamic environments, a multitude of influences enable or inhibit the nature and quality of patient care. These influences are shaped by many factors associated with interactions between people, technology and the environment or the context in which patient care is provided (Healy & Sampford, 2011). At the level of the unit or ward, a place in a hospital where groups of patients who share similarities such as age, health conditions or treatments are cared for, NUMs have a key role in shaping the nature of that care.

NUMs, formerly known as ‘charge nurses’, have always, and continue to be, responsible for the quality of care provided to patients by nursing staff working on their units or wards (Bradshaw, 2010). Traditionally, NUMs were responsible for the clinical teaching of students and registered nurses. They ensured student nurses were allocated appropriate patients and played a role in clinical teaching and provided direct oversight to student learning (Duffield & Franks, 2002). As nurse education moved into tertiary institutions during the 1990s, as a result of the need for more comprehensive education (Australian Government Department of Health, 2013), and student learning responsibilities were passed on to university educators, NUMs’ direct clinical teaching roles were diminished (Bradshaw, 2010). Their teaching role was confined to organising opportunities for ongoing learning and professional development for Registered Nurses (Duffield, Wood, Franks, & Brisley, 2001). At the same time, a move towards achieving greater efficiency in healthcare saw the role of NUMs change from one of clinical oversight to one that was more managerial, including tasks such as budgeting, staffing, managing systems and processes, quality assurance with much less involvement in clinical matters (Bradshaw, 2010; Duffield & Franks, 2002).

As NUMs’ work moved away from more explicit learning facilitation roles, contemporary research tended to limit its focus on learning facilitation aspects of NUMs’ work. The limited presence of NUMs’ learning facilitation practices in the academic literature was also reflected in practice with NUMs in one study reporting
time spent on learning facilitation work as little as five per cent of their total work time (Armstrong et al., 2015) and in another, considered lost altogether (Bradshaw, 2010).

Challenging these views, it has also been proposed that, rather than disappearing, NUMs’ learning facilitation roles have been transformed (Duffield et al., 2001; Gerrish, 1990). As the role of student nurses in the clinical workplace has changed from service delivery to learning, the focus of NUMs’ learning facilitation roles have changed from providing direct instruction to developing and maintaining their units as designated learning environments (Bradshaw, 2010; Duffield et al., 2001; Gerrish, 1990). This renewed focus on learning also includes developing mentors, and delegating responsibilities to maximise learning opportunities for qualified staff (Gerrish, 1990). Further, owing to the rate of change and complexity of healthcare within contemporary nursing units, there is a corresponding need for continual learning by Registered, Enrolled and Assistant Nurses (Duffield et al., 2001). This learning occurs within units as routine parts of daily nursing work and the culture and learning focus of these environments is largely shaped by NUMs. NUMs also have a key role in supporting the professional development of Registered Nurses through mentoring and coaching, as well as assisting staff to understand and translate organisational processes into clinical care (Duffield & Franks, 2002). Within these environments, NUMs’ work is multifaceted with multiple tasks carried out simultaneously, and roles and activities blended as NUMs move between people, processes and activities in establishing an environment in which safe, quality patient care can be provided (Mintzberg, 2002). NUMs’ learning facilitation practices are no longer as explicit as they were during the era of hospital-based nurse training, when NUMs engaged in direct instruction and oversight of student learning. Their influence on learning now is more complex, nuanced and is likely hidden within the routines that define their management work. Deeper understanding of the nature of NUMs’ diverse, implicit and explicit learning facilitation practices will open possibilities to enhance these practices and maximise their influence on the quality of care that is provided to patients on their units.

Since the transfer of nursing education to the tertiary sector, NUMs’ roles have changed. Within the renewed scope of their practice, their learning facilitation roles have become less well recognised. In the following section, findings from a detailed
review of academic literature on NUMs’ educational roles since the transfer of nurse education to the tertiary sector is presented.

3.3 Contemporary understanding of NUMs’ learning facilitation practices

In this section I present a detailed review of literature that explores NUMs’ learning facilitation practices. Three key themes emerged from this review: NUMs’ learning facilitation roles embedded within their established practice (summarised in Table 3.1: NUMs’ learning facilitation roles embedded within their established practice); understanding and developing the learning context; and developing a community of professional practice. This section concludes with a synopsis and appraisal of key findings from this review that situate my research within a body of contemporary and relevant literature.

3.3.1 NUMs learning facilitation roles within their established practice

Studies that reported an exploration of the scope of NUMs’ work (i.e. what do NUMs do?) (see Table 3.1: NUMs’ learning facilitation roles embedded within their established practice) were reviewed in order to understand the extent to which NUMs’ learning facilitation roles were recognised in relation to the full scope of their management practice. Management, in this research, is considered to be a social practice, embedded in context (Mintzberg, 2009). Management work consists of a multitude of roles and activities bound to context and networked and “infused” with one another (Mintzberg, p. 94), an observation that is consistent with NUM work (Chiarella & Roydhouse, 2011; Duffield, Roche, Dimitrelis, Homer, & Buchan, 2015). Individual roles must therefore ideally be understood within their wider social context and in relation to the network of roles and activities that constitute their practice. Studies of NUMs’ roles are of value to organisations, as behaviours associated with effectiveness can inform the development of selection criteria, education and training programs for NUMs (Duffield, 1992) and can provide insight into factors that contribute to their job satisfaction (Paliadelis, 2008).

Twenty-two studies that explored NUMs’ work since 1990 were included in the review (see Table 3.1: NUMs’ learning facilitation roles embedded within their established practice). Each was evaluated to determine whether NUMs’ learning
facilitation roles had been embedded within their established practices, that is, identified within a broader examination of their roles, and how their learning facilitation roles were perceived. Overall, studies that identified an association between NUMs’ roles and staff learning typically did not discuss the nature of the learning facilitation relationship in any depth. Ten studies specifically identified a learning facilitation role (Anthony et al., 2005; Armstrong et al., 2015; Duffield, 1994; Gunawan & Aungsuroch, 2017; Lin, Wu, & White, 2005; McCallin & Frankson, 2010; McSherry et al., 2012; Pegram, Grainger, Jones, & While, 2015; Shirey, 2009; Sveinsdottir, Blondal, Jonsdottir, & Bragadottir, 2018). Four of these studies (Anthony et al., 2005; Lin et al., 2005; McSherry et al., 2012; Shirey, 2009) reported that NUMs placed a high level of importance on the learning facilitation aspects of their work. These four studies were dissimilar in their perspectives on the circumstances that deemed their learning facilitation practices to be important.

NUMs’ closeness to the point of care was emphasised as instrumental in enabling mentoring and coaching staff and translating organisational goals into unit practice (Anthony et al.): practices consistent with learning facilitation. Key priority areas for training, identified by NUMs, gave emphasis to learning facilitation (Lin et al.): an interesting finding from a large survey conducted across multiple organisations that extended literature that simply identified the role, to consideration of enabling skills. Being able to negotiate a complex network, was emphasised as critical in NUM facilitation of staff learning (McSherry et al.). Finally, in an environment otherwise characterised by multiple stressors NUMs emphasised their teaching activities as sources of pleasure (Shirey). While this was a small study (n=5), the case study method enabled deep interpretation of participants’ responses to their work within a particularly challenging context, and the relief that was found in teaching activities was an interesting finding. This small amount of literature gives emphasis to the presence of a learning facilitation dimension of NUMs practice, but also of their varied perspectives on this aspect of their work.

Other studies that explored NUM roles (Armstrong et al., 2015; Duffield, Pelletier, & Donoghue, 1994; Gunawan & Aungsuroch, 2017; McCallin & Frankson, 2010; Pegram et al., 2015) gave scant attention to their learning facilitation roles. While only a small number of studies identified a learning facilitation role, differences in
the emphasis and value placed on learning facilitation roles signals an aspect of NUMs’ practice that warrants deeper understanding.

Among studies reviewed in this section (see Table 3.1), the authors’ chosen research paradigm significantly influenced the nature of the findings, including those suggestive of a learning facilitation role. Most research that identified NUMs’ learning facilitation roles were undertaken in an interpretive paradigm (Anthony et al., 2005; Gunawan & Aungsuroch, 2017; McCallin & Frankson, 2010; Shirey, 2009) which invited the participants to openly describe their roles guided by a semi-structured interview. Of the seven studies that followed an empirico-analytic paradigm, only three (Lin et al., 2005; Pegram et al., 2015; Sveinsdottir et al., 2018) identified a learning facilitation role, perhaps as a result of the closed structure of the survey instruments that restricted opportunities for individual contributions. Fixed questions in these surveys asked about nurse training (Lin et al., 2005), providing opportunities for staff to learn management work (Pegram et al. 2015) and arranging education and providing information to staff (Sveinsdottir et al., 2018). Two studies that drew from mixed methods (Armstrong et al., 2015; Duffield, 1994) identified a learning facilitation role within the interpretive component of their research. This review revealed that, when given an opportunity to speak openly about their role, NUMs were more likely to reveal learning facilitation activities. The exclusion of learning facilitation roles from closed surveys is suggestive of the low visibility of this aspect of NUMs’ practice. This finding heralds the significance of qualitative approaches for understanding NUMs’ work, and justifies the choice of an interpretive methodology in the current study to understand its dimensions.

Studies that did identify a learning facilitation role within NUMs’ broader scope of practice presented varying perspectives. Learning was deemed to occur as an outcome of established relationships with unit staff (Duffield, 1994; Purnell, 1999) and included coaching, teaching staff, modelling, removing barriers to learning, evaluating performance, providing feedback and enabling staff to reach their full potential (Duffield, 1994) and effective communication (Purnell, 1999). NUMs’ learning facilitation roles were also viewed more rationally as ‘resourcing’ the work of nurses to provide quality outcomes, similar to providing access to equipment, administrative support and fiscal arrangements (Anthony et al., 2005; Everson-Bates, 1992). These rational perspectives that view NUMs’ learning facilitation work as a
tangible commodity contrast with the “human skill” (Duffield, 1994) perspective that considers the implicit aspects of human relationships as foundational to learning. The dissonance between these two perspectives signals that this area requires further exploration.

Generally, studies reviewed revealed that NUMs valued teaching activities, and viewed teaching as part of their role even if their busy schedule prevented them from engaging in this work. Teaching was identified as a “source of joy” (Shirey, 2009) and as a means to enhance staff development (Skytt et al., 2008). Conflicting with this finding, Armstrong et al. (2015) reported that NUMs did not see learning facilitation as a part of their role, despite spending a portion of their time on it. In this comprehensive qualitative study, which explored a large sample (n=36) of NUMs’ working in a stressed practice environment, a shortage of staff meant that NUMs worked extensively in the clinical area, and perhaps resented the additional demands of teaching. These different perspectives highlight the significant impact of the work context on NUMs’ learning facilitation practice and on their perspectives on their roles, particularly those related to learning facilitation.
Table 3.1. Summary of NUMs’ learning facilitation roles within their established practice

<table>
<thead>
<tr>
<th>Article</th>
<th>Aims and research questions</th>
<th>Methodology, participants and research paradigm</th>
<th>Findings relevant to phenomenon. Where was the learning facilitation role identified?</th>
</tr>
</thead>
</table>
| Anthony, M., Standing, T., Glick, J., Duffy, M., Paschall, F., Sauer, M., … Dumpe, M. (2005). Leadership and nurse retention: The pivotal role of nurse managers. *Journal of Nursing Administration*, 35(3), 146–155 | • To describe the roles and skills of NMs, whether they possess these skills, the characteristics of the NM that facilitate or serve as barriers to nurse retention, and to describe the strategies that NMs believe will improve retention. | Method: Focus groups  
Participants: NUMs (n = 32)  
Paradigm: Interpretive                                                                                                                                         | • Identified learning facilitation role as resourcing work of nurses. NUMs valued mentoring and influencing staff development.                                                                                   |
• What characterises first- and second-line HCMs’ work and their use of time?                                                                                     | Method: Observations and interview  
Participants: Mostly NUMs (n = 6)*  
Paradigm: Interpretive  
*Social workers (2), doctor (1) and psychologist (1)                                                                                                              | • No identification of learning facilitation role. Time on clinical work, working close to the action, and disseminating information suggest an educational role.                                                   |
Participants: NUMs (n=36)  
Paradigm: Interpretive/empirico-analytic                                                                                                                            | • Identified learning facilitation role as 3.6% of role. Roles included direct education and organising professional development.                                                                                  |
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<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Research Question</th>
<th>Method</th>
<th>Participants</th>
<th>Paradigm</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Baker, M. S., Marshburn, D. D., Crickmore, B. K., Rose, C. S., Dutton, C. K., &amp; Hudson, C. P.</td>
<td>What do you do? Perceptions of nurse manager responsibilities. <em>Nursing Management (Springhouse)</em>, 43(12), 24–29.</td>
<td>To examine nurse managers’ perceptions of: the frequency of performing specific key responsibilities of their role, level of importance of these responsibilities, and levels of expertise in meeting the expectations of the role.</td>
<td>Survey</td>
<td>NUMs (n=29)</td>
<td>Empirico-analytic</td>
<td>No identification of learning facilitation role. However, “coaching while rounding” reported by 83%. Mentoring and disseminating information, preparing and writing staff evaluations suggest a learning facilitation role.</td>
</tr>
<tr>
<td>Boldy, D., Della, P., Michael, R., Jones, M., &amp; Gower, S.</td>
<td>Attributes for effective nurse management within the health services of Western Australia, Singapore and Tanzania. <em>Australian Health Review</em>, 37(2), 268–274.</td>
<td>To identify the perceptions of nurse managers in Western Australian, Singapore and Tanzania regarding those attributes that are desirable for effective management of their health services, and to discuss the implications for health-management education provided by Australian universities.</td>
<td>Survey</td>
<td>NUMs (n = 211)</td>
<td>Empirico-analytic</td>
<td>No identification of learning facilitation role or attributes associated with educational work.</td>
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<tr>
<td>Duffield, C.</td>
<td>Nursing unit managers: Defining a role. <em>Nursing Management</em>, 25(4), 63–67.</td>
<td>To determine the role of the NUM in NSW</td>
<td>Delphi</td>
<td>Panel: senior nursing academic and industry experts</td>
<td>Interpretive/empirico-analytic</td>
<td>Identified learning facilitation role, based on Katz’s framework, that 49% of skills were technical, 34% human, and 17% conceptual. Learning facilitation roles including staff development were included under human skills.</td>
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<td>Author(s)</td>
<td>Title</td>
<td>Method</td>
<td>Participants</td>
<td>Paradigm</td>
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<td>Ericsson, U., &amp; Augustinsson, S. (2015)</td>
<td>The role of first line managers in healthcare organisations – A qualitative study on the work–life experience of ward managers. <em>Journal of Research in Nursing</em>, 20(4), 280–295.</td>
<td>Longitudinal study (4yrs) action research, interviews, observation and continuous dialogues</td>
<td>NUMs (n = 6)</td>
<td>Critical/interpretive</td>
<td>To describe the ward managers’ experiences of their professional role, their work and how they are handling their everyday practice. To interpret these experiences through the lens of regenerative work.</td>
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<tr>
<td>Kallas, K. D. (2014)</td>
<td>Profile of an excellent nurse manager. <em>Nursing Administration Quarterly</em>, 38(3), 261–268.</td>
<td>Cross-sectional survey</td>
<td>NUMs (n = 233)</td>
<td>Empirico-analytic</td>
<td>To identify the profile of an excellent nurse manager who can lead effective healthcare teams. How do nurse managers translate the values of the organisation into actual practices?</td>
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<td>No identification of learning facilitation role. Role of translator of organisational process and sense makers suggest a learning facilitation role. Regenerative work theory (various authors) limited in framing analysis.</td>
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<td>No identification of learning facilitation role. Emphasis on social role, the intensity of human interaction, resourcing staff via skills development, maintaining standards, coaching and disseminating information suggest a learning facilitation role.</td>
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<td>Identified learning facilitation role: developing skill level of staff within the category of organising. However the focus was minimal.</td>
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<td>No identification of learning facilitation role. Enabling others to act: “Leaders foster collaboration and strengthen others to create a climate of teamwork, trust, and empowerment” (p.263) suggests an educational dimension.</td>
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<tr>
<td>Authors</td>
<td>Title</td>
<td>Method</td>
<td>Participants</td>
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<tr>
<td>Kantanen, K., Kaunonen, M., Helminen, M., &amp; Suominen, T.</td>
<td>Leadership and management competencies of head nurses and directors of nursing in Finnish social and health care. <em>Journal of Research in Nursing</em>, 22(3), 228–244.</td>
<td>Survey</td>
<td>NUMs (81%) and Senior Nurse Managers (19%) (n = 1025)</td>
<td>Empirico-analytic</td>
<td>No identification of learning facilitation role. Did not identify educational competencies or skills.</td>
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<tr>
<td>Lin, L.-M., Wu, J.-H., &amp; White, L. P.</td>
<td>Managerial activities and skills of nurse managers: An exploratory study. <em>Hospital Topics</em>, 83(2), 2–9.</td>
<td>Questionnaire</td>
<td>NUMs (n = 382)</td>
<td>Empirico-analytic</td>
<td>Identified learning facilitation role. Found that nursing training was considered by nurse managers at all levels among the top five critical management activities. Possibly more important in the Taiwan environment.</td>
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<tr>
<td>McCallin, A. M., &amp; Frankson, C.</td>
<td>The role of the charge nurse manager: A descriptive exploratory study. <em>Journal of Nursing Management</em>, 18(3), 319–325.</td>
<td>Descriptive exploratory interviews</td>
<td>NUMs (n = 12)</td>
<td>Interpretive</td>
<td>Identified learning facilitation role. Mentioned developing staff as a challenge, but minimal emphasis given to this role.</td>
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<tr>
<td>Source</td>
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- To undertake a discursive analysis of key issues associated with providing excellence in nursing care.
- To explore aspects of the working life of ward managers and their views regarding their role, perceived challenges and potential enablers to empower ward managers to lead clinical care.
- To analyse and predict the kinds of nurse managers who will be needed in the complex healthcare organisations of the very near future and what the education of these nurse managers should be.

- Identified developing staff and nurturing a learning environment as central.
- Identified learning facilitation role. Challenging poor practice, organising professional development and training staff to undertake management work included in the survey, but not highly rated by participants.
- No identification of learning facilitation role. Participants ranked “people developer” highly among the top roles they identified, suggesting a learning facilitation role.
- No identification of learning facilitation role. Human resource management, leadership and quality suggest a learning facilitation role.
<table>
<thead>
<tr>
<th>Source</th>
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NUMs’ direct engagement in learning activities was implied rather than explicitly stated in several studies. Activities identified that were suggestive of a learning facilitation role included disseminating information (Arman et al., 2009; Baker et al., 2012; Everson-Bates, 1992; Skytt et al., 2008); overseeing staff development (Skytt et al., 2008) mentoring (Baker et al., 2012; Drach-Zahavy & Dagan, 2002); coaching (Baker et al., 2012; Everson-Bates, 1992); and skills development (Everson-Bates, 1992). However, the precise nature of NUMs’ roles in performing these activities, whether through delegation or direct action, and their relationship to staff learning was not clearly articulated in the articles reviewed.

In summary, research that explored the scope of NUMs’ work gave scant attention to their learning facilitation roles. Studies that did identify a learning facilitation role were few in number, and most drew from small scale interpretive research. Where an educational role was identified, findings were largely confined to specific, tangible learning facilitation roles and tasks that can be articulated and understood as discreet activities, such as organising training. These studies did not elaborate on how NUMs’ learning facilitation practice was conducted, did not refer to any pedagogical aspects, nor to the significance of it in relation to the management of the unit or in relation to other activities. NUMs’ role in enabling less formal and implicit forms of learning such as learning through social relationships and creating challenge for example, were not identified. This omission from the academic literature establishes a justification for deeper exploration of NUMs’ less explicit roles and practices in facilitating learning that underpin my research.

In the following sections, literature that reveals NUMs’ learning facilitation practices in relation to specific dimensions of clinical practice is presented. Two themes: understanding and developing the learning context; and developing a community of professional practice, guide discussion in this section.

3.3.2 Understanding and developing the learning context

NUMs’ work is largely considered as ‘pivotal’ to the achievement of outcomes in their clinical units (Pegram et al., 2015); and instrumental to converting the policy and organisational context of work into actions at the operational level (Orovigoicoechea, 1996). Communication, as the primary means by which NUM
work is carried out (Everson-Bates, 1992), includes communicating work requirements to staff, but also actively seeking to understand the way that work is being performed by listening, feeling, observing and questioning (Robbins, Bergman, & Coulter, 2018). Effective communication enables NUMs to develop better understanding of their units by monitoring, interpreting and responding to the learning needs of staff working in the unit. In this section, the actions taken by NUMs to understand and develop their units or wards as learning contexts are examined. This understanding is foundational to my research, which sought to more deeply understand the influence of context on NUMs’ learning facilitation practices.

In general, managers’ understanding of their workplaces informs decisions to intervene when a discrepancy exists between actual and desired states (Robbins et al., 2018). In hospital contexts, this understanding may come from quantitative measures of workplace performance such as data acquired from audits of falls or medication errors. Understanding can also emerge from qualitative measures such as the ‘feel’ of the workplace, the nature of it, a sense of the morale, energy and uncertainty that exists (Robbins et al., 2018). NUMs’ ability to know about and respond to nursing practices on their units is dependent on their relationship with their staff, their degree of emotional intelligence, and importantly, the nature of the workplace culture and patterns of communication (Henderson, Burmeister, Schoonbeek, Ossenberg, & Gneilding, 2014). Furthermore, NUMs’ ability to understand and shape workplace context is foundational to the generation of knowledge (Lunden, Teräs, Kvist, & Häggman- Laitila, 2017). Thus context becomes an important resource for facilitating staff learning and achieving unit patient care outcomes.

Few studies evaluated in this review directly explored NUMs’ perspectives on how they developed an understanding of the learning context of their units. However, several studies identified NUMs’ capacity for developing a learning culture as a powerful contextual influence on learning. Actions that contributed to the development of a learning culture included engaging with staff, sanctioning staff involvement in clinical learning (Henderson et al., 2014); promoting knowledge sharing (Lee, Kim, & Kim, 2014) and developing environments that are collaborative and interactive (McSherry et al., 2012). Reported benefits of NUMs’
development of a learning culture included staff development of self-esteem and confidence (Hegenbarth, Rawe, Murray, Arnaert, & Chambers-Evans, 2015); effective transfer of learning (Currie, Tolson, & Booth, 2007); effective adaptation of new staff (Baxter, 2010); and an openness to organisational learning (Lee et al., 2014). While these studies recommended actions that NUMs could use to establish a learning culture, exploration of NUMs’ perspectives on how they establish a learning culture was limited, and few details about the circumstances, values or rationale that informed NUMs’ actions were provided.

NUMs’ capacity to influence the development of a learning culture has also been associated with the generation of knowledge that can be stored, processed and shared to enhance workplace learning (Carr & Clarke, 2010). Such generation of knowledge can be interpreted and understood as a dimension of ‘organisational learning’, a conceptual framework based on the work of Argyris and Schön (1978), that is commonly used to explain distributed learning in workplaces and organisations. Organisational learning refers to learning that is shared throughout an organisation and wider context. It aims to extend immediate learning (‘single loop learning’) from a position of measuring performance based on established standards and assumptions (such as audits), to one where established standards are critically challenged, and new ways of conceiving problems and performance are explored (Argyris & Schön, 1978). Organisational learning refers to a collection of practices that merge individual learning with collective learning and is highly dependent on culture and team approaches (Senge, 2006). NUMs have an important role to play in recognising and removing obstructions to organisational learning, such as being locked in to entrenched practices (Carr & Clarke, 2010), and developing a culture that opens up opportunities for challenge and consequently learning.

NUMs’ contribution to the development of a culture of organisational learning within clinical workplaces is increasingly being acknowledged (Abdi, Delgoshaei, Ravaghi, Abbasi, & Heyrani, 2015; Ammouri, Tailakh, Muliira, Geethakrishnan, & Al Kindi, 2015; Carr & Clarke, 2010; El-Jardali et al., 2010; Lyman Hammond & Cox, 2018). Several studies referred to the role of NUMs in influencing organisational learning in relation to incident management (Abdi, Delgoshaei, Ravaghi, Abbasi, & Heyrani, 2015; Ammouri, Tailakh, Muliira, Geethakrishnan, &
Al Kindi, 2015; El-Jardali et al., 2010) although examination of the nature of their role in this process was limited. Other studies presented more comprehensive analyses. Carr and Clark, in their extensive study of practice within the National Health Service in the United Kingdom, identified NUMs as instrumental in challenging entrenched practices and mobilising staff towards engaged practices that supported innovative enhancements to service delivery. More recently, Lyman, Hammond and Cox more deeply defined the role of NUMs in organisational learning in their detailed conceptual analysis of organisational learning. Both studies present strong arguments that position NUMs as brokers in the process of organisational learning. These studies emphasise that the double loop or ‘generative’ learning that occurs can be augmented by NUMs’ encouragement of questioning and a culture of openness to challenge, and by inviting and responding to staff ideas (Carr & Clarke, 2010; Lyman Hammond & Cox, 2018). These descriptions of NUMs’ contributions to organisational learning highlight the centrality of NUMs’ roles within a frame of organisational learning and are suggestive of practice areas worthy of deeper exploration.

Research studies that seek understanding of NUMs’ work in developing safety cultures and practices in clinical workplaces convincingly illuminate the concept of organisational learning (Abdi et al., 2015; Ammouri, et al., 2015; Chiang et al., 2011; El-Jardali et al., 2010; Merrill, 2015). NUMs’ roles in achieving these aims include communicating awareness about error, encouraging learning from error by supporting open communication (Merrill, 2015), effective team work and inviting staff suggestions about ways to improve safety (Ammouri et al., 2015) and convening knowledge gathering activities and team reflection (Lyman Hammond & Cox, 2018). Other roles directed toward developing safety cultures and practices include facilitation of NUMs’ understanding of error through analysis and reporting of incidents (Abdi et al., 2015), made possible by the development of a non-punitive culture (Chiang et al., 2011; El-Jardali et al., 2010; Merrill, 2015) and through effective leadership behaviours (Ammouri et al., 2015). While these researchers have interpreted NUMs’ work practices within the frame of organisational learning, NUMs’ accounts of their experiences of implementing strategies for the purpose of facilitating a learning culture in their units were not explored to any depth. These
studies, which conceptualise NUMs’ work within an organisational learning frame signal a focus for deeper exploration.

It is increasingly accepted that NUMs’ work in influencing learning in the workplace requires developing a culture of open communication and challenging common and entrenched practices, and using information and seeking understanding as a precursor to decision making. However, NUMs’ perspectives on their role in fostering learning within these domains, and of the circumstances and rationale for their practice decisions, have not been explored.

3.3.3 Developing a community of professional practice

NUMs’ work has long been acknowledged as being carried out primarily through their interactions with people (Everson-Bates, 1992; Hartung & Miller, 2013). While communicating and gathering information enables NUMs to better understand the workplace, as explored in the previous section, they also play an important role in directly influencing the performance of staff, both individually and collectively, in their units. This review has identified that NUMs’ interactions with staff primarily influenced learning in two ways: through professional interpersonal relationships that facilitated individual learning; and through leadership of teams.

*Professional interpersonal relationships: Influencing individuals*

NUMs’ professional, interpersonal relationships with staff has been identified as a key influence on staff learning (Anonson et al., 2014; Galuska, 2012; Lievens & Vlerick, 2014; Muldowney & McKee, 2011) and on staff engagement (Manning, 2016) as an antecedent to learning. NUMs' support of staff work, and provision of opportunities for learning and empowering and ‘connecting’ with staff has been demonstrated to facilitate staff learning (Muldowney & McKee, 2011). These activities are also associated with the development of positive learning environments (Anonson et al., 2014). Further, NUMs’ explicit interest in creating opportunities for learning and challenge, giving feedback and mentoring to foster development has also been reported as indicative of an effective professional relationship with staff, factors which enable or constrain development and learning (Galuska, 2012).
NUMs’ relationships with individual staff are often developed through mentoring, considered one of the most common learning facilitation activities that occur in nursing (Stoddart et al., 2014). Mentoring, as an activity that NUMs engage in directly or delegate to other experienced nurses, is carried out close to the point of care. Mentoring is considered vital for staff learning, as effective mentoring relationships can sustain professional and career development over a longer period (Anonson et al., 2014), contribute to strong learning cultures (Anonson et al., 2014); and to the development of management skills in Registered Nurses (Ekström & Idvall, 2015; Galuska, 2012). The NUM’s mentorship role was valued in these studies as an important influence on individual staff learning and culture. Mentoring activities included knowledge sharing and questioning in relation to patient care, providing opportunities to undertake new challenges whilst being supported, being active in others’ learning (Anonson et al., 2014) and providing feedback and guidance (Galuska, 2012). In bringing the NUM into the nurse-patient workspace, mentoring affords opportunities for synchronous learning and feedback as work is being carried out.

Modelling has also been considered a powerful learning facilitation strategy that is associated with leaders (managers) who have a high degree of presence in the working context of the learner (Anonson et al., 2014). Learning through modelling occurs vicariously as models provide cues that communicate desired, important and valued behaviours (Schunk & Zimmerman, 2012). NUMs’ cultivation of effective professional relationships with staff establishes a firm basis on which to model effective behaviours. Through modelling NUMs can shape the social context and the nature of relationships, of values and culture that in turn, can influence the behaviours of staff as models for others to learn from.

Modelling, as a learning facilitation strategy, also occurs within mentoring relationships (Stoddart et al., 2014). However, while studies explored and advocated for modelling and or mentoring as an important role for nursing managers (Ekström & Idvall, 2015, p. 84) none of these studies explored to any depth how NUMs carried out mentoring work, were not able to distil any intention, rationale or purpose from these activities.
Further evidence of NUMs’ direct influence on learning within work activity was found in Matsuo’s (2012) study that explored NUMs’ roles in developing staff learning through reflection. Reflective practice is often advocated as a key learning strategy for nurses’ ongoing professional development (Bolton, 2014; Dubé & Ducharme, 2015) and evidence of reflective writing is a requirement for registration with AHPRA in Australia (Nursing & Midwifery Council of Australia, 2016). Reflective practice has been described as learning that arises from active consideration of past experiences, (‘Reflection-on-action’), and in relation to deliberation and inquiry-based thinking about a situation and the underlying assumptions that inform action, as it is occurring (‘Reflection-in-action’) (Schön, 1983). The critique of tacit experience that occurs during action, ‘reflection-in-action’ is thought to enable release of explicit knowledge, which can be recognised and drawn on subsequently (Raelin, 2008). While experiential reflection, occurring through reflection ‘on’ and ‘in’ action is a component of individual learning, collective or team reflection provides other possibilities for learning from modelling, sharing ideas and perspectives, questioning assumptions and testing ideas (Raelin, 2008). Matsuo identified a key role of NUMs in enabling this process, encouraging reflection by being present in the clinical area and actively questioning staff on aspects of their practice. Matsuo’s work extended reflective practice beyond that of individual reflection, as explained by Schön (1983), to reflection in a social context where group models and goal development provide a basis for learning about individual professional practices. While Matsuo’s study identified the role of NUMs in influencing learning through support of reflective practice, the use of a survey limited the depth to which NUMs’ perspectives on this aspect of their practice could be collected and understood.

The inherently human nature of learning in acute hospital settings highlighted in these studies is suggestive of the distinctively individual nature of nursing unit management work in facilitating learning. However, most of these studies reported the perspectives of Registered Nurses and other unit staff on NUMs’ learning facilitation practices. How NUMs perceived this aspect of their roles and the circumstances under which they sought to enrich interpersonal relationships to advance staff learning had not been explored in the literature reviewed. This highlights a need for a deep exploration of NUMs’ perspectives on their interactions
with staff for the purpose of learning, and on the conditions under which these interactions occur.

*Leadership: Influencing teams*

Leadership, as discussed in Section 3.1 is considered integral to NUMs’ work in influencing teams as sites of professional practice. Leadership has gained prominence in nursing as an essential strategy for achieving effective healthcare across all levels of the healthcare system, nationally and globally (Broome & Marshall, 2017). The World Health Organization (2016) recognises the role of nursing leadership in achieving universal health coverage and as agents of change in creating responsive workplaces. The International Council of Nurses (2018) emphasises leadership in its core values, priority areas and projects; an approach that is reflected in the priority areas of Australia’s peak nursing organisation, the Australian College of Nursing. Leadership capability is also embedded in the core knowledge and skills for Registered Nurses and Nursing Unit Managers included in the NSW Public Health System Nurses’ and Midwives’ (State) Award 2017 (Industrial Relations Commission of New South Wales, 2017). Leadership is firmly embedded in the language and culture of health services and of the health professions who work throughout the healthcare system.

Numerous studies have explored leadership in nursing management (Anthony et al., 2005; Asamani et al., 2016; Azaare & Gross, 2011; Duffield et al., 2011; Fischer, 2016; Merrill, 2015; Saleh et al., 2018). Of particular interest to this review was literature that explored NUMs’ learning facilitation work as a component of their leadership role. Leader behaviours associated with learning included effective communication, advocacy, developing an enabling culture and an environment that supports autonomy, effective relationships and continuing education (Anthony et al., 2005). Being perceived as a good leader/manager, engaging with staff regularly on clinical matters, providing flexible work rosters, being visible and accessible, praising and recognising good work, communicating a clear philosophy of work, including staff in decision making and encouraging innovation, associated with nursing staff retention (Duffield et al., 2011), have also been identified as positive NUM leadership behaviours. Leadership behaviours identified in these studies
suggest NUMs’ high degree of ‘presence’ in the work of staff opens up opportunities to facilitate staff learning.

Several studies that explored NUMs’ leadership of learning emphasised transformational leadership as a central quality (Lievens & Vlerick, 2014; Salmela, Eriksson, & Fagerström, 2012; Sorenson, Marshall, & Broome, 2017; Witges & Scanlan, 2014). Transformational leadership is associated with a leader who inspires others to support common aims; is able to communicate a shared vision, stimulate thought and challenge common assumptions; and uses personal skills to create an enabling culture (Sorenson, Marshall, & Broome, 2017). Learning has been implicated in multiple ways in studies of transformational leadership in nursing, including influencing personal learning and transformation in response to change (Salmela, Eriksson, & Fagerström, 2012); as a catalyst for learning through the encouragement of intellectual stimulation (Witges & Scanlan, 2014); and as staff knowledge-seeking behaviours (Lievens & Vlerick, 2014). Teaching and clinical supervision have also been identified as important NUM leader behaviours particularly in achieving safe care (Pinnock, 2012). In addition to achievement of safe care, the provision of learning opportunities within leadership roles has also been associated with the development of healthy workplaces (Tomey, 2009). Leader behaviours that embed opportunities for growth (or learning) are considered essential for developing an empowered workplace (Laschinger et al., 2009). A recent study (Choi, Kim & Kim, 2018) explored NUMs’ educational leadership roles, and recommended NUMs provide opportunities for learning, seek to understand staff skill levels, and organise learning activities to enhance learning and team performance. Many of these leadership of learning interventions were also valued as ways to retain staff, a salient challenge in the current healthcare climate where staff attrition is high (Anthony et al., 2005; Duffield et al., 2011; Kleinman, 2004; Laschinger et al., 2009; Lievens & Vlerick, 2014; Tomey, 2009). NUMs’ use of interpersonal skills in encouraging, empowering and inspiring staff performance illuminated learning facilitation work as integral to their transformational leadership role.

Implications for NUMs’ leadership of learning have also emerged from studies that report a lack of adoption of Evidence Based Practice (EBP) in nursing, despite its
known association with enhanced quality and safety of care (Melnyk Gallagher-Ford, Thomas, Troseth Wyngarden, & Szalacha 2016). Learning in EBP occurs as nurses engage in critical questioning, consideration and use of evidence in relation to practice (Melnyk, et al, 2016). Recent studies have identified a central role for NUMs in supporting teams to embed research into practice, (Caramanica & Spiva, 2016; Skela-Savič, Hvalič-Touzery, & Pesjak, 2017; Timmins, McCabe & McSherry 2012). Practices that seek to raise the interest of staff, cultivate a research culture and vision, modelling, organising journal clubs (Timmins, McCabe & McSherry), monitoring staff engagement with research, providing mentors, encouraging questioning to stimulate use of EBP, and providing necessary resources (Caramanica & Spiva, 2018) have been suggested as important practices for NUMs to adopt to facilitate EBP in nursing teams.

However, while these studies recognised the capacity of NUMs to facilitate learning, they did not explore NUMs’ perspectives on their enactment of these activities, or of the circumstances or precursor events that influenced their leadership of learning work for individuals and teams. This limitation has been recently highlighted by Fischer (2016) who identified, in a comprehensive conceptual analysis, an absence in the nursing leadership literature of an exploration of how leadership activities are carried out or of their foundations. This omission in the literature establishes a basis for deeper understanding of how NUMs influence learning as reflected in my research focus.

This literature review has revealed that NUMs’ learning facilitation roles are poorly recognised within the scope of their management work. Although substantial recognition has been given to the potential for NUMs to influence development of the learning context, and of individuals and teams as members of the unit’s community of professional practice, NUMs’ perspectives on their learning facilitation practices have received minimal attention in contemporary literature. My research focus on NUMs’ learning facilitation practices will contribute new knowledge and understanding in this space. To assist development of a deeper understanding of NUMs’ learning facilitation practices, a theoretical framework founded on relevant practice and workplace learning theories was sought. Given the lack of focus on the pedagogical dimensions of NUMs’ learning facilitation practices in contemporary literature, development of a theoretical framework founded on
relevant pedagogical theories is needed to assist development of a deeper understanding of NUMs’ learning facilitation practices. The theoretical framework built on the literature presented in this review, guided interpretation of my experiential texts, of how NUMs directly influence staff learning during the process of work and facilitated development of a deeper understanding of NUMs’ role in influencing learning within the routines of unit work. This understanding challenges the assumptions that NUMs no longer have a role to play in directly influencing learning in clinical workplaces.

3.4 Towards a theoretical framework

The relationship between NUMs’ learning facilitation roles and other roles, activities and relationships, and contexts that constitute their practice is complex and multifaceted. NUMs’ learning facilitation roles, while mentioned in the academic literature, have not been explored in any depth. To address this deficit in the literature and to guide my development of a deeper understanding of NUMs’ roles and perceptions of what they do to influence learning in the clinical workplace, I have developed a theoretical framework that encompasses theoretical ideas from management, practice, and workplace learning theory. More specifically, in developing this framework, I drew on the work of three theorists, each providing a different yet complementary lens with which to view my experiential research findings. This framework assisted me to focus interpretation of my experiential findings on learning dimensions of NUMs’ managerial work.

In this theoretical framework, Mintzberg’s (2009) ‘model of managing’ (Figure 3.1) provides a means to better understand where NUMs’ learning facilitation work might be enacted in management practice and how it relates to other aspects of their management work. From the broad area of practice theory, Kemmis et al.’s (2014) ‘practice architectures’ (Figure 3.2) provides a means to better understand NUMs’ interactions with the social, material and relational factors that underpin and sustain learning in the clinical workplace. Finally, Eraut’s (2012) work on informal learning including his ‘Two-triangle model of factors influencing learning at work’ (Figure 3.3) provides a means to more deeply understand how NUMs influence learning within their routine activities. Together, the work of these three theorists forms the
basis of the theoretical framework I used to guide my interpretation of my experiential text.

3.4.1 Management: Mintzberg’s theory of managing

In my search for theories that would enable deeper understanding of NUMs’ learning facilitation work, I considered ideas that would enhance my understanding of the dynamic nature of NUMs’ work. I sought to visualise dimensions of management work beyond the traditional management roles of planning, organising, coordinating, commanding (now termed leading) and controlling (Fayol, 1949) that continue to dominate management literature. I sought a theory that would enable me to understand NUMs’ practice more deeply, and to extend the largely atheoretical and cursory interpretation of NUMs’ learning facilitation work found in the academic literature. I searched for a theoretical lens that would foreground deeper understanding of NUMs’ learning facilitation practices in relation to the overall scope of their management work, and in relation to the ordinary routines of unit operations. Mintzberg’s (2009) model of managing provided this lens.

I chose Mintzberg’s (2009) model of managing (Figure 3.1), which views management as a dynamic, complex, multifaceted, blended and often intangible activity that is bound to context, because this model provides a framework for exploring NUMs’ learning facilitation practices within the wider scope of their practice. Mintzberg’s perspective contrasts with that of other management theories that define management as lists of defined roles (Mintzberg, 1973), functions (Fayol, 1949), or competencies (Boyatzis, 1982). These alternate perspectives on management focus generally on the actions of the individual. They pay limited attention to the experience of management which is individually and situationally defined and unique in its dynamic response to the context in which it is performed, and much more than the ‘sum of its parts’.

Mintzberg’s (2009) model of managing (Figure 3.1) provides a framework for understanding the unique nature of management work as it occurs in equally unique contexts. Mintzberg’s model is presented as a series of concentric circles which represent the centrality of the manager’s underlying thinking and decision-making processes in relation to the work that is performed. The layers of this model signify
parts of the job that a manager engages in, in order to be “well rounded” (p. 89), that is, management work needs to include all of these activities to be considered ‘complete’. Mintzberg’s model (Figure 3.1) identifies the influence of contextual factors and managers’ personal characteristics and preferences on the nature of management work, which is carried out through information, people and action.

Mintzberg (2009) also emphasises the values, attributes and experiences that an individual brings to management work. Together, these qualities form the individual’s style of management. “Style … is about how the incumbent makes the job as opposed to just doing the job” (2009, p. 117). In ‘making the job’, represented in the centre of Mintzberg’s model (Figure 3.1) as ‘framing’, knowledge is processed to form ‘mental models’, personally constructed theories that shape individual approaches to management work. These models, explained by Mintzberg as the ‘frame of the job’, include the manager’s conception of the purpose of the job, ‘perspective’ which is the manager’s personal approach to managing, ‘position’ which is the manager’s view on specific details of operation, and the ‘pitch’ of the workplace in relation to the environment. As managers interact with the frame, they create their unique and individual management style and shape the context in which the work of the unit (including learning facilitation) is carried out (Mintzberg, 2009).

Figure 3.1. A model of managing.

Recognition of the unique histories, values and experiences that individuals bring to management work, depicted in the centre of Mintzberg’s (2009) model (Figure 3.1), aligns well with the focus of this research which seeks to more deeply understand how these characteristics influence NUMs’ learning facilitation practices. While Mintzberg’s (2009) model of managing is generic, it draws attention to NUMs’ individual qualities, diverse backgrounds, experiences, conceptions on learning and unit specialisations, to the relationship of these characteristics to their work, and to the context in which it is practised.

From these cognitive and practice foundations of management work, Mintzberg (2009) also identifies scheduling as crucial to management work. Scheduling, represented in the centre of Mintzberg’s model (Figure 3.1), is associated with development of plans and agendas, which determine what managers and others need to do, and communicates to them what is valued in terms of the work to be performed. Scheduling, or resourcing the work of the unit, is a primary role of NUMs (Industrial Relations Commission of New South Wales, 2017). Examples of scheduling include developing plans to meet unit goals such as accreditation, developing rosters and shift teams, assigning staff to mentor other staff, and organising staff to attend professional development opportunities and clinical meetings. Scheduling, as a distinct management role, defines the authority and centrality of each NUM’s position.

The sections of the model discussed so far – the person in the job, working within a frame that is activated by a schedule – are explained by Mintzberg (2009) as the core of management work. The core, represented by the outline of the person in Figure 3.1, highlights that the person in the management role is situated in a context, the ‘milieu’ in which management work is undertaken. The three dimensions that make up the context where management work is undertaken are represented in the outer circle of Mintzberg’s model (Figure 3.1). ‘Into the unit’ refers to the area of direct responsibility, such as the unit in which NUMs work; ‘within the rest of the organisation’ refers to the rest of the organisation beyond the work unit, such as other units, departments and processes that exist outside the unit but within the hospital; and ‘outside the organisation’ refers to influences beyond the organisation: the environment, which could include government departments, the Area Health Service and other health services with which NUMs interact, as well as the
regulatory and professional frameworks that influence nursing work. Mintzberg explains that most management work occurs inside the work unit, but some work occurs at the boundaries, in areas where there is no formal responsibility.

Mintzberg’s (2009) inclusion of context in his management model is consistent with the proposition made within this thesis that management is closely linked to context, including, in the case of NUMs, the unit, the hospital and the external environment. As the participants in this research worked in the same general context (a hospital) but different local contexts (units), interpretation of their learning facilitation roles within their own work contexts was important and enabled a more nuanced understanding of the unique nature of management practice. Further, the relationship between management work and context is reciprocal: management work influences, and is influenced by, context. Managers’ interactions with context enable them to shape the nature of the unit and its relationship with others outside the unit, within and beyond the immediate workplace.

Mintzberg (2009, p. 49) identified that management roles are performed on three planes: information, people and action, represented in his management model (Figure 3.1) by the three distinct vertical planes in the arrangement of circles. He points out that, to “get the job done” (p. 49), managers work indirectly by generating information (through controls such as audits), processing and communicating information to others; by communicating, leading, working with staff and networking with others; or through action by participating directly in the work of the unit. Mintzberg explains that managers perform their roles on each plane, but their preferences for a particular plane can determine their style of management. They could be planners, leaders or doers. This perspective recognises the unique nature of each manager’s practice, and of the different approaches (i.e. through information, people or action) that define their work.

Mintzberg’s (2009) model of managing (Figure 3.1) provides a useful platform for more deeply understanding the scope of NUMs’ learning facilitation practices within the information, people and action planes. Mintzberg’s model represents individual and contextual influences on management work as it is performed through information, people and action. Furthermore, the model provides an avenue for understanding relational aspects of these practice dimensions: how NUMs’ learning
facilitation practices traverse the three planes of activity and their different contexts. The utility of the model in enabling deeper understanding of relational aspects of management work was demonstrated by Mintzberg (1994) in a study of NUMs’ work based on an earlier version of his model of managing (2009). Mintzberg observed NUMs’ work carried out on all three planes simultaneously, and found that work activities were not clearly distinguished, but ‘blended’ or ‘infused’, shaped by NUMs’ dispositions and the constantly changing environment of the clinical unit (Mintzberg, 2009). The findings from this study demonstrate the potential for this model to further illuminate relational aspects of NUMs’ learning facilitation work, and how these practices can be understood within the complex but ordinary routines of nursing work.

Mintzberg’s (2009) model of managing provides a framework for broadly understanding key domains and relational aspects of management practice. For my research, it offers a useful platform for understanding and interpreting the unique nature of each NUM’s learning facilitation practices as they traverse the information, people and action domains, and in response to the specific context of their unit. Mintzberg’s model is however limited in its capacity to illuminate specific factors within the context of work that might also constitute NUMs’ learning facilitation practices.

Kemmis et al.’s (2014) concept of ‘practice architectures’ (Figure 3.2) provides an additional lens through which to view these dimensions. Kemmis et al.’s practice architectures include the ‘doings’ (actions), ‘sayings’ (language), and ‘relatings’ (relationships) that communicate and shape practice. In a general sense, Kemmis et al.’s ‘doings’ relate to Mintzberg’s action plane; ‘relatings’ relate to the people plane; and ‘sayings’ relate to the information plane. Kemmis et al.’s (2014) ‘practice architectures’ (Figure 3.2), which forms the second pillar of my theoretical framework, complemented and deepened my understanding of NUMs’ learning facilitation practices developed through the lens of Mintzberg’s model of managing.
3.4.2 Practice theory: Kemmis et al.’s ‘practice architectures’

Kemmis et al. (2014) emphasise temporal and social aspects of practice in their conceptualisation of practice as representative of the past and present, and as a ‘blueprint’ for future practice. Kemmis et al. (2014, p. 31) define practice as:

a form of socially established cooperative human activity in which characteristic arrangements of actions and activities (doings) are comprehensible in terms of arrangements of relevant ideas in characteristic discourses (sayings), and when the people and objects involved are distributed in characteristic arrangements of relationships (relatings), and when this complex of sayings, doings and relatings, ‘hangs together’ in a distinctive project.

The sayings, doings and relatings that characterise the relationship of individuals to a practice have been defined by Kemmis et al. (2014, p. 31) as “practice architectures”. Kemmis et al.’s model of practice architectures has been reproduced as Figure 3.2. Practice architectures are considered foundational to practices.

Practice architectures, represented in Figure 3.2, include:

- cultural-discursive arrangements (language) which enable or constrain both the language that is inherent in the practice (‘sayings’) as well as enactment of practice itself;
- material-economic arrangements (activity) which enable or constrain the activities that occur within a practice (‘doings’) and in so doing shape current and future practices; and
- social-political arrangements (power, occurring in social space) which enable or constrain the relationships between individuals and objects that are inherent in the practice (‘relatings’).
Kemmis et al. (2014) contend that the nature of a practice is carried in the language that people share, in the physical environments within which individuals engage as the practice is carried out, and in the rules and conventions that connect people and determine relationships in the practice area (Kemmis et al., 2014). For example, practice in clinical workplaces can be influenced by the language used by NUMs to communicate a new procedure (the sayings); the placement of equipment and adjustments made to physical space to enable the new procedure (the doings); and by the roles of those who are involved in supporting the new practice such as the Clinical Nurse Specialist and their relationship to staff (the relatings). Practices bring these architectures together in the context of a project, which, in this example, is the implementation of the new procedure.

Kemmis et al. (2014) consider ‘projects’ as central to defining a practice, recognising that, while sayings, doings and relatings can occur within the routines of work, they are best understood in relation to a project. In the practice architectures model (Figure 3.2), the outline of a ‘project’ that overlays the practice architectures neatly

**Figure 3.2. Practice architectures.**

Source: Kemmis et al. (2014, p. 34) Reprinted with permission from the publisher.
illustrates this relationship. A project is considered an activity or an undertaking, such as the performance of a new procedure, or the induction of a new staff member. These projects originate from an intention or desire for a specific outcome, that is, they are not random happenings. A project is conducted through practices that are made up of the sayings, doings and relatings that are important to it, and which together form the history of the practices. The history is then carried forward as the project is enacted in the formation of current and future practices.

Through projects, each individual is immersed in practice along with others, and the nature of their participation in the practice is determined by the practice architectures (Kemmis et al., 2014). Further to the above example, the practices involved in implementing the new procedure, as a project, are determined by the language, the physical environment and equipment, and the relationships between those involved with it.

Associated with the construction and shaping of practice architectures are notions of leadership and transformation of individuals, as improved practices benefit the context (inclusive of people) in which they are enacted (Kemmis et al., 2014). This transformative quality has implications for management and education and resonates well with the topic of my research. Kemmis et al.’s (2014) ‘practice architectures’ model provides a lens for examining how NUMs reconfigure practice architectures in order to develop a context in which staff can learn and how they enable staff to construct their own practice architectures in relation to their learning. This has important implications for leadership and change in clinical workplaces.

Understanding the practice architectures that influence work involves capturing the notion of practice subjectively through observation, and individual perspectives and accounts (Kemmis, 2009). Recognition of the underpinnings of a practice is not dissimilar to the philosophical hermeneutic tradition upon which this thesis is based that recognises individual experiences as representative of their histories and traditions (Gadamer 1975/1989). It is an approach that enables research of practice and understanding of how practice is formed, maintained and changed, and of the connections between activities and relationships that make up a practice and are communicated through language.
Together, Mintzberg’s (2009) model of managing and Kemmis et al.’s (2014) practice architectures provide a lens that enables deeper understanding of NUMs’ learning facilitation practices. Mintzberg’s model situates NUMs’ learning facilitation practices in a context where work is carried out in three domains: through information, people and direct action. Kemmis et al.’s practice architectures model alerts us to the language, activities and relationships that shape NUMs’ learning facilitation practices within Mintzberg’s three domains, and as they relate to specific projects such as inducting a new staff member. While these two models in tandem enable understanding of practices that aim to influence learning, they do not illuminate the particular arrangement of practices that are known to influence learning. Eraut’s (2004, 2011) theories of informal and workplace learning provide the required focus, adding a third lens to the theoretical framework that enables visualisation of practices performed by NUMs within their ordinary work routines that are likely to facilitate learning.

3.4.3 Theory of learning at work: Eraut’s two-triangle model of factors affecting learning at work

Eraut’s theories of learning, including theories of formal and informal learning (Eraut, 2004), and ‘Factors influencing learning at work: The two-triangle model’ (Eraut, 2012) (Figure 3.3), recognise the influence of social contexts on individual learning. These theories have been chosen in this research to guide interpretation of NUMs’ learning facilitation work, as a practice that is bound to its social context. Eraut (2004) espouses that learning facilitation activities, relationships and artefacts traverse the planes of management work that have been described by Mintzberg (2009), and can be similarly conceptualised as professional practice based on their cultural discursive, material economic and social political foundations described by Kemmis et al. (2014). Eraut’s theories (2004, 2011) illuminate factors in the workplace such as social aspects of learning contexts and “knowledge resources” (Eraut, 2004, p. 263) that influence individual learning.
Eraut’s theory of informal learning

Eraut (2004) identified four different ways that learning occurs at work: participation in group activities; working alongside others; tackling challenging tasks; and working with clients. He emphasised that learning is largely dependent on the nature of the interpersonal relationships to which learners belong. These learning activities can include formal or informal learning activities. Of interest to my research are the factors that enhance the quality of informal learning, which occurs during the ordinary routines of work. Paradoxically, while most workplace learning is acquired from informal workplace activities, workplaces tend to place greater emphasis on formal learning activities (Eraut, 2004), and this is characteristic of clinical environments. Knowledge that is acquired from informal learning in the workplace may be tacit and assumed, although these aspects of learning may be suppressed by the greater visibility of formal learning (Eraut, 2004). Given the salience of informal learning in clinical environments, I have included Eraut’s theory in my theoretical framework to better understand the nature of NUMs’ facilitation of informal learning, and of the circumstances, values and rationales that influence their facilitation of informal learning within the ordinary routines of work.

Eraut (2004) describes three different forms of informal workplace learning that are of relevance to this discussion: implicit, reactive and deliberative. Implicit learning is that which occurs without knowledge that it is occurring (Reber, 1993) and can occur alongside explicit learning. Reactive learning is near-spontaneous and occurs in response to an unexpected event. Deliberative learning is learning that is planned, such as a course. Tacit knowledge arises from implicit learning and from the implicit organising of knowledge acquired explicitly (Eraut, 2004). Importantly, all learning regardless of the type is dependent on the social environment (Eraut, 2004) and, in this research, the clinical work environment constitutes the social context of that learning. Nursing work involves constant interaction with other nurses, health professionals and patients, and it is within these interactions that tacit knowledge is generated. The nature of the social and cultural environment in which the work of the unit is carried out can shape the learning that occurs, and this has implications for the work of NUMs.
Eraut’s (2012) model ‘Factors influencing learning at work: The two-triangle model’ (Figure 3.3) builds on his earlier theories (2004) of informal learning to build a model of workplace learning. In the upper triangle of the model is the development of individual confidence as the focus of workplace learning. Confidence is achieved through exposure to appropriate challenges in a supported environment. A triangular relationship formed by an association between individual confidence, challenge of work and the presence of support recognises individual learning within a social context. Confidence is both related to ability to perform the work and to the sense of being supported. Eraut considers support to include feedback and trust, and challenge to encompass work that is of value and of an appropriate level of complexity. He asserts this is instrumental in promoting motivation and a sense of personal agency. These learning factors, the performance of work in a supported and trusting environment that is valued by the employee and of an appropriate level of challenge, is dependent on contextual factors, illustrated in the lower triangle. The most significant of these is the allocation and structuring of work, which determines the nature of the work in terms of challenge, and the nature of the social context that is available for providing feedback and support. These contextual learning factors, allocation and structuring of work, and opportunities for social encounters influence individuals’ participation and their expectations of the work. These contextual factors influence individual learning factors.
Eraut’s (2012) ‘Factors affecting learning at work: The two-triangle model’ (Figure 3.3) provides a means for understanding individual learning within a social context, and factors that enable or constrain learning experiences. NUMs’ close proximity to the point of service delivery creates opportunities to influence the conditions that enable learning to occur: allocating and structuring work that is valued, providing opportunities for encounters and relationships with other people, and designing work experiences that offer challenge, feedback and support. Interestingly, Eraut’s central tenet of structuring and allocating work as a prime stimulus to learning is well aligned with Mintzberg’s (2009) emphasis on the central management role of scheduling as the main ‘cerebral’ activity managers perform to activate the work of the unit. Mintzberg, as a management author, not surprisingly does not identify the relationship between management activities and learning, for example, between scheduling as a management activity and the development of a supportive social learning context as a learning outcome. Eraut’s model opens possibilities for creation of deeper understanding of the educational value of these management activities.
Eraut’s (2012) ‘Factors affecting learning at work: The two-triangle model’ and his earlier theory of informal learning together provide a powerful means to better understand how NUMs facilitate learning through delegation of challenging work tasks. Examining NUMs’ roles in shaping the social context of learning through the lens of Eraut’s model and theory, can generate deeper understanding of the nature of their work in influencing individual learning as it occurs within the ordinary routines of work in their units. Eraut’s theory draws attention to the relationship between challenge and support for learning in workplaces and opens up possibilities for development of new understandings.

3.4.4 Theoretical framework of NUMs’ learning facilitation work: Management, practice, and learning

My theoretical framework for understanding NUMs’ learning facilitation work (Figure 3.4) merges key aspects of management, practice and workplace learning theories into a structure designed to facilitate better understanding of NUMs’ learning facilitation practices. Within this framework, NUMs’ learning facilitation roles traverse three concentric circles that represent key focal dimensions of NUMs’ work: conceptualising the learning context; developing the learning community; and participating in the work of the unit. Consistent with the dynamic nature of management work, it is acknowledged that these dimensions are interrelated. Communication, recognised as the mainstay of management work (Mintzberg, 2009), as a central tenet of professional practice (Kemmis et al., 2014) and as foundational to workplace learning (Eraut, 2012), is represented within each dimension.

The first concentric circle in Figure 3.4, ‘Conceptualising the learning context’, represents NUMs’ approaches to understanding the way that work is being performed in their units, including the quality and nature of the work carried out. Central to their work in understanding their unit is generating and processing information, and conceptualising and planning actions to support ongoing practice. This circle incorporates Mintzberg’s (2009) information plane where information is generated, processed and communicated, and forms the basis of understanding and action, and Kemmis et al.’ (2014) ‘practice architectures’ model which recognises
that language constitutes knowledge about practice, and underpins, communicates and sustains clinical practice.

The second concentric circle, ‘Developing a learning community’, represents NUMs’ work in developing a professional practice community, and refers to their interactions with staff. In this dimension of my theoretical framework, NUMs’ work with people is highlighted, reflecting the nature of management work explained by Mintzberg’s (2009) ‘people’ plane. The emphasis in this dimension of the framework is on NUMs’ influence on the development of individuals and teams, on shaping the social context of learning. NUMs’ work on this level involves creating teams that are supportive, goal directed and collaborative, and, consistent with Eraut (2012), offer challenge and opportunity for learning. NUMs’ work in this dimension also reflects Kemmis et al.’s (2014) ‘relatings’ as they influence the social conditions under which staff interactions and learning occur. This dimension also includes leadership as a relevant management activity in the development of learning communities.

The third dimension of my theoretical framework, ‘Participating in the work of the unit’ (Figure 3.4), represents NUMs’ work in actively working alongside staff in caring for patients. Examples of NUMs’ participation can include assisting staff with the care of a patient, or mentoring and modelling work practices. NUMs’ work on this layer reflects Mintzberg’s action plane, where managers are ‘doing’ the work of the unit and Kemmis et al.’s (2014) ‘doings’ as they act to influence staff performance and shape the factors that constitute their clinical practice.

Surrounding the three concentric circles depicted in Figure 3.4 is the outer circle: ‘Unit environment’, which includes the broader unbounded environment of the unit: organisational, national and global. The unit environment, which forms the context of the unit, includes a complex web of factors that influence the work of the unit, including policies, regulations and technology. NUMs’ work in influencing learning across the three dimensions represented in this framework is sensitive to these environmental factors. The importance of context is reflected in each of the three theories that have informed my theoretical framework.

Traversing my theoretical framework are ‘NUMs’ learning facilitation practices’. This aspect of the theoretical framework represents activities undertaken by NUMs to influence learning within the three bands of NUMs’ learning facilitation work:
conceptualising the learning context; developing a learning community; and participating in the work of the unit. This dimension of the model provides a lens for understanding how NUMs influence the individual and contextual factors that Eraut (2012) associates with learning in the workplace. These activities include, but are not limited to, those that seek to support, challenge, enhance confidence and motivation, provide feedback, and recognise progress. The model also recognises formal and informal learning practices that NUMs draw on to facilitate learning in their units. In explaining individual and social learning and its relationship to the context of work, Eraut’s (2012) theory forms a strong basis for understanding NUMs’ learning facilitation practices as they are performed across all three dimensions of their learning facilitation roles.

Figure 3.4. Theoretical framework of NUMs’ learning facilitation work: Management, practice, and learning
3.5 Conclusion

The learning facilitation dimension of NUMs’ work is a blended practice that is uncertain, complex, multifaceted (Mintzberg, 1994) and highly networked within a dynamic social context. I have developed a new theoretical framework that encompasses the contextual, interpersonal and individual nature of NUMs’ learning facilitation practices to more deeply understand these dimensions and NUMs’ learning facilitation practices in their entirety. Mintzberg’s (2009) ‘model of managing’ frames NUMs’ learning facilitation roles within the wider activity of managing. Kemmis et al.’s (2014) ‘practice architectures’ model enables deeper understanding of the structures with which NUMs interact to influence learning in their units. Eraut’s (2004, 2012) theories of informal learning enable understanding of influences on informal learning that emerge within the ordinary routines of NUMs’ work.

My theoretical framework, which draws from management, practice and professional learning theories, opens possibilities to more deeply understand the learning facilitation dimensions of NUM’s work as a dynamic and interdependent, and sometimes hidden social practice that is performed by each NUM within unique workplace contexts. In the following chapter, I outline my philosophical framework, philosophical hermeneutics, which aligns well with my theoretical framework in recognising the relationship between individuals and their social context and the centrality of traditions and histories that shape their perceptions. Philosophical hermeneutics, as an interpretive approach, enables understanding of individuals in their social world (Higgs, 2001) and provides a pathway to deeper understanding through a spiral of enquiry. Together, my philosophical and theoretical frameworks enabled me to more deeply understand NUMs’ work in influencing learning in their clinical workplaces.
Chapter 4: Research Approach

This research explored Nursing Unit Managers’ (NUMs’) perceptions of how they influence learning in clinical workplace contexts. As this research aimed to develop deeper insight into human experience, I sought an approach that invited openness and generated opportunities for deep understanding and meaningful interpretation of human experiences. An interpretive paradigm invites such openness and meaningful interpretation (Denzin & Lincoln, 2008). From the many research approaches within the interpretive paradigm, I chose philosophical hermeneutics to frame this research as it enabled deep understanding of the complex practice of nursing unit management within its historical and cultural contexts, enabling meaningful understanding of its learning facilitation dimensions.

Consistent with a philosophical hermeneutical approach, this research explored NUMs’ influence on learning in the workplace through interpretation of texts constructed from interviews and periods of observation. Key hermeneutic principles of fusion of horizons, hermeneutic circle, and dialogue of question and answer guided all stages of the research including text construction and interpretation. The conduct of the research adhered to rigorous ethical and quality standards that are foundational to interpretive research.

4.1 Research aims and questions

The goal of this research was to explore NUMs’ influence on learning in clinical workplaces. In this exploration, I was particularly interested in developing my understanding of the participants’ (NUMs’) influence on staff performance and learning, and of their conceptions of staff learning that underpinned their learning facilitation practices. I was also interested in enhancing my understanding of the influence of contextual factors, arising from both within the unit and from the wider organisation, on decisions made in relation to staff learning. I entered this research with an understanding that generally NUMs did not identify themselves as educators, but rather as managers, who organised formal learning experiences collaboratively with other staff who were designated as educators. This pre-understanding or initial
horizon\textsuperscript{8} was developed through my own experiences as a NUM, as well as through my interactions with NUMs and nurses through my academic roles in nursing and health services management. In this research, I particularly sought to explore tacit aspects of NUMs’ work, where explicit management intentions and work implicitly influenced learning, through application of a theoretical framework that privileged practice, management and education aspects of NUM’s management work.

The aim of this research was:

To gain deeper understanding of Nursing Unit Managers’ practices in facilitating learning in clinical workplaces.

My overarching research question was:

How do Nursing Unit Managers facilitate learning in clinical workplaces?

To achieve this understanding, four sub-questions were developed to guide the research process:

1. What contextual factors influence Nursing Unit Managers’ learning facilitation practices?
2. How do Nursing Unit Managers perceive their role in facilitating learning in the clinical workplace?
3. How do Nursing Unit Managers’ perspectives on staff learning shape their learning facilitation practices?
4. What activities do Nursing Unit Managers undertake to facilitate staff learning?

4.2 Research paradigm and philosophical stance

A research paradigm can be described as the approach taken to produce knowledge in the research. Research paradigms represent the interests and beliefs held by a research community about the nature of the world (ontology) and how it can be

\textsuperscript{8} Pre-understandings/initial horizons in philosophical hermeneutics are the initial views of the interpreter/researcher on the subject matter. By establishing pre-understandings/initial horizons, new understandings become clear (Gadamer, 1975/1989).
known (epistemology) (Higgs, 2001). Generally, research communities follow three paradigms:

- empirico-analytic paradigm, which perceives reality as consisting of objects that can best be understood through measurement;
- interpretive paradigm, underpinned by a view that there are multiple realities that are socially constructed, able to be better understood through interpretation; and
- critical paradigm, which views reality as being shaped by social influences and knowledge as emerging though critical argument, and which aims to be emancipatory (Higgs, 2001).

This research was located in the interpretive paradigm as it aimed to understand the experience of humans (NUMs) within their social world (workplaces) (see Higgs, 2001). Within the interpretive paradigm, recognition of the existence of multiple realities gives voice to the meaning individuals attribute to their experiences within the social world (Bailey, 2007). This recognition of multiple realities underpins how interpretivist approaches differ from positivist or empirico-analytic approaches that seek a single truth, and consider reality as occurring without humans knowing about it (Schwartz-Shea & Yanow, 2013).

Researchers within the interpretive paradigm view individuals as the source of knowledge about social reality, and develop their understanding through interpretation of individual perceptions, feelings, experiences, beliefs and values (Higgs, Trede, & Rothwell, 2007). In the interpretive paradigm knowledge and knowing is viewed as embedded in ‘Being’, which is consistent with my ontological stance that purports reality as being determined by people, in the case of my research, the participants (NUMs), and by their interactions with others in a socially constructed context (clinical workplaces). Reality, constructed and understood in this way, cannot exist independently of our knowing about it (Crotty, 1998). This stance contrasts with positivist paradigms, traditionally used in management research, that seek to establish cause and effect and to improve efficiency through statistical control (Cassell, Symon, Buehring, & Johnson, 2006). Research in the interpretative paradigm also differs from research conducted in the critical paradigm. Research in the critical paradigm is conducted in response to a known problem, to a state of
injustice or oppression (Trede & Higgs, 2010). Knowledge produced through critical debate seeks to enable individuals to act to remove constraints within the participants’ social context that prevent progress, and is emancipatory and transformative (Higgs, 20010). The critical paradigm was not chosen to frame my research, as the intention was to more deeply understand rather than to enable participants to change by navigating contextual constraints that impacted on their work.

The interpretive paradigm, which makes understanding humans within their social world possible, offered a congruent approach for the development of deeper understandings of NUMs’ perceptions of their influence on learning in the workplace. NUMs’ work can be considered a social practice, one that is strongly bound to people and context, constructed and experienced individually through their histories, assumptions, perceptions and interactions (see Kemmis et al., 2014). In my research, an interpretivist approach enabled the development of understanding of meanings that each participant attributed to their work, their multiple constructed realities (Easterby-Smith, Thorpe, & Jackson, 2012) of their individual workplace contexts, and their understanding of and activity within those contexts. The explication of multiple dimensions and perspectives on the participants’ work in relation to facilitation of workplace learning enabled meaning making about their learning facilitation practices.

4.3 Research approach

The interpretive paradigm encompasses a number of research approaches, which share a central goal of seeking to interpret the human world (Higgs et al., 2007). Within the interpretive paradigm, data is collected during fieldwork including interviews and observation, or through text, artefact or document analysis, and interpretation forms the basis of understanding (Denzin & Lincoln, 2008). These approaches enable deep understanding of phenomena through interactions between researchers and participants.

Hermeneutics is among a number of interpretive research approaches including phenomenology, ethnography and narrative enquiry that seek to understand and interpret the human world within the interpretive paradigm. Specifically, philosophical hermeneutics enables researchers to engage in a spiralling journey
towards deeper understanding of multiple perspectives within social contexts (Paterson & Higgs, 2005). Thus using philosophical hermeneutics enabled me to more deeply understand the multiple meanings the participants ascribed to the learning facilitation dimensions of their work. In this research, within the philosophical hermeneutic approach, two text construction strategies were employed: interviews and observation. Consistent with research conducted within the hermeneutic tradition, field notes and interview transcripts formed the texts for interpretation.

4.3.1 Overview of hermeneutics

Hermeneutics is the art and science of interpreting texts. Historically, hermeneutics provided the means by which written scriptures in the 17th century were interpreted and understood (Gadamer, 1975/1989). Over time, hermeneutics has continued to provide a means for interpreting text beyond the scriptures, including written texts as well as human artefacts such as artwork, conversations, practices and other human activities that represent human understanding (Crotty, 1998). Within hermeneutics, language, as represented in text, not only provides a means by which humans communicate but can be considered a means by which they shape and understand their world, their “situations, events, practices and meanings” (Crotty, 1998, p. 88), as central to the human world, and to reality. Interpreting language as text enables understanding of human experience.

Hermeneutic research does not follow a single approach; rather it has become diverse in its use and several branches have emerged over time (Trede & Loftus, 2010). Classical hermeneutics was concerned with the development and use of a set of tools that enabled literal translations of a text (Prasad, 2002). Schleiermacher extended classical hermeneutics from a focus on text translation to interpretation of the meaning that was intended by the original author, and the context in which it was created, including the author’s psychological processes (Schleiermacher & Kimmerle, 1977). Part of this empathetic approach, where the interpreter engages with the author’s perspective, involved the development of understanding of self as well as text (Schleiermacher & Kimmerle, 1977). Dilthey, Makkreel and Rodi (2002) extended these ideas, embracing hermeneutics as a means for understanding human and social phenomena, through engagement of the interpreter with the mental
objectification of the author, and gaining meaning by relating parts of a text to the whole.

Philosophical hermeneutics, as an approach to understanding through interpretation, also rests on an ontological foundation described as a means of understanding ‘Being’: “what is … the nature of existence … the structure of reality” (Crotty, 1998, p. 10). As human beings, our understanding of our own ‘Being’ enriches our experience in the world and our interpretation of it. Heidegger’s (1923/1962) emphasis on meaning making was based on our pre-understandings of ‘Being’ and making the implicit explicit, represented by ‘the hermeneutic circle’ that recognised understanding between wholes and parts and parts and wholes. Heidegger’s philosophy formed the basis of Gadamer’s philosophical hermeneutics, which is the approach used in this research.

4.3.2 Philosophical hermeneutics

Philosophical hermeneutics asserts that reality, or our sense of ‘Being’ or existence, is a social phenomenon constructed and given meaning by individuals through language (Gadamer, 1975/1989). The historical hermeneutic threads discussed above including interpretation of text, making self-understanding explicit, moving between parts and wholes within the hermeneutic circle, the interpreter’s engagement with the intentions of text authors, and the notion of ‘Being’ represent some of the historical foundations of Gadamer’s (1975/1989) philosophical hermeneutics. Building on these foundations, Gadamer (1975/1989) identified a key role of language in both shaping and representing human experience. Interpretation of language within its social, cultural and historical context enables understanding of human existence, described succinctly by Gadamer: “in language the world presents itself” (p. 466). A reality that is not known to us is represented by language, and openness to it can bestow understanding on that which is otherwise strange and unfamiliar (Gadamer, 1975/1989).

Gadamer drew particularly on the work of Heidegger in his writing about philosophical hermeneutics (Crotty, 1998). However, unlike Heidegger, whose work focused on ‘Being’ as central to our understanding, Gadamer (1975/1989) focused on history and tradition as central to our understanding, as represented through the
medium of language. Language, in philosophical hermeneutics, can be viewed as a representation of past traditions and in interpreting it we gain understanding of the traditions that shaped its creation. Language is the means by which we create and understand the world, and through human interactions meaning is derived (Crotty, 1998). Understanding is achieved through language, as partners in a dialogue seek to understand, beyond factual details, the basis of the other’s thoughts and behaviours. Partners in a dialogue explore interests, assumptions and pre-understandings to make meaning through dialogue (Gadamer, 1975/1989). When engaging in dialogue with a text, the text and the interpreter are inseparable and, while the author’s original meaning is sought, there is also recognition of the influence of “traditions”, “prejudices” and “preunderstandings” of the interpreter as a condition for understanding, noted by Gadamer as the “historicity of understanding” (p. 278). The role of the interpreter’s traditions, prejudices and pre-understandings in interpretation contrasts with positivist and some qualitative approaches that view the researcher’s pre-understandings and biases as potential threats to the integrity of the research. Gadamer’s view is that these pre-understandings are vital to the development of meaning and cannot be ignored or set aside, but need to be challenged and questioned.

Gadamer (1975/1989) explains in detail the particular characteristics of language that enable us to access meaning. He refers to “logos”: the meaning in language that reflects thought and brings into the present images and thoughts that are triggered by language and merge within the process of communication. Gadamer acknowledges that language does not stand alone: it cannot be interpreted literally, but must be interpreted in relation to the “history of motivations” (Gadamer, 2006, p. 46) and as the answer to a question. Gadamer considers language as central to understanding: “all human knowledge of the world is linguistically mediated” (Gadamer, 2006, p. 48) and explains that human experience and interpretation of the world is a fluid process that occurs through language. As change over time buries some of the connections, they can be resurrected through later questioning. Interpretation of language as text can provide an avenue for understanding and knowing about the traditions that underpinned its construction.
Gadamer (1975/1989) described three separate but interrelated concepts that facilitate text interpretation and development of deeper understanding of a phenomenon:

1. fusion of horizons,
2. dialogue of question and answer, and
3. the hermeneutic circle

**Fusion of horizons**

Gadamer (1975/1989) argued that interpreters’ awareness of their pre-existing understanding of a phenomenon, or ‘horizon’, forms the basis of meaning making arising from text interpretation. A horizon is “the range of vision that includes everything that can be seen from a particular vantage point” (Gadamer, 1975/1989, p. 313). Gadamer recognised that human understanding is influenced by pre-understandings, or the traditions, histories, values, thoughts, views and perspectives of the interpreter. He reasoned that pre-understanding cannot be shed during the process of understanding. Pre-understandings are fundamental to our understanding of the world, and their acknowledgement enables us to recognise and embrace that which is new and that which challenges our expectations. Gadamer argued that pre-understandings influence understanding as soon as a text is encountered, and are foundational to the derivation of meaning from it. Understanding becomes a fluid process as the meaning of text constantly challenges and refreshes our pre-understandings (Gadamer, 1975/1989). Remaining aware of the nature of pre-understandings enables advancement towards understanding of the whole, that is, a ‘fusion of horizons’, where an interpreter’s own ‘initial horizons’ are extended in response to those within the text, even if there is disagreement between the interpreter and the meaning of the text. This approach towards understanding contrasts with other approaches to interpretation such as grounded theory that seek to discount pre-understandings as potential threats to the integrity of interpretation (Crotty, 1998).

The concept of ‘fusion of horizons’ can be understood through an analogy of two people gaining an understanding of each other through conversation, as they open up
and immerse themselves in what the other is saying (Gadamer, 1975/1989, p. 405). During conversation, each person relates to the other’s views, aiming to deepen understanding, by asking questions and probing what the other has said. The subject matter is the common ground that is shared between the two. This process of enquiry and interaction through which those in the dialogue construct meaning is termed a “hermeneutical conversation” (p. 406). The understanding that each partner achieves is termed “fusion of horizons” (p. 406): the horizon or thoughts of each partner are ‘fused’ or have been constructed with understanding of each other’s perspectives, and in relation to each original perspective.

A ‘fusion of horizons’ also occurs during text interpretation, as the text is understood and given meaning by the interpreter in relation to the interpreter’s pre-understandings or initial horizon. The interpreter places his or her own thoughts or horizons ‘at risk’ when interpreting text, inviting challenge from it, revising original ideas and understandings, seeking to understand the context in which the text was written and continuing this process until a deeper level of understanding is achieved (p. 406). A fusion of horizons can occur in two ways: between partners engaged in dialogue, and between an interpreter and text.

In my research, I utilised fusion of horizons as an iterative and ongoing process as I engaged with literature that focused on NUMs’ influence on learning, with the participants during observation and in dialogue during interviews, and with text arising from interviews and periods of observation. My pre-understandings, declared at the outset of the study, and evolving horizons of understanding were embedded in this process of interpretation. For example, my pre-understandings incorporated a view that NUMs’ work was largely administrative, with a small component of learning facilitation work that was largely formal. During interviews, I was surprised to find evidence of the participants’ work in creating various learning artefacts, and in developing team-based problem-solving activities. In further probing and interaction with interview texts I developed a deeper understanding of the participants’ values and ideas about how learning occurs, and found that their learning facilitation practices were representative of these ideas, and that many provided opportunities for staff to learn from informal rather than formal learning activities. From these insights, my initial understandings or horizons were
challenged: I saw that the participants’ learning facilitation work was not limited to arranging formal experiences; instead they constructed activities that enabled informal learning, although they did not always recognise the learning potential of their actions. During this process of interpretation, I gained greater depth of understanding of these aspects of their work through development of new horizons of understanding.

*Question and answer*

In philosophical hermeneutics understanding is conversational, achieved through dialogue and intimately bound to language, with understanding being achieved through a dialogue of question and answer (Gadamer, 1975/1989). As interpreters recognise differences between their pre-understandings or initial horizons and those of the text, questions surface and are asked of the text to develop greater understanding. These questions are central to development of deeper understanding of a phenomenon or text. Gadamer emphasised the significance of these questions that guide interpretation in his assertion that “The path of all knowledge leads through the question” (1975/1989, p. 371). To be able to better understand text, the interpreter needs to remain open to the possibility that the text is not what they expected, and to embark on questioning with open qualities to better understand its meaning. Thus the “horizon of the question” (p. 378) is foundational to understanding, and emerges as the interpreter considers what question is being answered by the text; it carries with it an understanding of text but with an expectation that there is more to understand, including the traditions and motivations that are behind the text. As further questions are generated and asked of the text, a cyclical approach leads to deeper understanding (p. 407). Similarly, the interpreter, in maintaining an openness to the text, invites the text to ask questions of the interpreter in relation to pre-understandings and growing understanding. For example, when Sue (research participant) indicated in her interview that staff took time to develop the ability to assess a patient’s visual acuity, I interpreted this to mean that a change occurred to enable this skill to develop, and posed questions about the processes that enabled that to occur, and about Sue’s role in that process. I was therefore able to merge Sue’s perception or horizon with my own to gain a
deeper level of understanding of how she influenced staff learning of a particular skill.

The hermeneutic circle and spiral

The hermeneutic circle is underpinned by cycles of question and answer that occur as the interpreter dialogues with the text (Gadamer, 1975/1989). The hermeneutic circle specifically relates to a researcher’s endeavours to understand the whole by understanding the parts in relation to it. The whole can be seen to provide a context for the parts. An interpreter’s understanding of text is based on their expectations of what the meaning of the whole text will be, and this expectation then influences understanding of each part (p. 279).

In my research, I deepened my understanding through the hermeneutic circle by interpreting each participant’s experience and perceptions (the parts) in relation to my emergent understanding (the whole), giving context to each. I also used my emergent understanding to deepen my understanding of each participant’s perceptions. Interpreting each part in relation to the whole and the whole in relation to each part is essential to development of understanding in philosophical hermeneutics: “the harmony of all the details with the whole is the creation of correct understanding” (Gadamer, 1975/1989, p. 302), and is an iterative process that can be expressed as the ‘hermeneutic circle’.

The combined actions of returning to and questioning text and reaching a fusion of horizons, and developing a growing understanding of the meaning of parts in relation to the whole, has also been referred to more recently as the hermeneutic spiral (Paterson & Higgs, 2005). This analogy of a spiral rather than a circle indicates growth: within each spiral or return to the text, the process and parameters of the activity are the same, but the researcher is not, developing instead a heightened level of understanding and a motivation to inquire further. In the discussion that follows, the term ‘hermeneutic spiral’ will be used to identify the growth of understanding that followed exploration through the hermeneutic circle.

In summary, the three principles underpinning philosophical hermeneutics – fusion of horizons, dialogue of question and answer, and the hermeneutic spiral – were used to guide the research design and strategies used in this research.
4.3.3 Rationale for use of philosophical hermeneutics in this research

Philosophical hermeneutics was chosen as an appropriate philosophical approach to guide this research for the following five key reasons:

- Including the researcher’s initial horizons in the process of gaining deeper understanding gives value to the existing relationship between the researcher and the participants in this research.
- Context is recognised as critical to understanding.
- Language is considered the central source of understanding.
- There is acceptance of the absence of a final end point.
- Voice is given to diverse participants.

*Inclusion of researcher’s initial horizons*

Within the philosophical hermeneutic tradition, researchers approach text interpretation with an openness to a two-way dialogue between their initial horizons and the text (Trede & Loftus, 2010). The researcher’s initial horizons, prejudices and traditions are critical to the development of understanding. Utilisation of philosophical hermeneutics allowed me to credibly and rigorously use my background as a Nursing Unit Manager and well-developed understandings of NUM practice to enhance and enrich meaning-making throughout the research. This differs from several other interpretive traditions such as phenomenology, which seek to remove, ‘bracket’ or simply acknowledge the assumptions and initial horizons of the interpreter (Leavy, 2014). Philosophical hermeneutics accepts that interpretation is based on commonality between the interpreter and the text, and so full participation of the interpreter is essential to the process of understanding (Gadamer, 1975/1989). As my own experiences and traditions were entrenched in the research phenomenon, I aimed to deepen my understanding through an approach that leveraged my experiences and consequently strengthened my research.

*Context as critical to understanding*

Context, in philosophical hermeneutics, is recognised as the source of deeper understanding. It is the locus of the historical and cultural traditions that generate the spoken and written text which hermeneutic researchers interpret in their pursuit of
greater understanding (Gadamer, 1985/1989, p. 163). This acknowledgement of the centrality of context to human endeavour and understanding is congruent with the study of management, as management activity is considered to be shaped and defined by its context (Mintzberg, 2009). Philosophical hermeneutics offered a way to visualise and develop deep understanding of the participants’ work within its contextual dimensions. This was important in my research as the dynamic context of the hospital and wider healthcare environment shaped the work of the hospital and was considered a likely influence on the participants’ learning facilitation practices.

*The significance of language in understanding*

Language is considered to be a valuable source of understanding of management work, which generally occurs through language in a social context (Braithwaite, 2004). These social encounters are more frequent in first-line management positions (Arman et al., 2009), consistent with the level of operation of the participants in my research. Although seldom used in researching organisational phenomena including management work, language analysis (Murphy & O’Brien, 2008) and specifically philosophical hermeneutics (Prasad, 2002) have been identified as having great potential for better understanding of organisational life. Philosophical hermeneutics, with its focus on language as the source of understanding (Gadamer, 1975/1989), therefore provided an appropriate research approach to guide my research.

*Absence of a final end point*

Contemporary healthcare environments are often considered dynamic and complex (Duckett & Willcox, 2015). The work of managers is sensitive to this environment: the variation in roles, context, responsibilities and continual adaptation to environmental change means that there is little uniformity between managers’ roles (Palmer & Short, 2014), and their work can never be completely ‘known’. In this research, the hermeneutic spiral, which emphasises never-ending question and answer dialogue in the development of deeper understandings of the parts in relation to the whole, aligns well with this quality, and leaves questions open for further interpretation. This is consistent with Gadamer’s claim: “I have designated as a central point of hermeneutical procedure that one is never supposed to have the last word” (Gadamer & Grondin, 2006, p. 91). Further, Gadamer emphasised that this innate lack of finality is not a procedural weakness through his assertion that “the
fact that it cannot be completed is due not to a deficiency in reflection but to the essence of the historical being that we are” (Gadamer 1979/1985, p. 313). Thus, use of the hermeneutic spiral in my research left scope for development of ongoing understanding beyond my research in acknowledgement of the dynamic nature of the participants’ work within contemporary healthcare environments.

*Giving voice to diverse participants*

As an occupation, NUM’s work is generally considered challenging, shaped largely by complex networks of contextual factors including the nature of the industry, workforce, availability of resources and patient acuity (Duffield et al., 2015). In designing my research, I did not expect the participants’ perspectives and experiences to be identical, and sought an approach to understanding that was sensitive to this variation. Philosophical hermeneutics, in giving voice to each participant, encompassed the “multiple realities” that characterised the participant group and enabled me to deepen my understanding of the participants’ perceptions of their roles in influencing learning. Through question and answer, my understanding of each participant’s perceptions emerged, and was extended as I interpreted each in relation to the entire fieldwork encounter with each participant. My emergent understanding was similarly extended as I compared the perspectives of each participant to those of others in the participant group.

**4.4. Reflexivity and my changing horizon**

Reflexivity allows researchers to recognise the role of the researcher and the participants in negotiating meaning during qualitative research encounters. Reflexivity is a process of considering how researchers’ perspectives and interactions with participants might influence or distort the integrity of the research (Finlay, 2003). Researchers engaging reflexively consider the influence of their language, use of power, their relationship to each participant, and their assumptions and biases about the research focus. They consider these influences on their interactions with participants and on their interpretations of their findings. Researchers can modify these effects by engaging in self-reflection, self-monitoring and self-audit throughout each stage of the research project, acknowledging such threats and consciously acting to enhance the integrity of the process (Finlay, 2003). Reflexivity is essential to philosophical hermeneutics due to the centrality of the
interpreter’s horizon to the interpretive process. Gadamer’s (1975/1989) explanation that “to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truths against one’s own fore-meanings” (p. 282) firmly grounds reflexivity in hermeneutic interpretation. The use of reflexivity facilitates researcher recognition of the prevailing position of the interpreter in the enquiry process (Alvesson & Skoldberg, 2009). Acknowledgement of and reflection on initial horizons is congruent with reflexivity in elucidating and moderating the researcher’s relationship with the participants and forms the basis of deeper understanding through fusion of horizons.

4.4.1 My initial horizon

Philosophical hermeneutics recognises the central role of researchers’ pre-understandings or initial horizons, that is, their thoughts and ideas in relation to the area of interest, and the traditions that have shaped them in reaching a new understanding or interpretation of texts. The researcher’s initial horizons are inseparable from text, and the interplay between the researcher’s initial horizons and interpretation of text form the new understandings that are sought. The researcher’s initial horizons give rise to questions that are asked of the text, and are challenged, extended and enriched throughout the processes of text construction and interpretation. New understandings develop through a ‘fusion of horizons’ of the researcher with the chosen texts and are represented in a new text that is created by the researcher (see Gadamer, 1975/1989). This central role of researchers in development of understanding highlights the importance of researchers’ declaration of their initial horizons prior to engagement with text in the enactment of rigorous research methodology.

My initial horizons were formed as my career pathway meandered through the healthcare system in a range of clinical and management roles, and then into the higher education system as an academic in Health Services Management. As a student nurse I became aware that my level of confidence was significantly influenced by individual NUMs’ management styles, and I gradually became interested in researching these different behaviours. As my career progressed, I moved into NUM roles where, without any management training, I activated and experimented with my own philosophy of management practice. As a junior manager
I resorted to the formal authority associated with my role, referring often to policy and procedure to influence staff performance, as well as ‘stories’ about consequences of non-compliance. With increasing familiarity with the role, I became more aware of the different factors that impacted on staff performance, and developed a more ‘mature’ management philosophy. I believed that staff worked most productively and happily when they understood work requirements, had the requisite skills to perform their job, and received accurate and confirming feedback. However, despite my growth in confidence and expertise, a lingering sense of uncertainty about the real effect of my management approaches on staff performance remained.

As an academic leveraging newfound pedagogical knowledge, I was able to reflect on these uncertainties and re-visualise my management career. I reflected particularly on learning within change management processes, and speculated on why change was sometimes successful and sometimes not. I surmised that my skills in influencing learning within the change process were not optimal and questioned whether change might be better accepted and sustained if I had understood more about how people learn. I wondered as well whether managers need to better understand learning theories and, if they do, how that might translate into management work to enhance change management practices and outcomes. Change management is complex, and caution is required in overseeing the operational and human aspects of change. Change is messy and ongoing, and it weaves a convoluted and disorderly pathway in healthcare. As I managed change I was in a sense a part of this disorder and needed to connect with the wider social and organisational context to enable change and to enable learning to occur within the process of change.

Across my career in health management, examples of change that I was required to manage included the introduction of new occupational health and safety incident reporting and management, in relation to health department policy change. My approach included talking to staff at a meeting, and following up with a copy of the policy and procedure and a sign sheet to ensure all staff had been exposed to the information. Changes were also communicated through the replacement of redundant forms and attachment of flow charts. My approach to new staff induction, as a time of intense personal change, involved organising formal learning away from the workplace, followed by a detailed tour of the unit, an opportunity to read policy
manuals and a couple of days being ‘buddied’ with other staff. I assumed these activities would lead to learning.

I also considered the possible consequences of poorly managed change, and whether nurses might have been lost to the system because they did not have opportunities to reach their full potential, because their self-esteem and confidence were low and there were few structures in place to enable growth. I questioned whether education and learning held a key to confidence and staff retention, and the possibilities that might exist for managers to have an educational role. Are they a substitute for nurse educators or making up for the lack of availability of other educational opportunities? Or is there something very special about the way that managers influence learning that cannot be separated from the management role, and cannot be achieved by the work of others? These were areas where I was starting to realise the potential to enrich management work by infusing it with educational theory. I wondered about the difference between education and managerial communication and how we differentiate managerial communication from an educational activity. I wanted to develop greater insights into where in the NUM’s role an educational dimension could be found, and how I could justify the inclusion of educational theory and practice in the health services management course that I was teaching.

I came to firmly believe that areas of nurse management work could be enhanced by application of educational theories. However, in order to apply educational theory to nurse management in a meaningful way, the role of NUMs needed to be better understood. My initial horizon was that NUMs’ work involved an educational dimension, and that education or adult learning as a subject area would be an appropriate inclusion in management curriculum. In more deeply understanding work as education, curricula could appropriately target contemporary health service needs in relation to NUMs’ facilitation of learning. From my own experiences, I identified explicit educational activities NUMs undertake such as directly showing a staff member how to do something, or explaining a new policy, procedure or change to a group of staff. All of these activities involve staff ‘learning’ and NUM ‘teaching’ to some extent, but as formal highly visible and didactic activities I felt they are less effective than activities that influence learning at work through contextual change, as they are routine, explicit and acknowledged. From my new frame of reference as an academic with a knowledge of learning, I felt that these
practices need to be performed differently if they are to impact favourably on behaviour change and on staff confidence in a sustainable way. I believed these learning practices still occurred in NUMs’ work and that I would find evidence of them in my fieldwork.

My initial horizons also related to my personal philosophy of management. My belief, which echoes somewhat the work of management guru Peter Drucker (2007), is that management is fundamental to people’s lives. In some form, we encounter the effects of management every day. For most adults, the quality of their day is shaped by the management practices that they encounter at work. Their careers, motivation, confidence and opportunities for development, success and remuneration are determined to a large part by the nature of management. Work-based achievements can have a significant influence on other aspects of life, including individual capacity for participation in relationships with families and communities. I therefore firmly believe that exploration of management dimensions is a worthy activity, as it involves formation of better understanding of the fabric that makes up our social world.

Throughout the research my insights into and understanding of the research phenomenon continually evolved through an ongoing and iterative process of fusion of the horizons of myself and the research participants. Reflection on my initial horizons provided the basis for the initial interview guide. Subsequent interview questions were formed through reflection on my initial horizons and participant texts (fusion of horizons). Following each fieldwork encounter, I challenged and reflected upon my initial horizons and took new understandings and horizons to the next fieldwork encounter. In tandem with a continual process of revision and engagement was a deepening of understanding.

4.4.2 Fusion of horizons and reflexivity

Articulation of my initial horizons enabled me to determine new understandings as fundamental to ongoing interpretation and development of understanding. Awareness of initial horizons is also fundamental to reflexivity (Finlay, 2003), which infused all phases of this research. As I engaged in critical self-reflection on how my background, assumptions and behaviours may have influenced the research process I
was able to modify any influence I may have had. My reflexive approach enabled the voices of the participants to be acknowledged and heard, and strengthened the credibility of this research.

Reflexivity was especially important in relation to interviews as the core text construction strategy in this research. By engaging reflexively, I considered the influences the wording and sequencing of my questions on participant responses, and I rephrased or probed issues from a different angle if there was a sense that a participant had either misunderstood or had responded to some ambiguity or bias in my questioning. For example, I enquired about managing underperformance and managing incidents as two separate issues, although these were deemed by some participants to mean the same thing. I reflected on my approach and rephrased the questions in subsequent interviews to elicit a more focused response. I monitored my influence on the participants’ responses by listening to recordings after each interview.

Reflexivity was also an important process in modifying the power relationship between myself as researcher and the participants. This is particularly important as the potential for power asymmetry can influence participant responses (Kvale, 2007). I was aware that my role as an academic, a PhD student and researcher, introduced a power relationship which could possibly influence participant responses. I modified this dissonance by establishing and maintaining rapport, talking casually about my work and experiences as a hospital-trained nurse (‘one of them’) and empowering the participants by demonstrating non-judgemental interest in their work.

I recorded reflections on my interactions with each phase of the research in my research journal, and I used these to modify my actions and interpretations. I was able to return to my entries to reflect on any changes in my views or perspectives, and to what extent they had influenced the research and what I should do to modify my approach during the next interaction. This process strengthened the integrity of the research process and underpinned my growing understanding of the participants’ perceptions of their learning facilitation practices.
4.4.3 Presenting my changing horizon in this thesis

My deepening understanding of the participants’ learning facilitation practices are presented throughout this thesis. My initial horizons are reflected in my introductory, background and theoretical framework chapters as I develop a rationale for the exploration of the research phenomena, and are explicitly stated throughout this chapter. In Chapters 5, 6 and 7 I present a themed interpretation of my research findings that reflects my deepening horizons. These findings are then coalesced in Chapter 8 in a Living Systems Model of NUMs’ Learning Facilitation Practices as a conclusion to this thesis.

4.5 Research design

My research design was guided by my research questions and was underpinned by philosophical hermeneutic principles. My empirical texts, which aimed to elicit the participants’ perceptions of their influence on learning in the workplace, were constructed through widely used interpretive research strategies, namely interviews and observation. Each of these strategies enabled me to construct text from different viewpoints, and to better encompass the participants’ multiple perspectives. Using a range of text construction strategies enables a wider range of perceptions and interpretations to be captured, enhancing rigour, credibility and quality of the research (Mays & Pope, 2006).

Prior to commencing text construction, through a process of deep reflection, I identified and recorded my initial horizons. I included these in my research journal. I then immersed myself deeply in my texts, by undertaking transcription of participant interviews myself during the fieldwork phase, conducting early and progressive interpretation of transcripts while simultaneously listening to interview audio recordings, and developing questions for use in subsequent interviews. Once fieldwork had been completed, I again reviewed the texts produced from each participant including the two interviews and field notes generated from the period of observation. Using philosophical hermeneutic concepts of fusion of horizons, question and answer, and hermeneutic spirals, I sought to more deeply understand the participants’ perceptions of their role in facilitating learning in the workplace.
4.5.1 Text construction strategies

My empirical text set was constructed from participant interviews and a period of participant observation. Thirteen NUMs on two hospital sites formed my participant group. I aimed to gain a deep understanding of their individual and collective perceptions, particularly about what they do and how their work facilitated learning within their workplaces. I sought deeper understanding of the educational dimension of their management work and what they did to facilitate learning.

In constructing my texts, I completed all initial interviews with participants at the first site, then all periods of observation, followed by all follow-up interviews (see Figure 4.1). This process was repeated at the second site. By completing each phase of the fieldwork before moving on, I was able to interpret the meanings of each participant’s interview in relation to all participants’ perspectives, and use this emerging interpretation to develop subsequent questions that enabled interpretation of the meaning of each phase of the fieldwork in relation to the fieldwork as a whole. In this way, my text construction strategies were aligned with the philosophical hermeneutic tradition of gaining deeper understanding by moving between parts and wholes.

Figure 4.1 illustrates the sequence of fieldwork encounters.
Interviews are commonly used in the interpretive paradigm, as they enable researchers to access participants’ perspectives on their world and the meanings that they attribute to it (King & Horrocks, 2010). Interviews also enable researchers to explore phenomena including understandings that cannot be directly observed (Kvale, 2007). As my research explored the participants’ perceptions of their role in influencing learning in the workplace, and the meaning it had for them, semi-structured interviews provided an appropriate way to access these perceptions.

Kvale (2007) explains the process and purpose of research interviews through the use of two metaphors. The first describes the interviewer as a miner in search of knowledge buried within the interviewee. Once uncovered, that knowledge remains intact and amenable to definition. The second describes the interviewer as a traveller who explores unknown terrain, engaging openly in dialogue with those he/she encounters and seeking stories that tell of interviewees’ lived worlds. Knowledge is
produced as the traveller (researcher) interprets and reflects on the dialogue that occurs throughout the journey, a process that might also lead to personal transformation. This transformation is consistent with Gadamer’s (1975/1989) concept of fusion of horizons. Knowledge and understanding, according to the metaphor of the traveller, is co-constructed during the traveller’s (researcher’s) interactions with others (participants), and later during interpretation. This metaphor contrasts with that of the miner, which assumes knowledge exists prior to us knowing about it, and that the researcher’s task is to find it.

The metaphor of the traveller is well aligned with the process of interviewing that occurs in philosophical hermeneutics and is reflective of my epistemological stance that views knowledge as being constructed by humans interacting in their social worlds. Interviews are central to philosophical hermeneutics, as language and dialogue provide the primary means by which text, as the basis of interpretation, is produced (Kvale, 2007). Interviews also enable the capturing of multiple perspectives (Brinkmann, 2013; Kvale, 2007) which, in the form of text, opens them to interpretation within the hermeneutic tradition. During interviews, knowledge is co-constructed as the researcher engages with the participant in a dialogue of questioning, interpreting, reflecting and re-questioning. Interviews are also fundamental to the meaning-making process as their representation as text is amenable to reflection, which informs subsequent interview questions that aim to probe the phenomenon to a greater depth.

In my research, semi-structured interviews were used as a text construction strategy. Semi-structured interviews offer a flexible approach to interviewing that enables participants’ voices to be heard (Brinkmann, 2013; Kvale, 2007). This approach contrasts with structured interviews whereby the researcher leads the interaction, following predetermined questions delivered in a specific sequence (Kvale, 2007), an approach that is unlikely to result in any meaningful representation of individual voices. Using semi-structured interviews, the researcher develops and draws from an interview guide that invites flexible interaction and an openness to unexpected responses (King & Horrocks, 2010). Knowledge emerges as the interaction progresses and the researcher and participant explore more deeply the participant’s perceptions of the research topic (Kvale, 2007). My choice of semi-structured interviews in this research as a means of text construction enhanced the rigour of my
research as it enabled deepening of my understanding of the participants’ perceptions through open and unconstrained dialogue, congruent with the philosophical hermeneutic tradition of question and answer.

**Interview process**

Two semi-structured interviews were conducted with 12 participants. One participant exited the research following the first interview for personal reasons. All participants chose to undertake their interviews in their offices, within the clinical workplace but away from clinical work with patients. Interviews were recorded using a password-protected tablet and a voice recorder which when not in use was stored in a locked filing cabinet at the university. The length of each interview was typically 45–60 minutes. Initial interviews aimed to establish rapport with participants and gain a general impression of each participant’s work context, role and perceptions about how they influence learning in their workplace. An interview guide was developed initially from my initial horizons and literature review (see Appendix 1). This also formed the basis of questioning during periods of observation and subsequent interviews for each participant. While the interview guide formed a basis for ongoing semi-structured interviews conducted with other participants, it evolved with use as questions that yielded rich and deep responses were retained and developed, new questions added in response to unexpected ideas/perceptions of the participants and those that were less valuable were changed or abandoned.

Prior to each interview, I noted my assumptions and initial horizons in my research journal. Afterwards I noted in detail the nature of the interview, the participants’ body language, the nature of interactions between the participants and other staff during interruptions, the environment, the general milieu of the work area, and emerging themes and challenges to my initial horizons. Following each interview, I also undertook a critique of my interviewing technique, reflecting on my manner, questions that were not well understood, awkward wording, and any leading questions, and changed my technique as appropriate for subsequent interviews. I did not take notes during interviews as I was keen to give the participants my full attention and to enable smooth development of our conversation. I then transcribed the interviews and returned the transcriptions to the participants for validation. Only one participant responded, with feedback on a spelling mistake. I made notes on
transcripts about responses to questions that conveyed the participants’ perceptions about learning. These notes then formed the basis of the questions that I asked the participants during a follow-up interview, and to guide the observation phase of the research.

Interview questions aimed to elicit the participants’ perceptions, for example I asked the participants to give accounts of situations that related to their roles in influencing staff learning. In particular, the participants were asked to describe a change they had introduced and how they went about introducing that change and preparing staff for the change. This question emerged from my initial horizons and knowledge of the learning aspects that accompany change in the healthcare workplace. I sought clarification on aspects that related to my research question, such as how did a participant know that the change had been successful? The participants explained what they did and, with further probing by me, a deeper level of understanding was developed.

Follow-up interviews were conducted after the period of observation. Follow-up interviews were also typically 45–60 minutes in length and were again conducted privately in the participants’ offices. Follow-up interviews enable the researcher to draw from their interpretation of initial interviews collectively, to probe issues that are of relevance to the research questions more deeply, and enable clarification of the participants’ values (Rubin & Rubin, 2012). In my research, interpretation of initial interviews and periods of observation were used to develop semi-structured questions to guide follow-up interviews (See Appendix 1). These follow-up interviews provided a useful opportunity for clarification of themes and gaps, and deeper exploration of emerging issues. For example, during observation of Rob’s unit meeting, there was considerable discussion about the use of checklists to assist staff in complying with a transfer procedure. I was able to focus on this topic during our subsequent interview to develop a deeper understanding of Rob’s views on checklists and how they influenced staff learning. As I conducted and interpreted each interview, I formulated additional questions to inform subsequent interviews with other participants. Furthermore, prior establishment of rapport and the participants’ knowledge of my growing familiarity with their units prompted a smoother flow of conversation in the follow-up interview and consequently opened valuable spaces to enhance my understanding of participants’ roles.
Maximising opportunities for hearing the voices and perceptions of all participants is essential in interpretive interviewing (Brinkmann, 2013). Keeping the interview open on one hand and maintaining a focus on the general topic of interest on the other can be challenging (Easterby-Smith et al., 2012). I took care to avoid leading the participants by avoiding using terms such as ‘learning’ and ‘education’, and instead referred to activities that I knew from my initial horizons to have a learning dimension such as orientating new staff, managing and understanding staff performance and underperformance, and preparing staff to adopt change. I also avoided bias by not judging or leading, but by listening openly with the aim to really understand the participants. While questions were open ended and semi-structured, I facilitated the interviews by moving through a topic guide and gently probing the participants for deeper insights on areas of interest. For example, I asked Fiona: “How do new staff adapt to your unit?” and probed further: “What is your role in that process?” and “How do you manage those staff who don’t perform as well as expected?” In questioning further, I gained a deeper understanding of her role and perceptions about influencing learning within the induction process.

As I developed a deeper understanding of the participants’ perspectives, I also considered whether their responses were moving away from the topic of interest and on several occasions needed to guide the discussion back. For example, in explaining formal learning opportunities for staff, Amanda provided a large amount of operational detail. I was interested in moving toward a deeper understanding of her perceptions of the value of these activities and what influenced her views, and so guided our conversation toward my topic of interest, through the question: “So as a NUM … what sorts of things tell you that these sessions they are going to, actually impact …?” Amanda then responded with a more focused answer that gave me deeper insights into her perspectives.

The semi-structured interviews conducted in this research formed the basis of my understanding of the participants’ perceptions of their work. However, semi-structured interviews are limited in that the participants’ perceptions and accounts of their work may not be aligned with their practice (Mays & Pope, 2006) and responses can be focused on more superficial details with limited depth. A period of observation was negotiated and arranged with the participants to extend the scope of text construction, to address the potential misalignment of the participants’
perceptions and practice, and to capture activity and conversation that may challenge my understandings developed from the first interviews.

*Observations*

Following initial interviews, I conducted a period of observation of nine participants to enable development of deeper understanding of the context of each participant’s work and to reveal taken-for-granted practices (Mays & Pope, 2006). While interviews enable understanding of participants’ perspectives through accounts of their work and decision-making practices, observation enables a more focused and direct view of the enactment of those practices and how they are received. Observation enables the researcher to see social interactions and hear the language used by the participants within their social worlds and how they achieve shared understanding with others (Mays & Pope, 2006). Following interviews, observation of participants in their places of work, particularly their body language, physical surroundings, and the nature of human interactions gives meaning to the voices of participants who have been interviewed (Angrosino, 2007).

Arrangements for the period of observation were made following the initial interview. I asked the participants to identify a suitable occasion for me to observe their interactions with staff, and all identified the ward meeting as the most appropriate occasion. Ward meetings were routinely held at intervals of two to four weeks and lasted for one hour. Meetings were arranged and chaired by the participant and attended by nursing ward staff. They were conducted mid-afternoon during the overlap of morning and afternoon shifts, thereby maximising attendance, and were held in a private staff or meeting room on each ward or unit. I attended one meeting each for nine of the remaining twelve participants, with each lasting approximately one hour. Three participants declined my request for a period of observation, as they viewed the meetings as important debriefing time for staff, and felt that my presence would constrain communication.

At the commencement of each meeting, I was given the opportunity to introduce myself and to explain the reason for my presence. I informed staff that I was there to research the role of NUMs for my own research, that I would take some notes during the session, that in these notes no staff members would be able to be identified and the notes would not be made available to anyone else, and that I had received ethics
clearance from the hospital to carry out my research. I emphasised to the staff that I was there to research the work of NUMs, not the work or performance of staff.

Participant observation during meetings was a plausible means of gaining insight into the NUM participants’ relationships with staff. Much management work occurs during meetings (Mintzberg, 2009) and, as a natural work setting, meetings enabled a naturalistic observation, considered desirable in interpretative research (Rosen & Underwood, 2010). Furthermore, NUM work is complex, ill-defined and ‘blended’ (Mintzberg, 1994), in that multiple tasks are often carried out simultaneously, and work involves movement in and around the work area, talking to patients, families and staff, often in confidence. Observation by a researcher in this environment is likely to be impractical and their presence censored, resulting in incomplete observation. The ward meeting, as a focused activity, carried fewer risks in these terms and observation of the ward meeting was therefore undertaken as the preferred option.

During meetings, I took care to remain unobtrusive, and to minimise effects of my presence on interaction by sitting to one side and not involving myself in the ward meeting discussion. Even so, as a non-participant observer, my presence was known to the participants and staff, and I acknowledge the possibility that I influenced the nature of the interactions. As Atkinson and Hammersley argue, “All social research is a form of participant observation, because we cannot research the social world without being a part of it” (1994, p. 249). I was a part of the meetings, albeit a discreet part. While I did not interact with the participants or other staff during the meetings, the conversations at the subsequent interviews placed me in the meetings, and the participants drew on my presence there to explain their thoughts. My presence at the meetings became a part of the dialogue that occurred during each follow-up interview.

Attendance staff at meetings provided an opportunity to view NUMs’ interactions with staff, and in particular to understand how they influenced staff knowledge during these meetings, what aids and artefacts were used, and what follow-up plans were made to sustain or develop knowledge and skill beyond the meeting space. Questions used to guide researcher text constructions during fieldwork are listed in Appendix 1: Fieldwork questions: Interviews 1 & 2 and observational visits.
Field notes

Texts were also generated from field notes that were made prior to and during each meeting. Prior to each meeting, I described my thoughts and initial horizons. During each meeting, I followed an unstructured approach to observation, which enabled me to consider which aspects were of interest in relation to my research and to my previously collected interview texts. I allowed the structure of my observations to unfold iteratively during each meeting encounter (Gibson & Brown, 2009). These observations were recorded as they occurred in my field notes. I also included details of the physical context, including arrangement of the room and staff, order of proceedings, interactions and presence of artefacts such as agendas, books, posters and schedules in the meeting room and any reference to these during the meeting. The participants’ behaviour in communicating with staff, the topics that were initiated and the manner in which any changes were introduced were of particular interest. The participants’ responses to their staff were also noted. Notes made afterwards detailed the overall nature of the meeting, the behaviour of the participants during the meetings and how they influenced staff performance.

4.5.2 Participants

Thirteen NUMs from two separate major metropolitan hospitals volunteered to participate in my research, with seven volunteering from the first hospital (Site 1) and six from the second (Site 2).

The two hospital sites from which the participants were recruited were similar in many respects. Site 1, a large tertiary referral hospital in a metropolitan area of an Australian state capital city, provided an extensive range of acute and specialised care services. Site 2 was also a major metropolitan hospital located in a geographically close district providing acute care and some specialised services. As both sites were administered within the same Local Health District, all participants worked within similar operational systems, although Site 1 was considerably larger and offered a more extensive range of services than Site 2, with a greater degree of complexity.
All participants were employed full time as NUMs in units or wards of the two sites, across a broad range of specialisations including renal, cardiac surgery, medical assessment, intensive care, special care nursery, ophthalmology, women’s health, respiratory, accident and emergency, aged care, day surgery and cancer care. Three participants were male and ten were female – a proportion that reflects the larger female workforce in nursing in Australia (AIHW, 2015). One participant from Site 2 who was in a long-term acting NUM position at the commencement of the research was appointed to a permanent NUM position in the same unit prior to the follow-up interview. Another participant from Site 2 participated only in the initial interview, and was unable to continue in the research owing to an unexpected personal issue. All participants had extensive experience in the acute care sector during and prior to their appointments as a NUM. Nine of the thirteen participants, due to their longevity, trained in the ‘hospital system’ – the system for training nurses prior to the introduction of university education. Five participants were in the forty to fifty age range, five were in the thirty to forty age range, two were in the fifty to sixty age group, and one was over sixty. Experience as a NUM ranged from one and a half to ten years.

To maintain the participants’ anonymity and the confidentiality of the information they provided, each participant was provided with a pseudonym for reference in this thesis. The participants’ characteristics are summarised in Table 4.1.

The participants were able to opt out of the research at any time, and were reminded of their rights prior to each encounter. Three participants from Site 1, Jane, Sally and Amanda, opted out of the period of observation and one from Site 2, Rosa, discontinued her participation following the initial interview for personal reasons. The participants from Site 1 explained that their staff meetings were important opportunities for staff to debrief and that the presence of a researcher might hinder such interaction.
Table 4.1. Summary of participants’ characteristics

<table>
<thead>
<tr>
<th>P</th>
<th>Pseudonym</th>
<th>Age range</th>
<th>NUM experience (years)</th>
<th>Qualifications</th>
<th>Hospital trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Fiona</td>
<td>30–40</td>
<td>5</td>
<td>Bachelor of Nursing, Master of Critical Care Nursing</td>
<td>x</td>
</tr>
<tr>
<td>2.</td>
<td>Rob</td>
<td>40–50</td>
<td>6</td>
<td>General Nursing Certificate</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>Sue</td>
<td>50–60</td>
<td>8</td>
<td>Master of Education, Diploma of Management</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>Amanda</td>
<td>50–60</td>
<td>10</td>
<td>Respiratory Nursing Certificate</td>
<td>✓</td>
</tr>
<tr>
<td>5.</td>
<td>Jane</td>
<td>60+</td>
<td>6</td>
<td>General Nursing Certificate</td>
<td>✓</td>
</tr>
<tr>
<td>6.</td>
<td>Kate</td>
<td>30–40</td>
<td>1</td>
<td>Bachelor of Nursing, Acute Care Certificate</td>
<td>x</td>
</tr>
<tr>
<td>7.</td>
<td>Sally</td>
<td>30–40</td>
<td>10</td>
<td>Critical Care Certificate</td>
<td>✓</td>
</tr>
</tbody>
</table>

| Site 2 |
|---|---|---|---|---|
| 8. | John | 30–40 | 1.5 | Bachelor of Nursing, Critical Care Certificate | x |
| 9. | Sam | 30–40 | 1.5 | Diploma of Nursing, Diploma of Management | x |
| 10. | Jenny | 40–50 | 4 | Clinical Leadership Certificate | ✓ |
| 11. | Jack | 40–50 | 7 | Midwifery/paediatrics certificates | ✓ |
| 12. | Rosa | 40–50 | 2 | Bachelor of Nursing | ✓ |
| 13. | Lisa | 40–50 | 5 | Acute Care Certificate | ✓ |

4.5.3 Text interpretation

Text interpretation forms the basis of understanding and meaning making in philosophical hermeneutics. Human experience is represented in language and interpretation of language enables understanding of human experience (Gadamer, 1975/1989). Interpretation of language enables insight into the historical and social-cultural foundations of experience. Text, as representative of language, speaks to the reader of what is valued and important to the speaker. Participants’ use of language
can reflect the traditions of their practice context and the values that underpin their work.

In my research, texts for interpretation included interview transcripts and field notes including those from periods of observation and prior to and following each interview. Text construction was guided by interview guides that were developed from research sub-questions posed to the participants during fieldwork encounters. Interpretation was performed alongside, and subsequent to, text construction (Trede & Loftus, 2010) and was guided by three philosophical hermeneutics principles: fusion of horizons, question and answer, and hermeneutic spiral. Embedded in my text interpretation was an ongoing commitment to reflexivity.

*Interpretation concurrent with text construction*

As I undertook and interpreted each fieldwork encounter, including participant interviews and observation, I worked closely with my initial horizons. My understanding deepened iteratively, as my enquiry wound between each fieldwork encounter and my initial horizons, eventually reaching a ‘fusion of horizons’ where the origins of the perspectives presented there were understood and merged with my own understandings (see Trede & Loftus, 2010). At the outset, I believed the participants’ work included a learning facilitation dimension that was not clearly known to them, that was hidden in other tasks. After several interviews, I became aware that there was a learning dimension within some of the participants’ routine tasks, for example, roster preparation. By probing the issue, using questions that evolved during the encounter and from my growing understanding of this practice within the participant group, I was able to elicit deeper understanding of the learning facilitation practices inherent in this task. I began to understand the participants’ need to know the capability of their staff when preparing a roster, and through further questioning developed my understanding of the different ways that they developed their understanding of their staff’s capability. Ongoing interpretation through question and answer led to a deeper understanding of these activities as foundational to the participants’ learning facilitation practices, a process that was consistent with the hermeneutic spiral (Paterson & Higgs, 2005).
Interpretation during text construction was carried out as follows:

1. Prior to the first fieldwork interview, I constructed questions to guide the interaction based on my research questions, knowledge of the field, and my initial horizons.

2. During the initial fieldwork interview, I interpreted the participant’s responses to my questions, and used a question and answer approach to achieve deeper understanding and gain clarification of meaning.

3. Interviews with the remaining participants were guided by my initial interview questions as well as questions that had emerged from interpretation of previous interviews. I also probed responses that were unclear or signalled the possibility of deeper meaning.

4. Immediately following each interview, I made field notes to contextualise each interview and record ideas for further exploration. My field notes recorded the physical location, the nature of the interview, the number and nature of interruptions and how they were handled, the participants’ attitude to me, and aspects of body language such as posture and facial expressions that gave context to our interaction. I also recorded my reflections on my own role in the interview and how my language, behaviours and interview questions constrained or enabled the interaction.

5. Questions that had emerged from interpretation of each participants’ first interview and observation were used to guide the follow-up interviews. I initiated deeper discussion and exploration of themes that resonated with my research questions, and signalled the possibility of deeper meaning. Questions arising from interpretation of text and observation from the participants’ first interviews collectively were also presented and deeper discussion of key themes initiated. Immediately following each interview, I again made field notes about the nature of the interaction to contextualise each interview.
6. Prior to the observation phase, I developed questions based on my research questions, and on themes that had emerged from initial interviews to guide my interpretation. During observations, I made brief notes in response to my questions, including topics discussed at the meeting. I maintained openness to NUMs’ interactions with staff that facilitated learning or performance, and especially those that were surprising. Following each period of observation, I made notes in my journal about the nature of interactions between NUMs and staff and how NUMs responded to staff learning needs, the physical space, how staff were seated in relation to the NUM, and how artefacts such as agendas and charts were used.

During my engagement with the phases of text construction, a spiral of understanding was developed as I used questions and answers to more deeply understand the participants’ perspectives on their learning facilitation practices. I developed a growing awareness of how each participant’s accounts related to those of the wider group of participants, a process that led to deeper understanding and a merging of horizons as I began to understand the participants’ perspectives in relation to my own. An example of interpretation during text construction is included below:

**Researcher**: And so what’s your involvement in that particular process of moving [staff] through [the skills pathway]?

**Participant**: …So a lot of your time’s taken up with the people who aren’t performing so well so that’s where my energy goes, so I meet with them regularly, I put them on plans, I talk to the educators. The people who are holding their own and performing, they (Beeper goes off) just kind of continue on and acquire the skills, and it’s the ones who don’t that I spend most of my time with.

**Interpretation**: NUM’s role is to “move” staff, arranging meetings, giving feedback, developing performance improvement plans. NUMs appear to have control over these formal processes that guide staff learning. They value regular contact, and liaison with educators. To gain deeper understanding, I probed this issue further.

**Researcher**: And…so what kinds of things do you feel works well with those staff who are not performing?

**Participant**: Early intervention (emphasis) (and sml laugh) identifying early discussing it with the person early cause…I get a lot of feedback from my staff and “so and so doesn’t do this” or “so and so doesn’t do that”, “she doesn’t seem to know what she’s doing” … so if it’s somebody new I want
to jump on top of that really early and talk to that person and say “how do you think you’re going?” because they're feeling it and this has just happened very recently, she was feeling it and I get a lot of feedback so I want to address that very quickly so, we had her on a plan probably within two months of being here to support and it and that’s the idea of it, to support through education so their performance improves. (Fiona, Interview 1)

**Interpretation:** The NUM valued early intervention to prevent worsening of the issue and effect on the staff. “They’re feeling it” gave a sense that NUM is empathetic. The NUM had established that the support provided improved performance. The NUM is in control of these performance improvement plans.

In this interview, the participant described her actions in relation to a staff member who was not performing well. I probed her perspective further, which provided an opportunity for the participant to explain her perspectives on learning, staff adaptation to their unit, and their role in enabling that process. Based on the insights obtained from this line of questioning, I followed on in subsequent interviews:

**Researcher:** So if a staff member is underperforming how do you determine that and what do you do?

**Participant:** We don’t as clinical NUMs have a lot to do with it. We’re there, a few times we’ve had to educate obviously, especially if the educator’s not on. That comes back to error or if they’re not sure about something so if they come and they’re asking questions about not being sure on how to do something so it’s a case of we do one on one education right there and then… if they’re not sure how to do a catheter or a NG tube or if they’re not sure how to do draw up a medication. If it’s medication based we will show them how to look it up and look up all the protocol, how to look up the protocol of actually administrations. So then they know how to do that. Which they generally would have been shown before but you forget. So if it’s an actual procedure if we can be by them to show them how to do it, …. (Interview 1, Lisa)

**Interpretation:** In this interview, the NUM described how she provides incidental clinical instruction to staff. She also revealed her acceptance of error, supportive approach to staff, and use of expert power. Interpretation of these responses provided additional insight into NUMs use of power, emotional intelligence and their sense of caring for staff, which emerged later in the interpretation as key themes.
Interpretation subsequent to text construction

As the above discussion and example suggests, interpretation infiltrated all phases of fieldwork. In this section I specifically discuss interpretation that was undertaken once fieldwork had been completed. On exiting the field, I was aware that the participants’ accounts of their learning facilitation work were not dissimilar to my own initial horizons, that is, their focus was on compliance with policy and procedure, on formal learning facilitation practices, and on prioritising administrative learning facilitation tasks they were charged with as managers. At the same time, I was aware of a developing understanding of practices that were scattered throughout their ordinary routines that demonstrated powerful approaches to learning facilitation that I had not considered or encountered before. My task in this phase of the research was to more deeply understand and make familiar the ‘strangeness’ of these findings that had emerged during the fieldwork phase.

To develop deeper understanding of these nuanced practices and to make visible the dimensions of NUM work that supported learning in participants’ workplaces, I engaged with the following process:

1. I deeply immersed myself in my texts. I listened to interviews while simultaneously reading my transcripts to ensure my interpretation was sensitive to the nuances of voice and manner, including pauses, laughter and exclamations.

2. I repeatedly read the transcripts and fieldnotes, and highlighted and extracted themes that emerged in relation to the research questions, and also unexpected themes that emerged beyond the boundaries of the research focus. I made notes within my transcripts that signalled themes that were relevant to my research questions.

3. Fieldnotes were interpreted alongside transcripts, with a specific focus on consistency/inconsistency with themes identified in interview transcripts. New themes were identified and served to form the basis of questions posed to participants in subsequent interviews. The example above demonstrates this process.
4. I drew together common themes into a concept map (See figure 4.2: Concept map of preliminary findings) and then interpreted them more deeply during the writing of the findings chapters. Writing, reading, questioning and reflecting were key interpretation activities which served to stimulate deeper thought, deliberation and questioning of texts. This is an important part of the hermeneutic process (Loftus & Trede, 2009).

5. As I moved from one text to the next, my emerging understanding inspired me to more deeply question previous and subsequent text. This to-and-fro process of question and answer, dialoguing with texts, understanding each on its own and in relation to the whole, is the core of understanding that is integral to the hermeneutic spiral (Paterson & Higgs, 2005). This process continued throughout the text interpretation process, and throughout the writing of this thesis as I refined the findings and drew them together into a final model.

Figure 4.2 Concept map of preliminary findings
Throughout this phase of text interpretation, I deepened my understanding on multiple levels. I interpreted individual participants’ quotations in relation to each text constructed for that participant during the fieldwork phase, and interpreted individual texts in relation to all participants’ texts. This enabled me to deepen my understanding of the phenomenon in its entirety. The interpretation of each part in relation to the whole and the whole in relation to each part is essential to understanding in philosophical hermeneutics: “the harmony of all the details with the whole is the creation of correct understanding” (Gadamer, 1975/1989, p. 302), and is an iterative process that can be expressed as the ‘hermeneutic spiral’ (Paterson & Higgs, 2005). As I reflected on my collective understanding, I was able to give context and meaning to each element and to further deepen my understanding of the phenomenon, achieving a sense of harmony as the relationships between the parts and the whole became known.

4.6 Ensuring research quality

Ensuring quality and credibility in interpretive research allows insights that have emerged from the research to be accepted by its readers as trustworthy. Research quality is also a necessary foundation for ethical research (Flick, 2007). Research credibility is strengthened by the rigour (Paterson & Higgs, 2005) and transparency (Mattson & Kemmis, 2007) of its conduct. Throughout this chapter I have described strategies used to ensure the quality of this research. These strategies are summarised in the following sections within the domains of credibility, rigour and transparency.

4.6.1 Credibility

Credibility refers to the extent to which the researcher’s interpretations represent the participants’ views (Schwandt, 2001). My research achieved credibility through extended fieldwork encounters, use of open-ended questions, member validation and interrogation against established academic standards. The credibility of this research was also strengthened by reflexive approaches, explained in Section 4.4.

Central to credibility in qualitative research is the assurance that participants’ voices are heard. This can be achieved by extending engagement in the field (Symon & Cassell, 2012). I achieved this by including three fieldwork encounters with each participant – two interviews and a period of observation – within my study design,
although one participant was unavailable for a second interview, and four opted out of the period of observation. By engaging with participants with different perspectives and at different points in time, I was also able to clarify my interpretations, and extend and deepen my understanding of their learning facilitation roles.

Credibility is also strengthened through use of open-ended questions. In my research, the use of open-ended questions enabled the participants to speak freely, ensuring authentic representation of their views (Silverman, 2009). I was also able to establish rapport and trust, inviting the participants to speak freely about their experiences and views in relation to interview topics. I was aware that the participants may have been intimidated by my researcher status, and modified this through friendly conversation and sharing of thoughts and memories of our shared hospital-based training and experiences in the ‘old’ system of nursing. These strategies were conducive to conversation and a sharing of understanding, and enabled me to construct text that was truly representative of the participants’ views.

Credibility and authenticity were also enhanced as I returned all transcripts to the participants for validation. Member validation is an important way to ensure participants’ voices are accurately represented (Symon & Cassell, 2012). In response to this activity, one participant identified a spelling error which was corrected. The participants’ voices were then faithfully represented in verbatim quotations in the findings chapters of this thesis, presented within the context in which they were spoken.

Credibility was also addressed through peer debriefing. Peer debriefing enables researchers to clarify their research aims and approach, to consider potential bias that could influence text construction during the fieldwork phase, and to validate and strengthen any underpinning arguments (Paterson & Higgs, 2005). Peer debriefing during the course of my research study enabled me to continually check that my emerging interpretations were grounded in participant transcripts and field notes. I engaged in regular review of my research with my PhD supervisors, and during regular presentations to other doctoral students, academics and visiting researchers within the research centre to which I belonged. Throughout my candidature I also participated in research master classes with a range of international and national
eminent researchers including Professor Stephen Kemmis, Professor Stewart Clegg, Professor Ted Schatzki, Professor Monica Nerland and Dr Dale Sheehan. During these master classes I presented my research and received feedback which strengthened my research. Peer review also occurred following presentations at four local and one international conference, and by reviewers of a credible management journal, which led to one publication during the period of this research study.

Credibility also involves interrogation of research against established academic standards (Paterson & Higgs, 2005). In developing my research aims, questions and methodology, I engaged in deep exploration of academic literature to determine the landscape of participant work, and of the extent to which existing literature considered NUMs’ role in influencing learning. Part of this engagement included understanding the history of NUMs’ role, and events leading to formation of contemporary perspectives that the learning facilitation aspects of NUMs’ practice are now redundant. This was important in establishing a basis for the unique focus of my work. Furthermore, in exploring academic and grey literature (government and industry policies and publications), I was able to gain an understanding of contemporary issues in healthcare that impact on patient care, as a basis for illuminating the important role of NUMs in facilitating learning in the healthcare workplace. Being abreast of the academic and grey literature throughout the period of the study enabled me to further enhance the credibility of my research.

4.6.2 Rigour

Rigour in philosophical hermeneutics is enhanced by the level of congruence between the philosophical approach, research questions, text construction and interpretation strategies (Fossey, Harvey, McDermott, & Davidson, 2002; Given, 2008). Rigour or trustworthiness refers to the worthiness of the knowledge that emerges from the research process (Lincoln & Guba, 1985).

In designing my research, philosophical hermeneutics offered a philosophical approach that enabled deep understanding of the research phenomenon and of the contextual, diverse, social and interpersonal nature of the participants’ learning facilitation work. Central to the tradition of philosophical hermeneutics is the development of understanding from language, considered to be well aligned with the
social nature of management work. Language, as the source of understanding in philosophical hermeneutics, justified my use of interviews and periods of observation of verbal interaction as the dominant forms of empirical text construction. Rigour, in this research, underpinned my deepening understanding as I engaged in the philosophical hermeneutic traditions of question and answer, hermeneutic spiral and fusion of horizons.

In this research, the use of questions and answers was key to achieving understanding (Gadamer 1979/1985). In seeking understanding, I followed a pathway of questions and answers, reflecting on each text, remaining open to the questions emerging from the text, revising my understandings and then working with new questions to probe and gain deeper understanding. This process of continually comparing texts, probing, allowing questions to emerge, reflecting and re-interpreting when uncertainty emerged, enabled deep immersion in the meaning of the texts, and established congruence between the research questions and my interpretations.

Working within a hermeneutic spiral, I was able to strengthen rigour through a methodical and focused pattern of dialogue with my text, while remaining open to its meaning. As I interpreted each part of each text (interviews, field notes from each participant), I deepened my understanding by relating each part to my emerging understanding of the whole text (the collective understanding of all participants). Conversely, I also drew from my collective understanding to deepen my understanding of individual texts. This ‘to-and-fro’ interpretation between each part of the text and the whole gave context to each and enabled exploration of the phenomenon in all of its complexity.

Rigour, in philosophical hermeneutics, is also strengthened by declaration of initial horizons and of ongoing changing perspectives or horizons (Loftus & Trede, 2009). Prior to commencement of my research, I identified and recorded my initial horizons to ensure I was able to determine any influence I had on the research and clearly identify new knowledge that emerged as a result of the research. This is important in ensuring the research outcomes are a true reflection of the voices of the participants, and are free from bias (Gadamer, 1979/85). Furthermore, I modified the influence of possible bias and misunderstandings by continually reflecting on my initial horizons.
By being aware of bias, and engaging consistently and reflexively with texts, I was able to strengthen the rigour of the research findings. By interpreting texts, moving between whole texts and parts, I also ensured the perspectives of all participants were heard, regardless of their similarity or dissonance to each other or to my own perspectives or to the focus of the research. By immersing myself deeply in the texts and undertaking interpretation reflexively and openly, inviting the text to speak to me beyond the confines of my research questions, I ensured the participants’ perspectives were represented wholly and faithfully. Being open and reflexive, and considering the text as a whole, strengthened the rigour of my research. A fusion of horizons emerged, a sense that my own initial horizons and the meaning of the text had evolved rigorously, and new insights were reached.

4.6.3 Transparency

Transparency is key to credibility, and is achieved by being open and explicit about research activities and processes (Given, 2008). In my research, I have been explicit in explaining my research approach, participant selection, fieldwork methods, text construction and interpretation. I recorded deliberations, decisions and uncertainties that I encountered during the course of this research in my research journal. I have openly declared in this thesis my assumptions and initial horizons, which have formed part of my hermeneutic analysis. I have also provided clarity about the theoretical perspective used in interpreting text, and how the research has been conducted. Furthermore, transparency has been achieved through accurate transcribing of interviews, and verification of transcripts by the participants. Extracts from transcripts have been accurately reproduced in my thesis.

Transparent research provides enough information to readers to enable them to understand the context of the research, judge the quality, and make decisions about the relevance and usefulness of the research in application to their situations. The conduct and reporting of my research demonstrate these qualities.
4.7 Ethicality

This research was conducted with approval from the Western Sydney Local Health District Human Research Ethics Committee (see Appendices 2 and 3) and from the Charles Sturt University Human Research Ethics Committee (See Appendix 4). The ethical principles of research – merit, integrity, justice, beneficence and respect – as outlined in the *National Statement on the Ethical Conduct of Human Research* (NHMRC, 2007) were foundational to the conduct of this research.

4.7.1 Research merit and integrity

My research met the ethical standard of merit in that it aimed to understand a previously under-researched area of nurse management work that has potential to enhance NUMs’ learning facilitation practices. My research has implications for staff performance and patient care. It contributes to development of a theoretical basis for extending understanding of NUMs’ practice and for designing professional development experiences that will contribute to practice enhancement.

The integrity of this research is reflected in the congruence between the research aims, philosophical approach, methods and findings. Philosophical hermeneutics provided an appropriate framework for me to develop a deep understanding of the complex nature of management work. The research aims, questions and approach are well justified by existing literature. Further, as an approach that seeks understanding by encompassing a social context, it is consistent with the highly contextual nature of management work.

4.7.2 Justice

The research was just in that the population from whom the participants were drawn were provided equally with information and an opportunity to participate in the research. On each site, a site supervisor, who was not a researcher but a senior member of the management team, facilitated the recruitment process. This was achieved firstly by providing the researcher with an opportunity to speak for ten minutes at a NUMs’ meeting about the research purpose, implications and process of participation, and to distribute participant information and consent forms (see Appendices 2 and 3). Site supervisors then followed up with an emailed request...
(written by the researcher) to all NUMs for voluntary participation, including participant information and consent forms as attachments.

Justice in the research process also involved ensuring the participants were not placed under any unfair burden as a consequence of their participation. The researcher was aware that the participants work in challenging environments where unforeseeable changes to the day’s routines may occur. In recognition of this possibility the researcher asked the participants to determine appointment times and days for interviews and periods of observation. The researcher confirmed availability prior to the meeting day and emphasised that if on the day or at the time of the meeting the participant was unable to keep the appointment, the researcher would be most agreeable to postponement of the meeting until a more suitable time. This occurred three times over the course of the fieldwork.

4.7.3 Beneficence

Beneficence involves ensuring the benefits of the research outweigh any harm to the participants or others who may be influenced by it (Beauchamp & Childress, 2013). This research was designed to reduce or eliminate any risk of harm to the participants. The risk of harm was minimised in the following ways:

- Interviews were designed around participants’ work schedules and changes were accommodated.
- The participants were advised that they could stop the interview at any time.
- Details of the organisation’s counselling services were included in the participant information and consent forms.
- A follow-up interview provided an opportunity for the participants to clarify any aspects of the previous interview they felt uncertain about.
- Clarity of the confidentiality of the interview transcripts, including de-identification, storage and use of information, was explained to the participants in the participant information sheet and was explained at the start of each fieldwork episode. The participants were advised that:
  - All recorded texts would be de-identified, pseudonyms would be used, and no defining features such as details of their workplace,
specialisation, role or significant defining events that would reveal their identify would be included in any publication.

- Texts would be stored in a secure location, in a password-protected hard drive.

Benefits to the research participants included an opportunity to develop a deeper understanding of their work role. This deeper understanding was demonstrated in fieldwork encounters subsequent to the first interview where the participants shared their reflections since the previous encounter. Participation in this research facilitated the participants’ ability to discuss and express thoughts and feeling on various issues pertaining to their work. It was likely that some social benefits were produced from these interactions.

Risks to the participants included the possibility of discussing aspects of practice that were uncomfortable or generated an emotional reaction. This did not occur; however, the participant information and consent form included details of a contact person should issues arise. The participants were also advised that they could choose to stop the fieldwork encounter at any time if they felt uncomfortable, although none did.

4.7.4 Respect: autonomy, privacy and confidentiality

During my research respect for the research participants was achieved by ensuring their rights to autonomy, privacy and confidentiality were upheld. I interacted respectfully with the participants throughout all stages of the research. I negotiated interview and observation times and locations, and was openly respectful of the demands of their roles, which sometimes affected our interactions.

My research was carried out with respect for the rights of the participants to make their own decisions in relation to their participation in my research. This was achieved through a recruitment process that invited voluntary participation. Furthermore, to facilitate participant anonymity, the decision to participate was communicated directly to the researcher and was not known to the site supervisor. Informed consent to participate was achieved by the provision of a participant information form, and by explanation of the process by the researcher at the NUMs’
meeting and prior to each fieldwork encounter. Respect for autonomy was also achieved by the provision for the participants to opt out of the research or of any of the fieldwork phases at any time without prejudice. Three participants exercised their rights by opting out of the observational fieldwork.

Gaining the participants’ informed consent to participate in the research was another important ethical consideration. This was achieved in a number of ways. One of the requirements of the health service in which I conducted my fieldwork was to arrange for a site supervisor to oversee my research. The site supervisor’s role was to enable my entry into the field and to ensure there were no issues of misconduct on my part, and facilitated the process of gaining consent. Prospective participants had the opportunity to contact me directly to seek further information about the research and/or to express an interest in participating. At the time of the initial interview, I again outlined the research aims and the level of involvement that was invited. The participants were advised of the option to opt out of the research or any part of it if they chose, without any risk of adverse consequences. Details of the use and storage of any text was outlined as well as aspects of de-identification.

The promotion of respect also involved assuring privacy and confidentiality of participant information. Interviews were recorded using a voice recorder and an iPad. The iPad was password protected and the voice recorder was stored in a locked filing cabinet in the researcher’s academic office. Field notes were also locked in the filing cabinet and stored and on a password-protected hard drive. Transcription of interviews was carried out by the researcher, and all participants were given a pseudonym to ensure anonymity. Privacy was also maintained by the conduct of the interview in a private area of each participant’s choosing, which in all cases was their office.

4.8 Conclusion

In this chapter I have presented philosophical hermeneutics as a relevant approach for understanding my research phenomenon. I have described and justified my research design in relation to its consistency with three key features of philosophical hermeneutics: fusion of horizons, question and answer and hermeneutic spiral. I have included details of strategies taken to ensure quality aspects of credibility, rigour and congruence, and compliance with ethical standards. The following chapters will
detail findings from my text interpretation, which reflects application of philosophical hermeneutics in guiding my interpretation.
Chapter 5: Contextual influences

In this chapter I present findings from my experiential exploration of contextual influences on Nursing Unit Managers’ (NUMs’) learning facilitation practices. These findings represent interpretation of experiential texts generated from participant interviews and observations of their interactions with staff during routine staff meetings. Contextual influences originated from the external environment of the unit, including the hospital and wider healthcare context, and from within the clinical unit. My interpretation of the context of the participants’ work provides a basis for exploration of the participants’ values and perspectives on learning and on avenues for understanding staff performance as foundational to their learning facilitation work, presented in Chapter 6.

5.1 Chapter purpose, frame and scope

This chapter is the first of three findings chapters. In this chapter, my presentation of contextual factors that impact on the participants’ learning facilitation practices establishes foundation for discussion in Chapter 6 of participants’ perspectives on learning. Chapter 7, my final findings chapter, draws on both of these chapters and presents NUMs’ learning facilitation practices as key findings from this research.

Consistent with a philosophical hermeneutic approach, my deepening understanding of the participants’ learning facilitation work represented a fusion of three horizons: my initial horizon or understanding that I brought to the research, the literature and theorists with whom I engaged, and the horizons of my participants, as represented in my experiential texts. From my literature review, I constructed a theoretical framework based on the work of Eraut (2007), Kemmis et al. (2014) and Mintzberg (2009). This theoretical framework enabled me to engage meaningfully with my texts, and to deeply appreciate the complex interrelationship between context, management practice and staff performance. The central tenets that guided my text interpretation were:

- Management can be perceived as a blending of concrete and conceptual activities that are bound to personal, job, situational, organisational and external contexts (Mintzberg, 2009).
Management practice can be perceived, and understood, as a practice that is shaped by its cultural-discursive, material-economic and social-political environment (Kemmis et al., 2014).

Contextual issues have a major influence on learning at work and managers are instrumental in responding to these factors to influence staff performance (Eraut, 2007).

Collectively, these tenets contributed to my understanding of the influence of work context on practice and, in this research, of the influence of broader systemic, organisational and more specific unit contexts on the participants’ practices in shaping the learning experiences of staff. In this chapter, in particular, Mintzberg’s (2009) ‘Model of managing’ enabled me to view contextual influences on NUMs learning facilitation work from within the unit, the organisation and the external environment. Kemmis et al (2014) ‘Practice architectures’ provided a lens for considering how these contextual factors shaped relationships within the organisation that influenced NUMs learning facilitation practices.

This chapter locates the participants’ learning facilitation work in a complex workplace context and examines how a range of composite factors occurring in this environment shape the participants’ practices as facilitators of learning. As discussed in Chapter 4, four research sub-questions were developed to guide the research process. This chapter addresses the first sub-question:

1. What contextual factors influence Nursing Unit Managers’ learning facilitation practices?

5.2 The influence of the organisational context on the participants’ learning facilitation practices

In this section I explore multiple organisational contextual factors that impacted on the participants’ learning facilitation practices. In Chapter 2, I positioned NUMs’ work within a technically charged, dynamic context that is characterised by a focus on safety and quality, and challenged by the effects of traditional power relationships, changing scopes of practice for nursing staff, staff retention issues, and limited opportunities for management development. In Chapter 3 my review of the literature identified that NUMs’ learning facilitation roles fall within the scope of
their work, and specifically within activity areas such as retaining staff, and supporting safe quality care. However, the studies reviewed did not explore these roles in any depth. Little attention has been given to the influence of contextual factors within the wider organisational environment on NUM’s work, and in particular their work in enhancing staff performance through learning (Yen, Trede & Patterson, 2016).

For the participants of this research, many contextual aspects of the hospital workplace significantly influenced the way they perceived and enacted their learning facilitation practices. To explore how contextual factors influenced NUMs’ learning facilitation practices I engaged in question and answer dialogue with the research texts about the participants’ management practices with a particular focus on their perspectives on contextual features that impacted on their role in influencing staff performance.

The participants referred to a range of factors that influenced their work generally and their learning facilitation practices more specifically, including the availability of Clinical Nurse Educators, the commencement of new staff, patterns of leave, expected resignations and retirement. These factors changed patterns of staffing and created a need for participants to focus on the knowledge, skills and combinations of staff who were available to staff their units. Beyond these human resource issues, three key factors emerged as most significantly impacting on the participants’ learning facilitation practices. These were policy, regulatory compliance and incident management.

5.2.1 Policy as a stimulus for learning

The participants in this research identified the hospital’s policy environment as a significant influence on their work. The participants understood policies to mean detailed statements, often originating from the Ministry of Health, that reflected the directives sanctioned by the hospital’s governing body to guide activity across the organisation. The participants and senior staff at all levels were responsible for implementing these policies. At the individual hospital level, policies were operationalised by procedures, which were sometimes adapted by managers to meet the requirements of each specialty area. All procedures originated from a policy. At
the level of the unit, much of the work carried out was determined by procedures, although the participants used the term ‘policy’ most commonly as an all-inclusive term, perhaps to emphasise the power base of the activity. Areas identified most often as being governed by policies and procedures included clinical practice, occupational health and safety, staff matters including formal staff education, and quality and incident management. Policies and procedures in these areas were considered particularly important as they stipulated standards and processes that aimed to enhance patient safety.

Policies adopted by the hospitals often originated from within the Ministry of Health. A significant policy that influenced the learning facilitation practices of the participants in this research was Employments of Assistants in Nursing (AINs) in NSW Acute Care (NSW Health, 2010a). Hospitals included in this research had developed their own policy responses governing the recruitment and inclusion of AINs into their clinical units. This change was also occurring more broadly in other parts of the health sector, and was largely driven by an economic imperative to reduce costs by employing a less costly category of nurse, and a view that less qualified staff could be employed to perform the non-technical aspects of nursing work (Kessler, Herron & Dopson, 2012).

To accommodate less qualified staff within unit work routines, the hospitals during the period of this study were replacing their primary nursing model of care with a team nursing model.\(^9\) This model required a different approach to work, and to the allocation of nursing staff to particular shifts. In a team nursing model staff needed to learn how to work together as a team, and how to work with less qualified colleagues. Understandably, this was met with some resistance. For many nurses, primary nursing was the model they had worked with for many years and for many this was the model that underpinned their education as a nurse. Moving from this model to a team nursing model changed the nature of staff relationships and represented a profound change in their work, as Kate explained:

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\(^9\) Within a primary nursing model each registered nurse takes care of all of the requirements of a group of patients. Team nursing models are task based and enable staff with varying levels of skill to participate in patient care, and are better suited to units that employ AINs (Davidson & Hickson, 2014).
It’s come through the Director of Nursing that that is the model of care that is to be implemented throughout the hospital. That is a team nursing approach because of the change in the ratios because we are changing to this 80% RNs and 20% ENs and AINs, so you have a better model, you have to have a team model because otherwise AINS can’t give drugs, they can’t be allocated patients and ENs always have to be under the supervision of an RN. And so it really means that you have to have the team nursing model. (Kate)

This change had significant implications for the participants’ learning facilitation practices. Staff needed to ‘unlearn’ the current way of working, and adopt the new model, and the participants were challenged by the need to overcome resistance and motivate staff to accept and adopt the new model. Addressing the learning needs of AINs was another challenge and, although there were supports and training offered within the hospital, the training was applied in the unit and was overseen by the participants. The policy mandate to introduce AINs into the acute care sector was a significant contextual factor in this research, one that brought with it a need for the participants to understand and address the learning needs of staff in establishing the new model and in relating differently to other staff during the process of care.

Adapting existing models of care was a challenge faced by the participants whose units were employing AINs. Kate provided an account of how she changed the model of care in her unit to better accommodate the newly employed AINs:

> I actually changed the whole way we nursed. We went from allocated nursing to team nursing and that was met with a lot of resistance. So I just met with everyone, and said “We have some research articles about the benefits for the patients.” So we talked about what research and evidence had shown about changing the culture of nursing or the model we were using and it still met with a lot of resistance. I had two or three people who were really enthusiastic about it so I worked with them and we’ve still ... the culture has changed. It was really just working with them and meeting with them and listening about the things they didn’t think were working and work through those things. So it’s really getting the group of nurses who needed to change what they were doing and to get them to have a look at it themselves and see how they thought things could be done better – wasn’t ideal but this is how to work better. (Kate)

10 An RN is a Registered Nurse who holds a Bachelor degree; an Enrolled Nurse holds a Diploma; and an Assistant in Nursing holds a Certificate III. The level of responsibility, knowledge and skill is commensurate with their level of education.
Kate assumed ownership of the change based on the new policy. She identified and drew on relevant research (available to the participants through the hospital intranet) about team nursing to support her efforts in modifying staff resistance and establishing acceptance. Kate also created opportunities to work with staff and to meet with them as a group to deliberate on the new model of care. As a group, staff were given an opportunity to challenge and build on each other’s ideas, and these opportunities provided Kate with deeper understanding of factors that were likely to constrain or enable their acceptance. In using change champions – “I had two or three people who were really enthusiastic about it so I worked with them”, and later “There’s been a change in culture and we’ve worked with the enthusiastic people and let the others just follow” and “they’ve jumped on board” – she demonstrated leadership, motivating team achievement of the goal by supporting existing team relationships and investing time in those who showed an interest. Her approach presented opportunities to staff to understand and accept the change, and to identify and address their needs for learning. Kate was cautious in her approach and chose personal\textsuperscript{11} rather than positional\textsuperscript{12} forms of power to facilitate learning and acceptance of the new model of nursing care.

Kate’s work in building acceptance of the new model of care had to be sustained. She identified later in the interview that, following a period of leave, she found staff had reverted to the previous way of working. She found a need to continue monitoring their adaptation, managing resistance and working through staff relationships to embed the model of care within the workplace.

However, where compliance was lacking Kate used more directive means, drawing on the power of her position:

\textit{I have spoken to people that haven’t, and said this is the model we’re using.} (Kate)

\textsuperscript{11} Personal power is associated with individual attributes regardless of their position (French & Raven, 1959).

\textsuperscript{12} Positional power is available to individuals by way of their position in an organisational hierarchy (French & Raven, 1959)
In responding to policy, Kate found a number of opportunities to influence learning. Kate was responsible for explaining the characteristics of the new model, preparing for that process by undertaking research and selecting relevant academic literature to support her position, and to provide a resource for staff. In communicating these ideas to the team, Kate was required to translate policy and literature into a form that was understood by staff, and to work to embed the language of team nursing within their clinical practice. She created stronger links with staff who showed enthusiasm for the model, potentiating acceptance of the change and knowledge of its dimensions through supported peer influence and personal power. Ongoing monitoring enabled Kate to understand staff acceptance, their degree of knowledge of the new process and areas where reinforcement was needed.

Integration of AINs into the nursing team was met with resistance in some units. Rob described that his main role in introducing an AIN involved overcoming prejudice:

> in our case we’ve been very fortunate with our AIN. She ... struggled under a great deal of prejudice, which is not the right word but it’ll do, I think ... only through her strength of character and the support she was given and ... to some very small extent, my determination that she was going to stay no matter what sort of bitching and carrying on went on. After about four or five weeks people realised that she was actually able to do these sorts of things and the world did not end, the patients did not die and it all actually worked out. (Rob)

Rob used determination, perseverance and support in advocating for the AIN’s acceptance and for staff to be able to learn how the AIN’s role complemented theirs and contributed to the work of the unit. Learning was apparent in this endeavour: “after about four or five weeks people realised”. This “realisation”, a desired outcome of staff learning about the capability of the AIN, was enabled by Rob’s support, sustained over time. Time enabled the AIN to develop an identity, to form relationships with the team, to learn how to perform her role, and to succeed in meeting the expectations of the wider group. Rob’s support enabled this process.

Responding to change arising from policy directives involves learning as staff are supported to understand, accept and embed new practices. The implementation of change originating from policy that has been imposed on clinical workplaces was the participants’ responsibility. While hospitals determine policy, and included formal supports to aid its implementation such as procedures, guidelines and in-service
education, the participants were ultimately responsible for shaping and embedding policy into the clinical workplace and everyday workplace activities. The participants had an opportunity to select resources, spaces, time frames and communication strategies that supported staff learning and adaptation to proposed change. They developed relationships within the team that enabled peer learning. They monitored and sustained change by considering ongoing learning needs of staff and effective facilitation strategies.

The participants’ accounts of their work context also revealed the meaning they attributed to the policy environment. Lisa’s strong propensity to follow policies and procedures to ensure safe practice (for patients and staff) reflected the view of the participant group on the pervasive influence and authority of policies on the work carried out in their units. Lisa’s emphasis on ‘being covered’ inferred compliance as a motivator for avoiding negative consequences for everyone:

*If you always follow your policies and procedures you’re covered. The hospital won’t cover you if you go outside that bound and do something that’s not written up in a policy or a procedure and the reason they are there is because then you’re doing a safe practice, so it’s all about policy and procedures.* (Lisa)

Lisa’s emphasis on policy was reiterated throughout our conversation. She regarded policies and their role in mandating staff compliance with a high degree of reverence. Lisa’s response implied that work that did not fall within policy should not be done, bringing into question the meaning for this workplace of professional judgement and its clinical reasoning foundations, and how these foundations could be developed within this policy-driven environment. The importance of policies to participants was also demonstrated during the observational phase of this research:

*The NUM had prepared a Powerpoint presentation which was screened on the wall above the table. Headings on the Powerpoint included uniform, infection control, safety, education. Points on the PPT were mostly policy based directives and included an interpretation written by the NUM, about the issue. Mostly the NM followed the PowerPoint, deviating only occasionally to assess understanding and to elaborate on points.* (Field notes: John’s unit).

Similar to Lisa, John emphasised policy compliance. He had a good understanding of the organisational policies and aided staff learning by translating and explaining how it was to be adapted to their particular clinical unit.
The participants frequently referred to policy as an adjunct to their own supervisory roles: a source of power, and a management tool that directed the work of staff and complemented direct supervision. Policy represented authority; it was the means by which the hospital communicated what was important with staff, enabled by existing hierarchy and power structures. Policy manuals were regarded as important artefacts. They were accessible online, and hard copies were kept in designated ‘protected’ locations, away from the hustle and bustle of the unit. Policy documents were updated periodically and each represented a culmination of changing practices and standards over time. There was an expectation that staff should know what is in policy documents, although staff were also encouraged to consult the participants and senior staff for advice on policy matters as needed.

*Influence of policy on the participants’ work*

The policy environment exerted a substantial influence on the participants’ work. In describing their daily routines, the influence of hospital policy was evident. Sally provided an example of her interaction with the rostering system and how it determined the timing of completion of other important tasks such as her ward round. The rostering system regulated Sally’s time during the morning, and she had to arrange other tasks around ‘Proact’ availability. (Proact is a computerised software system that calculates and costs staffing across the hospital.)

*I like to do my round at 10.30 because that’s when the Proact locks us out. We can’t do anything on the computer regarding Proact rostering so it's a good time, 10.30. My mind’s always, 10.30, go back out and find out what’s happened since eight o clock.* (Sally)

These administrative requirements, which were determined by hospital policy, directly influenced the participants’ work routines and the amount of discretionary time remaining to relate to nursing staff. A number of participants mentioned ‘Proact’ as a major influence on their work, and one that created some anxiety (“Proact locks us out”) during the turbulence of each hospital morning; although, as a hospital requirement, it also provided some consistency to their work routines and unity to the NUM group.

Policy also guided the participants’ relationship to wider hospital activity. Kate described a hospital policy requirement for all NUMs to meet as a group each
morning to discuss the status of the hospital in terms of staffing, patient numbers, acuity and movement between different clinical areas. The aim of the meeting was to facilitate coordination of hospital activities and to forecast ‘trouble spots’. This requirement framed Kate’s work schedule and the interactions between her unit and the rest of the hospital that were likely to occur during the day.

at 8.30 I go to a bed meeting with all the NUMs and we discuss the state the hospital is in, what’s in the ED [Emergency Department], how soon we can get them [patients] out so they [the Nursing Administrators] go around and ask each NUM of each area what time they can get their first admission up to reduce the waiting times [in Accident and Emergency] … And after that we meet with our SNM [Senior Nurse Manager] and she’s got about 10 wards she looks after and discuss our staffing needs for the day. It works really well because we swap staff as needed, so if one’s got too many they’ll send some to another area. (Kate)

The meeting also provided the participants with an opportunity to interact and to share information, which they then drew from to organise and respond to the challenges of the coming day. These policy requirements also brought NUMs together, fostering a team approach to their own work and a sense of connectedness to the needs of the whole hospital. The strong presence of this networked relationship, which extended to other non-nursing groups and systems, was reflected across the participant group and was a significant contextual factor that influenced their work, and provided an important resource for their learning facilitation practices (see Chapter 7).

The prominence of the participants’ references to policy and procedure during interviews and observational visits highlighted their importance as the mainstay of hospital operations, and as formal and highly visible directives that demand compliance. The participants, as managers working at the point of service delivery where policies are operationalised, played a central role in their implementation. By exploring the participants’ accounts of how they introduced policy into their units, I began to more deeply understand where in that process they influenced staff engagement and learning.

The requirement for the participants to introduce new policies and procedures originated either from within the hospital, such as the introduction of new clinical equipment, or externally from the Ministry of Health. An example of a new external
policy was the NSW Health Policy Directive ‘Recognition and management of patients who are clinically deteriorating’ (Clinical Excellence Commission, 2013), which was being introduced within the hospital during the fieldwork period. Implementation of policies such as this aimed to enhance the safety of patients, and involved significant changes to the way in which nursing assessment and patient management was conducted. At a local level, the participants were responsible for ensuring all staff had the knowledge and skills to be able to incorporate these changes into their practice. The participants explained this during interviews, and I also observed their focus on policy implications during observational visits. Rob focused on education for the program underpinned by the “Care of the Deteriorating Patient” policy because it was of great importance to the care of patients on his unit:

*Look, there’s already the online training for Care of the Deteriorating Patient and I focus on that because it is a big part of what we do.*

(Rob)

Rob was very familiar with the policy, the nature of the training and its relationship to the needs of his clinical unit. Rob also identified himself, and not the CNE, as the decision maker on staff training and what was important. His choice of the word ‘training’, which implies a skills focus, rather than ‘education’ or ‘learning’ was interesting given the highly conceptual nature of clinical reasoning that is applied to assessment of deteriorating patients. Rob was unclear about whether this training enhanced practice, but was supportive of the topic and valued the availability of online learning opportunities which enabled learning to occur within the unit.

Further to providing access to online training for their staff, the participants used two main processes to introduce new policies, each dependent on the importance of the change required in terms of patient care. In response to new hospital-wide policies and procedures, such as clinical procedures, staff attended a centralised mandatory hospital education program (known as ‘mandatories’) which was then reinforced back in the unit with a policy ‘sign off’ (a practice commonly used within the hospital where staff were required to read a new policy and then sign to confirm that they had read it). In response to minor changes, such as a change to a documentation requirement, the participants introduced the policy to the unit during a meeting and/or via a ‘sign off’. Regardless of the level of importance, policy changes had
implications for staff practice, and their learning fell within the scope of the participants’ responsibilities.

Fiona’s account of introducing policy summarises these activities and was generally representative of the views of the participant group:

so it’s a policy that comes out from the Ministry of Health, a new policy and “here are new labels that you’ll be using” so we just align with the hospital on that in that respect going to in-services ... but if it was something a bit more local ... I would have a little ward meeting ... specifically about that, put the policy out, have some education locally for whatever it is, and might even have a sign off to say you have read the policy and they sign to say “yes I’m aware of the policy”. So we can capture all the staff and have a bit of a paper trail on what we’re doing. (Fiona)

The sign off procedure was also demonstrated during my observation of the unit staff meeting:

Discussion also about two new policies. One was the way to arrange for agency nurses ... and some detail was given by the NUM on the types of patients that required an RN agency nurse as opposed to Enrolled Nurse (EN) or Assistant in Nursing (AIN) .... The NM also said the policy will be placed in a folder with a sign sheet with the roster. The educator contributed to this discussion as it was clearly her role to place the policy in the folder accompanied by a read and sign sheet. (Field notes: Fiona’s unit)

In introducing policy mandated by the ministry that had been channelled to units via hospital policy processes, Fiona drew on the formal nature of the policy and the power that it represented to influence compliance. In these instances, Fiona employed directive language, such as “Here are new labels you’ll be using” as evidence of her endorsement of the authority of the policy, and was supported by the CNE. In introducing more local policies, a less formal ward meeting was used, although supported by formal processes such as policy “sign off”. Fiona valued the use of a paper trail to formalise the process and establish documentary evidence of staff exposure to the policy: evidence which might be required if non-compliance should occur, potentially compromising the quality or safety of patient care. The participants reported few cases of non-compliance; however, it was not clear whether this was an outcome of the ‘sign off’, or of other perhaps tacit influences on learning.
The participants used formal processes as a means of emphasising the importance of the policy to staff, and drew on the authority of the policy to complement and support their implementation objectives. Policy, education and ‘sign offs’ constituted the formal language used by the participants in relation to policy implementation, itself an outcome of another set of hospital policies that determined how policies should be implemented. However, the participants did not identify their work in introducing policy as enabling learning and their relationship to staff around policy and procedure implementation was hierarchical and mediated through policy and sign off documents. Learning about policy and compliance with it seemed to be two different things. The participants’ views on the relationship between being aware of a policy and being able to apply it were not clear. While hospital-initiated approaches to policy adoption were presented as formalised educational activities (‘mandatories’), ‘sign offs’ were less so, and were not defined in educational terms. The ‘sign off’ approach only demonstrated that the policy/procedure document had been read, and there was no gauge that indicated the degree to which it was understood or applied. There seemed to be an assumption that staff members would retain and apply the new policy to their work on the basis of the ‘power of the process’ and from their status as professionals with an interest in compliance.

While most participants initially implemented policies through staff meetings and ‘sign off’ sheets, during deeper exploration of their roles, some identified local informal strategies to aid implementation of policies in their units. As an example, Jenny explained that she had developed ‘how to’ manuals to ensure staff were comfortable in performing what was required:

_We’ve got policies and procedures … I have a lots of little manuals out there that’ll show you how to do an IIMS or how to deal with this, or how to deal with that. (Jenny)_

Jenny appraised the level of staff understanding and capability to apply policy directives. She modified the constraints imposed by more formal compliance structures to enable learning by staff in her unit. She created tools that bridged the gap between generic policies and specific needs of the unit and staff capabilities. In developing ‘how to’ manuals, Jenny translated policy language into a form that was meaningful to staff in her unit. Her development of the ‘how to’ guides, which aimed to resolve the dissonance between policy and practice, involved thinking through
strategies that would enable learning and adoption of the changed practice. The participants’ use of artefacts to facilitate learning is described in more detail in Chapter 7.

While Jenny aided and empowered staff to apply policy to practice independently, other participants expressed a view that staff should already have the requisite skills to independently adapt policies to their unique workplaces. Rob felt that, as professionals, staff should be able to recognise what to do and he expected that his staff’s intrinsic professional motivation would guide the process of adaptation. Rob felt that the application of policy to workplace context was an integral part of nursing work:

If it’s a new policy it will be either put in the communication folder – and people will be directed – everyone is expected to read the records of all the minutes and hopefully my expectation is that, as professionals, they should follow through on these sorts of things [implementing policy]. Sometimes my belief is let down by outcome. (Rob)

Rob viewed staff on his unit as adults and as professionals who are capable of guiding their own development including learning and reading about new policy and applying it to practice. The intrinsic power of the policy continued in his account of its implementation – “people will be directed” – but again, the expectation was limited to reading the policy, without any detail of how Rob would enable application. However, Rob acknowledged that adoption of policies did not always occur and expressed disappointment when policies were not translated to practice, and described in a separate conversation how he undertook informal checks of the unit to see whether policies and procedures were followed. If not, then he advised staff of the correct process at the time. In this case, policy implementation was formal, regulated through compliance, and any learning involved was assumed.

Policy implementation was revealed as a complex process that required professional judgement to balance the implications of the policy with the specific focus of the unit. To achieve best patient outcomes some policies needed to be adapted while others deemed irrelevant by the participants could be ignored altogether (e.g. nightshift procedures for a day-only unit). Jenny provided an example of how she
felt that staff should be able to adapt policies to the workplace, and of the tension that existed between policy and practice:

OK, it’s not visiting time, she just lost the baby which has a major impact on that person but, you mean, you don’t do any harm, you know. When I spoke to her she said, “Oh well, it wasn’t visiting hours, they shouldn’t be here.” She couldn’t see the point, she could not look behind that square, you know. The policy of it says it makes it very hard. Sometimes I think you have to allow some of those policies out there to break them. I mean you can’t always go by policy. There’s certain aspects, I mean, you have to do it a bit different or just open the policies up a little bit. (Jenny)

Jenny’s instructions to her staff on other occasions spoke of a different approach that illuminated her reliance on the power of policy:

Item: Breastfeeding arm bands: NUM emphasised “there is a policy, breech it then be sacked.” No discussion invited. (Field notes: Jenny’s unit)

Jenny’s responses highlight the importance of staff being able to determine which policies could be adapted, and under what conditions. She brought an ethical perspective to the process of policy adaptation, although she did not identify this. Her view that staff should be able to “look beyond the square” gave an impression that she encouraged independent thought, a similar view to Rob, and that adaptation of policy should be within the capability of professional staff. Both felt let down when staff did not demonstrate this capability, but did not explain how they redressed this. There seemed to be a tension between compliance with policy and autonomous decision making. The latter, although potentially a risky activity that could have negative consequences, was deemed necessary, as Jenny explained, when situations arose that did not fit neatly with existing policy, or where staff were working at times of the day when fewer senior support staff were available to advise. It involved moving beyond unquestioning compliance with policy to professional judgement and critical thinking. I interpreted Jenny’s response to be indicative of her awareness of practice that is based on tacit knowledge: knowledge that involves judgement and reason, critical thinking rather than simple following instructions (Eraut, 2000). This may have been a challenge for staff, especially new staff or students, who were working in an environment that is so heavily bound to policy and power structures and where there could be serious consequences for non-compliance.
For the participants the implementation of policies and procedures into their units involved understanding each policy, its relevance to the clinical area, and the skills required by staff to carry it out. While the participants influenced staff engagement with policy, including their transformation of practice to align with policy requirements, they did not identify this as educational work. Furthermore, there appeared to be a tension between following policy and providing the best care for patients in individual circumstances, signalling a possibility for meaningful staff professional development.

Mandatory training

Policies and procedures that stipulated performance of clinical procedures such as intravenous cannulation, blood transfusion, administration of intravenous antibiotics, maintenance of intravenous therapy and manual handling were introduced, in the first instance, via the hospital’s staff education department. Staff attended mandatory centralised training in these skill areas, and following assessment by a Clinical Nurse Educator were then authorised to implement those skills in the unit. All staff were required to attend mandatory training and timeliness of attendance was often highlighted. Sally emphasised the desirability of new staff completing these ‘mandatories’ as soon as possible to enable them to work to the scope of practice required by their job:

so it’s very essential I feel in the beginning that in the supernumerary period [a period of time when new staff work alongside other staff, as extras] to do the mandatories because otherwise once they’re three years later they say “I’ve never heard of” IIMS or whatever, so that induction program is very important. (Sally)

Sally identified the time when staff were new and working as ‘extras’ as a time for completing mandatory training. Her concern was that, once they were given a full workload, less time would be available for attending mandatory education. She did not acknowledge factors that enable application of learning acquired external to the workplace, nor the learning value of working alongside another staff member before undertaking mandatory education.

Mandatory clinical skills training posed a challenge for the participants, as they had to ensure opportunities were provided for staff to attend the training, arrange for their
assessment, and most importantly ensure their units were staffed by appropriately skilled staff at all times. The participants worked to ensure all staff had the skills required to perform their roles. In describing her role, Samantha emphasised ensuring staff mandatory training was up to date, and that her unit was compliant with mandatory hospital training requirements:

*But at the same time, I look after the education as well, the education of the staff, making sure that their mandatory training is completed and they’re compliant.* (Samantha)

Samantha’s account identified her view of her educational work as ensuring compliance and completion of mandatory training. Her emphasis on compliance echoed the views of Lisa and Rob. During the observation phase of this research the participants’ work on maintaining skills and ensuring compliance with mandatory training was widely discussed in most unit meetings. The participants’ approach to mandatory education was underpinned by an assumption that completion of a course equated with acquisition of a skill that enabled greater utility for the unit. The participants were also aware of a broader need for learning; however, they did not articulate specific details of their own actions until I probed for accounts of their engagement in particular learning activities. These findings are discussed in detail in Chapter 7.

In working to achieve staff compliance with existing policy and procedure, the participants arranged learning experiences aimed at developing staff knowledge and skills in relevant areas. These learning experiences took varied forms including formal educational sessions within the hospital, formal and informal teaching at unit level conducted by the Clinical Nurse Educator, and arranging for company representatives to visit where learning issues related to technology or specific equipment or products. The participants also had an important although less well recognised role in influencing learning directly within the routine work of the unit, with staff, within teams and through artefacts. These activities are discussed in more detail in Chapter 7.

In this section I have explored the influence of the policy context on the participants’ work, and in particular on their work in influencing staff performance and learning. The participants mediated the adoption of organisational policy into clinical nursing
work and prioritised formal learning approaches. The value they placed on policy was reflected in their language, a type of ‘management speak’ that reflected formality and authority: “policy”, “procedure”, “mandatory”, “compliance”, “sign off”, “paper trail”, “Ministry of Health”, “directed”, “should”, “cover yourself”.

Their motivation to enable staff compliance with policy was visible in various policy ‘artefacts’ such as sign-off sheets, policy manuals and mandatory training attendance checklists. These were the learning facilitation activities the participants engaged with to embed policy requirements within their units. Staff compliance with policy was influenced by power relationships, supported by the hospital hierarchy (i.e. the seniority of participants and of their superiors in relation to the more junior status of nurses) and the authority attributed to the policy. This was largely a one-way process. Practice changes stipulated by policy tended to be enforced, with the participants seeking and recording evidence of compliance.

5.2.2 Regulatory compliance as an influence on learning facilitation practices

Another significant contextual influence on participants’ learning facilitation work was the regulatory influence of the Australian Health Practitioner Regulation Agency (AHPRA). In Australia, all Registered and Enrolled Nurses are required to be registered by AHPRA. AHPRA, as the national registering authority, sets the standards for practice across a range of health disciplines including nursing. Statutory requirements mandate that hospitals employ only registered staff. Among the requirements for registration is the condition that all staff undertake twenty hours of professional development activities annually and maintain a portfolio of professional development activities (Nursing & Midwifery Board of Australia, 2016a).

While the responsibility to maintain current registration and meet these requirements rests with individual nurses, the participants supported this process by advising staff of opportunities to meet professional development requirements, keeping records of staff progress (portfolios) and arranging in-service education. During our conversation, Jane gestured to a long row of white ring binders kept on a shelf in her office, and indicated these were the portfolios she had created for each staff member. She shared the contents of one with me and explained what was in it:
I created for each of my nurses a professional portfolio. So each of them have their appraisal there [gestured to the section of the portfolio where completed performance appraisals were kept]. They have all of the things required to maintain their registration with AHPRA so we gave them an in-service about what we were to do for them [how the NUM and CNS would support their compliance with AHPRA requirements]. (Jane)

The folders were clearly important to Jane, who proudly shared them and explained how she had arranged the sections and organised the content. From their location in Jane’s office, it was evident that her staff required permission to access their folders, a practice that protected the privacy of other staff. Jane used the folders as a means to monitor staff compliance with AHPRA professional development requirements, and it was clear she had assumed control of this process. The uniformity, order and formality that Jane had created suggested these artefacts were sources of power for her. However, there was also a sense that Jane viewed her record keeping practice as an act of benevolence: “I created for each of my nurses” and “We gave them an in-service about what we were to do for them”. This reflected her caring approach to staff, and use of referent power to shape the structures that influenced staff learning in her unit.

Jane’s support for staff compliance with AHPRA registration requirements was also reflected by other participants. The language of ‘AHPRA’ and ‘registration’ was threaded through most conversations. The participants referred to supporting their staff to meet registration requirements alongside references to policy and procedure compliance. The participants enacted this focus by developing systems to support compliance, and through communication to their staff about professional development opportunities that would satisfy AHPRA requirements. The formal nature of these requirements tended to lead to a focus on registration rather than on learning. Ensuring staff were compliant with AHPRA professional development requirements was a key motivator for their educational practice.

5.2.3 Incident management as a stimulus for learning

Participants in this research accentuated incident management policy and processes as highly significant contextual factors that shaped their work. The emphasis given to safety and quality in healthcare in the acute hospital sector, and in particular in
relation to the participants’ work, has been described in detail in Chapter 2. Participants emphasised the provision of safe care as a key aim of their work:

...so there’s lots of activities we do essentially all centres around providing that safe patient care. (Jane)

Managing the unit to primarily ensure safe patient care. That would be my ultimate gold standard is safe patient care (Sally)

An important component of the safety and quality management systems used in the fieldwork hospitals was the Incident Investigation and Management System (IIMS). The IIMS is an incident management system that enables the collation of organisation-wide data in response to significant clinical and workplace-environmental issues. This system, mandated by hospital policy, was widely used and controlled the participants’ activities as they were required to prioritise incident management within their work schedules. The types of incidents that were most frequently cited were medication administration errors and patient falls. The participants contributed to the IIMS data by responding to and managing incidents in their units according to the policy and then feeding reports into the IIMS management system.

The participants played an important role in raising staff awareness of incidents, including incident identification and reporting standards. The participants supported their staff to understand the incident reporting requirements as they occurred, and during staff meetings. Of particular significance was the learning potential embedded within each reported incident. The participants’ leading of team learning activities based on incident reports are fully explored in Chapter 7.

In investigating and managing incidents, the participants were required to act in accordance with the NSW Health Incident Management Policy (Clinical Excellence Commission, 2014). All participants had all been fully trained in the requirements of this policy, which obliged them to adopt an approach that fostered openness (a blame-free approach), learning, action, accountability, justice and teamwork that is based on trust and respect. This approach is reflective of some contemporary approaches to the advancement of quality and safety in healthcare workplaces that
value developmental and collaborative rather than punitive approaches to incident management (Mannion & Braithwaite, 2017). These values were evident in Sally’s description of her role in incident management including her supportive, no-blame approach to staff who were involved in an incident:

*IIMS is not about dobbing people in and them getting into trouble; it’s about a learning, sharing learning experience from previous mistakes.*
(Sally)

Samantha gave a more detailed account of how she interacted with staff in relation to an incident:

*Yes, we do. We investigate what happened first and then we encourage the staff like, “What do you think is the best thing that we have done? What do you think that we didn't do this time?” We ask them to think that way like, “What do you think we're going to do in the future to prevent this one? Do you need any assistance with anything about that, information or any gaps or you want more training?” ... Because at the end of the day, with the IIMS report, before we have to provide that we have educated the staff: What are the things that we need to do in the future to prevent the same incident coming again?* (Samantha)

Samantha detailed a positive process of ‘guided reflection’ on the issue, by seeking staff views on the issue in a non-threatening manner, and empowering them to identify their own learning needs. She was however driven by the formality of the incident management policy, and of the requirement for NUMs to provide evidence of providing some education to the staff member. Her role focused on identifying and meeting training needs generated by the incident.

Incident management procedures provided opportunities for the participants to influence staff learning. While most participants described the process of incident management as a task, perhaps driven by the formalised schedule of reporting, deeper exploration revealed an awareness of educational opportunities, some of which transcended formal requirements. Several participants took up opportunities to use incidents to further the learning of the wider nursing team, using personal forms of power to enable learning in response to these more formal power structures. Deeper discussion of the strategies the participants employed, including case presentation and social learning activities, is provided in Chapter 7.
5.3 The influence of the immediate unit context on learning facilitation practices

This section examines a cluster of contextual factors present within immediate work units that the participants perceived significantly influenced their practice. Mintzberg’s perspective of the work unit as the zone where managers have direct responsibility for the work performed has informed interpretation of NUMs perspectives on their work in this section. Clinical units in this section were similar in their focus on the delivery of quality, safe patient care, although diverse in terms of level of acuity, hours of operation, staffing dynamics and work routines. These differences shaped the nature of the participants’ work including their work in facilitating learning.

5.3.1 Unit specialisation as an influence on learning

The participants’ learning facilitation work was shaped by a number of factors at the unit level. Unit specialisation, based on biomedical classifications such as cardiology or respiratory, the nature of interventions undertaken, such as chemotherapy or rehabilitation, and patient age, for example aged care, strongly moulded participants’ practices in facilitating learning. Unit specialisation identified the nature of the work undertaken, skills and knowledge required, relationships, environment and likely equipment that might be used, and the routines and language that underpinned the work and enabled it to be done. These characteristics defined the identity of each unit, and of the staff who worked there. The influence of specialisation on learning was demonstrated by Kate during her unit staff meeting:

The NUM expressed concern over the lack of nurses able to undertake a particular specialized highly skilled treatment. She advised the meeting that they needed to fast track nurses into [specialized care] with the use of learning packages and the help of the CN. Staff would spend two to three rosters learning [specialized care] and would then work in the area one day each week to maintain skills. This would increase the flexibility of the rostering to ensure adequate cover. NUM says ‘this is a good specialty to have and good for your cv.’ (Field notes: Kate’s unit).

The participants in this research were particularly concerned with staff acquisition of the specific skills and knowledge required to undertake safe patient care within the specialisation of their unit. Staff working in areas where chemotherapy was administered, for example, needed to have knowledge of the properties of
chemotherapy drugs, and the skills to be able administer them safely and to manage patient side effects. Staff working in an outpatients’ department needed to know how to administer vaccinations and counsel patients who had exposure to infectious diseases. Regardless of unit specialisation, participants were accountable for the quality of care that was delivered in their units, as an outcome of staff capability. However, constraints imposed by organisational processes sometimes limited the extent to which the participants could achieve this outcome. Fiona’s experience provided an example of the influence of these factors:

“…It’s really a bit different here because I have two quite different specialties that exist on this ward so it’s a matter of having skill to cover both specialties and ideally you’d like senior and junior staff on each shift, which doesn’t occur all the time, but its allocating appropriately. So it’s a safe workplace because it’s a limited number of senior staff and more junior staff. So it’s just a matter of making that fit to cover two specialties as well … My environment is very difficult [laughs] because my ward changes very regularly, my bed base changes, my specialty changes, so in this, I opened this ward two and a half years ago and there’s been a lot of change to what makes up my ward, the specialties involved, the bed base involved. So this is really hard to manage performance when I’ve got comings and goings and it’s been like this for two and a half years and it’s just happened again last week [laughs] so that makes it very difficult because it’s chopping and changing – yeah. (Fiona)

Fiona’s description of her situation seemed akin to ‘herding cats’. Fiona was clearly worried by this situation as she punctuated her comments – “My environment is very difficult” and “it’s just happened again last week” – with nervous laughter, perhaps aimed at modifying her disclosure of the enormous challenge of the situation. In declaring “it’s really a bit different here” she identified the identity of her unit and its distinguishing features. Having two different specialties meant that there were two different sets of skills and knowledge, relationships, routines and language to navigate and to embed in the work of the unit. Complicating this situation was the need to allocate staff appropriately to each shift, ensuring their levels of knowledge and skills were appropriate and complementary. She clearly needed to know the levels of competency of staff in order to allocate shifts appropriately. Furthermore, the history of change in her unit and her experience of it provided a reasonable concern that such unpredictability would be ongoing.
Fiona’s account provided a powerful description of the uncertainty of the context in which she was responsible for securing the capability of the team to provide quality, safe care at all times. Opportunities for her to influence learning were constrained by these unpredictable changes to specialisations, bed allocations, and team relationships. Furthermore, she had limited opportunities to influence the systems and processes that underpinned these arrangements, as changes to the nature of her unit were determined by others within the hospital over which she had no control. In spite of these challenges, Fiona indicated in a later conversation that she felt they succeeded in achieving these objectives, and that in the end she was happy with the capability of the nursing team to provide quality care.

5.3.2 Working hours as an enabler of learning

Opportunities for the participants to influence staff performance were both enabled and constrained by the unit’s hours of operation. Hours of operation presented a “social political arrangement” (Kemmis, et al., 2014, p. 34) that impacted on unit relationships. Some participants worked in day-only units where patients attended for specific treatments such as chemotherapy, but did not stay overnight; some worked in day-only satellite units which were located in community centres away from the main hospital campus; and others worked in more traditional hospital wards that were operational 24 hours a day, seven days per week.

Participants working in day-only units had much greater contact with staff, as their hours coincided, and the number of staff was generally smaller. These participants also had more involvement in the clinical work of the unit. These arrangements provided opportunities for the participants to gain a deeper understanding of the capability of the team to perform safe, quality care and to achieve the aims of the unit. Jane’s perspective provides an example of this:

My role here is that I am on the floor with them. I am checking [treatment] with them because ... and every single treatment gets checked by two nurses here. So I’m here checking and when I’m checking I know how they cannulate, how the nurses are going along with the patients ... So I’m always there and I have said my door is open and if there is no one to check, you come and get me because this I can stop at any time. So we all work as a big group trying to help each other out ... If they’re not performing well or they’re clashing with some patients I call them here. (Jane)
Jane’s perspective conveyed the nature of the close relationship she had with her staff, which she attributed to their coinciding hours of work. She was able to demonstrate caring behaviour to the whole group and was sensitive to their need for support, and was also better able to exert control over the staff. Coinciding hours of work meant that there were more opportunities for Jane to influence staff learning.

Participants working in 24-hour units tended to have more staff and needed to manage the challenges of overseeing the work of the unit indirectly. This was overcome by the development of team leaders, experienced nurses who coordinated the work of the unit in the participants’ absence. Team leaders also worked at the same time as the participants, as often these units were larger, more complex and needed a greater degree of oversight in the clinical area. Participants in these units worked at a greater distance from the activity of the unit, dealing more with planning, administrative and liaison work.

Fiona explained how she worked through the team leader on her unit:

*There’s a team leader on every shift. So I allocate the team leader. So when I go home it would be one of the most senior person who is the team leader. So if anything happens out of hours that person manages and then if they can’t they go to the after-hours manager and that person would help them manage that incident [Beeper goes off], whatever that might be, and then usually I would hear about it the next day and I would address the issue as well.* (Fiona)

In Fiona’s unit, the team leader role was directed toward managing incidents and ensuring the work of the shift was carried out. Fiona was confident in the systems that enabled her to manage the unit vicariously after hours, the systems available to support the team leader in that process, and her own in following up the next day. During the time that Fiona was not in the unit, team leaders directed the work of staff and provided a conduit for information between the unit and the senior nurse managers.

The participants’ opportunities to develop relationships with their staff were influenced by the hours of operation of each unit. Participants were more likely to be able to develop and understand their staff when working the same shifts and days, than when working different shifts and days. The potential for the participants to understand and influence their staff’s capability was greater in the day-only units,
where they had more frequent contact with staff. Participants working in 24-hour units found it more challenging to develop relationships and enable learning vicariously. The participants’ strategies to facilitate learning in these circumstances are explored more fully in Chapter 7.

5.3.3 Staff allocation requirements as an influence on learning

The process of allocating staff to a roster was determined by hospital staffing policies. Hospitals had a responsibility for ensuring each unit was staffed appropriately and according to specific designations, such as the ratios of RNs, ENs and AINs on particular shifts. This placed an onus on the participants to roster staff with complementary skills to ensure the delivery of safe care. In units that operated over a 24-hour period, competent team leaders had to be available as well. Allocating staff to rosters required a complementary skill/designation mix for the level of patient dependency. It also involved ensuring there were opportunities for less experienced staff to work with those who were more experienced to ensure oversight, provide support and reduce risk. The process of assigning staff to rosters was ongoing, and something of a ‘juggling act’ as staff frequently took leave at short notice, or asked to change shifts. However, despite these inherent challenges, the participants were also able to roster staff in such a way as to create learning opportunities, as Jenny described:

*They make us roster all nights first and weekends, then afternoons and then mornings. So I’ve got the least skilled people on in the mornings during the weekdays because they have the manager and the educator to back them up.* (Jenny)

Jenny created an opportunity to support the skills development of less experienced staff by ensuring senior staff were on hand to provide support. Jenny’s rostering practices enabled the development of relationships between staff that facilitated support and feedback for less experienced staff.

Sally’s busy and very large high-dependency unit required staff to have a very broad range of clinical and technical skills. However, staff could be allocated to patients whose needs were commensurate with their skill level. To enable this process a skills register had been developed.
In the allocation folder there’s a guide of people’s skills, where they’re up to, especially with specific skills, the higher level skills, whether they can look after [complex treatments], that’s whether they’re access nurses, they’re team leaders, they are very highly skilled. Performances are charted there for the TLs [Team Leaders] to go by and sometimes they don’t know if someone’s really stepped in to looking after [complex treatment], so that helps them with allocations. (Sally)

Sally’s account identified her (and team leaders’) need to know about the level of skill of each staff member, a priority also disclosed by other participants in allocating work. The “allocation folder” was an important practice artefact in Sally’s unit that enabled her to keep track of staff skills; a necessity in view of the very large staff and the complex and diverse care required by patients in her unit. Knowing about staff competence was important to the participants, as understanding enabled them not only to roster staff appropriately but to gauge the learning needs of individuals and teams. Deeper analysis of the approaches taken by the participants to acquire this understanding has been described in Chapter 6.

Consideration of formal learning needs further challenged the participants’ rostering practices. The participants were required to ensure staff attended formal ‘mandatory’ education. Allocating staff to rosters with formal learning skills development in mind was challenging, as Rob explained:

I’m not necessarily creative but I have to be a bit more pragmatic ... and creative in managing, not managing as a manager, but being able to deal with the challenges of not having, with not having enough senior staff for the day, not being able to educate people and saying that, “well I cannot send particular people who need to go to a particular learning skills session because there is not opportunity we’ll just have to wait”, and “yes they may not be able to get the skills they need”. (Rob)

Rob considered rostering as a means for enabling staff to attend formal in-service education, although service needs took precedence. He did not associate rostering with the development of opportunities for team approaches to informal learning.

In enabling AINs to practise safely, the participants paid careful attention to work allocation, as Jack described:

we just started a new AIN, she started about a month ago and I teamed her up with, I checked the roster, who’s on the morning shift
most of the time and I teamed her up with her and we had an interview already and she found it quite helpful. Like the first week she was working a whole week with only one person and that helped because she felt more secure, more comfortable and if there’s any problem she probably doesn’t come straight to me, she goes to that person and says, “Oh this has happened and that has happened” and I think it makes them feel more secure. (Jack)

Jack organised staffing within the new team nursing model to provide a supportive environment for a new AIN to learn. Through staff allocation, Jack enabled development of a social relationship in which the new AIN could learn, receive feedback, “feel secure” and develop confidence in her work. Jack took control of the allocation, and in monitoring the new AIN’s progress through “an interview” was able to gauge her progress.

In undertaking rostering practices, opportunities existed for participants to shape shift teams that provided support for less skilled staff, and enabled application of known skills to appropriate situations. These activities extended participants’ work in rostering staff from simple facilitation of staff attendance at formal learning events. Underpinning these staff allocation practices was participants’ knowledge of clinical care and dependency requirements of patients, blended with their knowledge of staff performance and learning needs.

5.4 Conclusion

In this chapter I have reported my findings on contextual factors that shaped participants’ learning facilitation practices. Mintzberg’s (2009) explanation of the context of management work in relation to the immediate unit, the organisation and the external organisational context has provided a relevant lens for interpreting and presenting these findings. The influence of these contextual factors on participants learning facilitation practice, and in particular through the mediums of language and social relationships as dimensions of Kemmis et al. (2014) practice architectures, has been expounded in this chapter. Interpretation revealed a multiplicity of contextual factors that impacted on participants’ decision making in shaping learning opportunities for staff. Within the broader policy context of the organisation, the participants prioritised learning activities concerned with achieving staff compliance and mediated staff application of policy to practice. Within the organisational
context the participants interacted with audits and incident management systems to measure compliance with policy, and to generate feedback which they used as a resource for influencing performance with the team. Within the context of the unit, the nature of the specialisation determined the focus of staff learning needs, and hours of operation and staff mix determined avenues for learning support. Together these contextual factors determined the priorities, influenced participants’ conceptions about staff learning and knowledge that ultimately shaped their learning facilitation practices. In Chapter 6 I explore the participants’ values in greater detail as a foreground to my final findings chapter, Chapter 7, where the participants’ learning facilitation practices are examined.
Chapter 6: Perspectives on learning and staff performance

This chapter complements my exploration (Chapter 5) of contextual issues that shaped the participants’ learning facilitation practices. The policy and regulatory environment, compliance measures, the unit context, including specialisation and hours of operation, were identified as key contextual influences on the participants’ learning facilitation practices. As the participants described their roles and how they influenced staff performance within this context, I was able to gain a deeper appreciation of their understanding of learning in their workplaces, and of their perspectives on staff learning that shaped their learning facilitation practices. In this chapter, I explore the participants’ perspectives on staff learning, and on aspects of their roles that underpinned their learning facilitation practices. I draw on my theoretical framework to understand conceptual foundations of NUMs’ practices as well as their use of language (Kemmis et al., 2014) and their influence on the social context of learning (Eraut, 2004, 2012). I explore more deeply strategies undertaken by the participants to understand staff knowledge and clinical practice skills as a basis for their learning facilitation actions and decisions.

6.1 Purpose, frame and scope of this chapter

This chapter explores the participants’ perspectives on learning in their clinical units, and on their role in that process. In particular the participants’ views on learning facilitation and their understanding of staff performance that underpinned their learning facilitation practices and decisions are illuminated. In this chapter the following research questions are addressed:

2. How do Nursing Unit Managers perceive their role in facilitating learning in the clinical workplace?

3. How do Nursing Unit Managers’ perspectives on staff learning shape their learning facilitation practices?
Findings presented in this chapter are set against the background context established in Chapter 5. A coalescence of Chapters 5 and 6 underpins my examination of learning facilitation practices in Chapter 7.

6.2 Participants’ tacit educational roles

The participants in this research strongly identified as managers, and articulated management tasks and roles that constituted their work routines. They spoke about rostering, managing incidents and staff matters, monitoring unit activities and attending meetings. These tasks, common to most participants, were central to unit operations. As I explored the participants’ accounts of the scope of their work, I sought to understand how they perceived their role in influencing learning and where this aspect of their work might be concealed.

As Fiona described her routine management tasks, including staff allocation and managing skill mix, she signposted the possibility of decision making that was underpinned by deeper and more conceptual processes:

A typical day is really bed management and staff management, 'cause that’s the bulk of my time is beds and staff. And then there’s the extra bits that go along with that, which is incident management and OH&S things and all that other stuff that goes along with it. But really the bulk of my time is beds and staff – managing those two things ... Rostering, staff allocation, mostly that, and the day-to-day managing sick leave, managing annual leave, you know, making sure the skill mix is appropriate, that sort of thing. (Fiona)

In describing a typical day, most participants gave little if any emphasis to an educational role, and focused on general administrative tasks. Fiona’s role in managing allocations and skill mix was common to all participants. They were aware that safe, quality care was dependent on the skills of staff allocated to each shift. Allocating staff to shift teams with the right level of skill was challenging, as there were several categories of staff, each with varying levels of responsibility and expertise. I understood that the process of allocation required participants to understand the capability of each staff member. I drew from Fiona’s response to seek a deeper understanding of how the participants determined their staff’s capabilities. I considered this process to be important, and deemed their understanding an important influence on their learning facilitation practices. These strategies are explained in Section 6.4.
Amanda added to her list of tasks her involvement in educational work, but clarified that it mostly consisted of organising rather than direct involvement, or facilitating learning by less direct means.

Amanda frequently referred to and emphasised her classification as a “clinical NUM” emphasising that she was involved in clinical matters – a ‘hands on’ NUM rather than a ‘hands off’ NUM – and perhaps also referring to a redundant award classification. She viewed education in formal, tangible terms, as a product that could be organised, manipulated and administered. However, later in our conversations and in response to focused questioning, Amanda explained in great detail how she instructed a staff member to take a blood sample, and how she facilitated team learning (see Chapter 7). Her initial perspectives, which included little recognition of these focused learning facilitation activities, were characteristic of the participant group.

Similar to Amanda, Samantha also included her role in managing staff education among her routine tasks. Samantha perceived the educational dimensions of her role as ensuring staff compliance with mandatory training and communicating unit changes. The notion of learning was not evident in her account:

> But at the same time I look after the education as well, the education of the staff, making sure that their mandatory training are completed and they’re compliant. I always communicate with them all the things happening in the unit, all the changes and improvements. (Samantha)

Samantha’s account reflected the policy orientation of participants’ work, where staff education served organisational requirements for compliance as a priority. Samantha also spoke about communicating ‘things’ to staff. Samantha viewed her role as an information source and translator of organisational information to staff. Other participants shared this perspective. Amanda believed that dissemination of information enabled understanding:

> There’s good communication between my staff and myself. Dissemination of information is vital so that staff understand what they are doing. And anything that comes out of [referral hospital] is
quickly, I mean every second there is a broadcast of something and something that has happened and I inform my staff of that both formally and informally. Formally we’ll have meetings but informally if something comes up they need to know I sit down individually with each of the staff. (Amanda)

This implied a didactic process, where it was assumed that exposure to information led to learning and was consistent with “good communication”. Engaging informally created an opportunity for interactions beyond communication of information, which could support collaborative learning and enquiry and transfer of new knowledge to practice.

Key sources of information referred to by the participants included policies, procedures, memos, journal articles and books. However, the participants were less aware of their own roles in enabling learning from these sources. During staff meetings, the participants explained and translated details from policies, procedures and memos into a verbal form that staff could understand and apply to their practice. Journal articles and books were made available for staff to access independently, and the participants gave examples of their use of research from journal articles to explain and reinforce aspects of clinical practice. During meetings, I observed the participants responding in an informed and credible manner to staff questions and matters relating to information about the clinical speciality. During interviews, the participants affirmed their value as information resources for staff. They had a high degree of knowledge and expertise in each clinical area, and of relevant policies and procedures and practice theory. They drew on their expert power to influence staff performance in different ways, but did not explicitly recognise these aspects of their roles as educational.

*Oversight of staff induction*

Participants viewed their educational roles as largely related to organising formal learning experiences. However, when I asked about their roles in developing staff who were new to the unit, I developed a deeper understanding of their perspectives. I included this activity as I was aware that induction was an intense learning period for new staff and expected that participants would have a significant role in that process. Most participants spoke of their role in induction as either directly orientating staff or directing others to perform this role. Either way, their role was focused, intense,
and underpinned by a desire to ensure an effective period of adjustment for the new staff member.

Samantha spoke of her approach to inducting a new staff member, and described her role as one of ensuring compliance. She emphasised the quality of the induction she provided. Her managerial approach, couched in requirements for compliance, was accompanied by an invitation to staff to seek contact if they identified unmet educational needs.

_I make sure that the staff are compliant with the requirements. So like with the training and education of the staff, so from the very first day I give them a very good orientation. I induct them well, properly, what are the things I expect them to do in the unit, what are the things that they need to focus on, what are the things that they are expected to do. And at the same time I always encourage them to make sure if there are some concerns or needs for further education they’re always welcome to come here._ (Samantha)

Samantha considered her active influence on the induction of new staff members an important focus of her role. In emphasising the quality of her induction and her commitment to ensuring compliance, she illuminated the centrality of her role in influencing performance, and of the legitimate power that was available to her. Other participants described their roles similarly, also undertaking to personally orientate new staff and emphasising compliance.

Similarly, Sue emphasised her role in new staff induction:

_So I do an orientation, always give an orientation of where everybody is and the fire extinguishers and the first aid and the resuscitation trolley, because we have quite a few arrests. And so I remind them, this area, we do have quite a few arrests because they’re elderly people ...._ (Sue)

Sue also chose to personally orientate staff to emergency procedures that were needed to ensure patient safety in her unit, which I understood to be indicative of her strong sense of responsibility and, similar to Samantha, the centrality of her own role in ensuring staff compliance with these critical safety procedures. Unit equipment provided a tangible focus for orienting staff to the unit, as indicated by Sue’s reference to fire extinguishers and the resuscitation trolley.
The participants identified the educational dimensions of their work as a series of managerial tasks that included emphasising standards of care that they deemed important, organising training opportunities, disseminating information and providing focused input to staff induction. They did not refer to their roles in establishing non-formal means of learning, or of the development of relationships or contexts within their units that may support learning. Participants did not explicitly conceive an educational dimension to their work beyond these tangible and compliance-driven activities.

6.3 Participants’ valued learning practices

This section reports my interpretation of approaches to learning that are most valued by the participants, including their views on how learning was best achieved in their clinical units. As the participants described their work as a blending of activities, histories, deliberations, understandings and preferences, I was able to understand more deeply their perspectives on learning, what it meant to them and how it was achieved. These perspectives underpinned the decisions and activities they performed to facilitate learning, explored in depth in Chapter 7.

6.3.1 Learning in clinical units

The participants’ descriptions of the scope and nature of their management work established a basis for deeper and more focused discussion of learning in their units. The participants considered education a means for staff to become compliant and to be able to prioritise their work, and was deemed essential for human service. Generally, they believed that education enhanced performance and established the foundations for safe quality care, as Jenny explained:

> that education’s the most important aspect as far as how your establishment [meaning staffing quota] and how you’re going to deliver safe healthcare. So that’s why I’m always really focused on it and education has always been my passion. (Jenny)

The participants emphasised, and clearly valued, formal educational experiences including external training courses and seminars. They encouraged staff to attend external courses and conferences and were committed and motivated to ensure staff delivered safe and quality care by ensuring everyone had access to these opportunities. Rob believed that staff ‘wanted’ education and spoke proudly about
the number of staff on his unit who had attended external courses through tertiary providers:

*Because that is and people do want education while really advocating and encouraging that in a formal sense as well. So while we’ve got, not a lack of resources, but limited resources to do it in-house here, really encouraging and supporting the nurses who want to go and do it externally through the college of nursing or uni and so forth and really, really pushing for that. It doesn’t always work but this time round for the last three years we’ve had, I think we’ve gone from one person with a postgrad to about eight and I think it’s been a really positive process.* (Rob)

Rob valued staff attendance at external courses, although he did not mention how their attendance enhanced unit work. Support for attendance at courses consisted of organisational support for the application process and time relief to attend classes. Rob valued having an increasing number of staff on his unit with postgraduate qualifications but did not elaborate on the value of postgraduate education to unit work or how it enhanced staff performance.

Jane, who was concerned about the expected exit of older nurses of retiring age, viewed education as vital for staff retention:

*But the key most nurses have told me here, we stay with you because you are providing us with education we never had in other units. And I said to CNC [Clinical Nurse Consultant] the key, the secret to retaining staff is to me to give them education, flexibility with the rosters, and all the mothers I am flexible with their family lives so we will never have to recruit. Easy to recruit but the hardest part is to maintain the retention of them.* (Jane)

Jane’s unit was highly specialised and she was concerned that with the exodus of staff into retirement it would be more difficult to ensure adequate levels of competent staff. She acknowledged her own efforts in providing education and valued education as a means for retaining younger staff. She viewed education as a tangible commodity, and she did not elaborate on informal or implicit sources of learning. Similar to Rob, Jane valued the motivational benefits of education. The participants did not elaborate on the value of education in enhancing unit work or in developing staff confidence with clinical work.

Although education was highly valued, it was not always a priority. Rosa explained how the turbulence of her unit displaced educational endeavours:
Sometimes you are so busy outside that you don’t have the time [to think about education] and you don’t even realise ...(Rosa)

A number of participants mentioned challenges to their engagement in staff learning due to contextual issues including the business of the clinical unit.

As the participants discussed their perspective on education and on how they influenced performance in their units, it became apparent that they considered education as a separate activity, one that is often separated from other work, a tangible commodity that was either present or not. Sue’s description of education in her workplace, separated by time and place, including the folders in which details were ‘housed’, summarised this perspective:

*We have an education time. Usually the hospital itself has an education session if it’s hospital wide so they would all go down – so, like the new IVs they all went down.* (Sue)

*So I have a big education folder that shows the things that they’ve been to.* (Sue)

The participants valued education as a means to achieve safe care, and they worked to enable staff to engage in educational opportunities within their units as well as those offered by external providers. Although not always a priority, they valued education as a means for developing teams and aiding retention. Education was considered as a separate entity, a finding that is consistent with the value participants placed on formal means of learning, which were generally separated from the workplace by time and space. The participants did not describe the application or transfer of learning, or the potential value to the wider team of sharing educational experiences.

6.3.2 Induction as an intense learning period

Induction of new staff presented a focal point for the participants’ articulation of their views on learning in their units. The participants were purposeful in creating opportunities for new staff to develop supportive relationships, and took advantage of the social nature of nursing work. The participants valued precepting\(^{13}\) as a means

\(^{13}\) A preceptor is an experienced staff member who guides new staff during their transition into the workplace.
for achieving this. Their descriptions of the qualities and behaviours of effective preceptors revealed their views about learning through precepting and how it occurred in their units. Their perspectives were shaped by their past personal experiences of induction as newly qualified Registered Nurses, and by their more recent experiences as NUMs overseeing preceptor relationships in their units. Participants considered that the preceptor activities that are most conducive to establishing learning include modelling good behaviours, being patient, and being able to establish rapport.

Participants’ views of their own experiences of being preceptored influenced their perspectives. Kate advanced quite quickly from Registered Nurse to NUM and her memory of being preceptored as a new Registered Nurse clearly influenced her perspective:

> I think they lead by a good example. They are able to engage the person, I think ... one of the important things is forming a bond with them that’s not – I have some senior nurses at the moment that I would not use any more, because it’s like standover tactics and “it’s my way or the highway” ... you don’t need senior nurses, you need someone who’s learning as well because they often learn off each other and it’s just the open minded people who are willing and not frightened that they might not know the answer to the question. I guess I learnt that when I was a new grad. I had some great mentors who if I asked something they didn’t know they didn’t pretend, we’d go and find out together, and those things stick. So it’s still someone who’s willing to learn. (Kate)

Kate valued interpersonal relationships that were fostered by precepting and considered it the preceptor’s role to form a bond with that new staff member to enable modelling to occur and to be effective. She rejected more didactic “my way or the highway” power approaches taken by some senior nurses, and felt that preceptors who were able to reduce the power relationship by participating in a preceptee’s learning were more effective. She chose preceptors on her unit who reflected these ideas, removing potential constraints imposed on learning from power relationships. Her focus on learning together was deemed to be an important and useful approach to fostering team learning, an approach that exposed the value of interpersonal relationships against a context that was heavily bound by policy and compliance.
Fiona also valued precepting relationships as a means to enable learning by modelling, although her description accentuated constraints imposed by the complex unit context:

So I’ve actually, she’s meant to have two preceptors. Because I have a lot of part-time staff I’ve given her four, which is probably not ideal. But because they work two or three days a week and she’s with the same people for the month, so she can build a rapport ... and probably model her nursing on the way they nurse and they know what she needs to achieve. So we can work at getting her assessments or whatever, the things that she needs to do done in that four-week period. (Fiona)

Fiona expected that learning for new staff occurred when experienced staff, as preceptors, modelled desirable behaviours. Fiona clarified however that the overarching goal of these relationships was to ensure that new staff were able to complete their assessments. She emphasised tangible outcomes, rather than the outcomes that might be achieved informally from relationships created during precepting.

Fiona’s views were similar to those of other participants who valued approaches that supported learning while simultaneously guiding new staff towards compliance with policy. John had also considered how to guide a newcomer towards policy compliance within the ambiguities of clinical work:

Patience to deal with people that take a while to grasp things and also the example, you know, you can’t cut the corners, even as the example they still cut the corners and you say, “look, when you are the training person you need to say, ’look, this is how it is done’”. And then that person can make a decision about when they need to cut corners in the future or prioritising again during the day. But you still need to set this as the standard. Whereas I find the standard stops very quickly as soon as the person learning sees that you’re cutting corners they cut the corners at a much lower ... because some days you can’t get 100% done but you learn how to prioritise that and maximise things throughout the day ... I can’t think of it as a quality but it’s the difference between ticking off a book and actually really guiding someone to progress. (John)

John identified patience as an important preceptor trait, and was sensitive to the needs of slower learners. He was concerned that preceptors should not cut corners when mentoring new staff. I was somewhat surprised by mention of ‘corner cutting’, a practice not usually recommended, or acknowledged, and something of a threat to
safe, quality practice. However, I understood John’s perspective that ‘corner cutting’ was sometimes the reality of clinical work in hospitals and that staff needed to be able to determine how, when and which corners to cut on occasions. Other participants spoke about ‘reprioritising’ and I understood that this is what John was referring to: how to change or adapt a routine when other priorities emerge; when the sheer messiness and time demands of the work require staff to adapt the usual formalised practices to suit the situation, and to ‘reprioritise’ to get the most important work done in the day. John was aware that an understanding of correct procedure preceded the ability to reprioritise, although he did not explain how this might occur. He felt that modelling incorrect practice led to an even lower standard of practice by the preceptee.

John also aspired to extending preceptorship into a longer-term relationship that enabled professional development to occur beyond the induction period. He valued mentorship for this purpose, and expected mentors to have the skills to really guide the person to develop rather than just help them to tick off a checklist of competencies.

*So, it’s more about the differences between ticking off a box and make sure you’re getting through and actually advising them on what they should be doing. “This is a course you should be doing, this is how you should be practising”.* You should look at identifying that they’d be good educators, they’d be good CNC’s, they’d be a good manager. “This is a specialty and this is the way you should be going, how about you focus on this”. And giving them those prompts because often people just need those pointed out to them. (John)

John had a vision of longer-term mentor relationships where mentors identified individual strengths and capacity and encouraged staff to seek and pursue opportunities for career development. In suggesting “people just need those pointed out to them”, he valued mentors who could enable staff to reach their full potential rather than simply achieve basic requirements and perhaps continue without ever truly knowing what they were capable of. John was the only participant who valued ongoing learning for staff through longer-term mentorship. His perspective extended beyond meeting shorter-term unit needs for competent staff, to meeting staff career development needs, even where such support may lead them into different roles and away from the unit. I considered his approach to be altruistic, and caring towards staff. Mentoring was less focused on meeting the immediate needs of the unit and
staff member, and more on longer term career development. Interestingly, in this example “This is a specialty and this is the way you should be going, how about you focus on this”, John used an assertive approach, drawing on the legitimate power of his position to influence staff to progress their learning.

Similar to precepting, discussion with the participants about goal development during new staff induction further revealed which learning strategies they most valued. Participants were familiar with goal development as a strategy embedded in the hospital’s formal performance review process. A goal was a statement that stipulated a particular skill deemed necessary for role performance, and a time frame for its achievement. Goals were articulated within a ‘skills pathway’, a scaffolded arrangement of clinical skills that enabled new staff to progressively work towards a higher level of performance. Goals included in the pathway originated from three sources: generic goals were determined by hospital policy, for example being able to perform work health and safety procedures; specialised goals that were relevant to the particular unit were developed locally by participants and CNEs; and individual goals that reflected personal learning needs were developed between staff and the NUM/CNE during performance review meetings. The ‘skills pathway’, which was at the core of performance review, was particularly prominent during the first year or two of employment where the focus was on incremental skill development.

Participants spoke positively about the skills pathway, as it not only guided the development of particular skills but also the pace at which they were to be achieved.

All participants identified tasks associated with enactment of the skills pathway. They referred to the systems and processes they had developed to maintain and guide compliance with skills pathway requirements. Jane shared her systems with me early on in our first interview. About 20 white ring binders were arranged neatly on top of a cupboard on a designated shelf. She explained the rationale behind the arrangement of documents that comprised each record, and she seemed quite methodical and disciplined in her management of these.

Jane explained how she used the folders to support staff goal achievement during the year:

*So to be able to follow that up in an effective way [CNC] and I created for each of my nurses a professional portfolio. So each of*
them they have their appraisal there, they have their all of the things required to maintain their registration with AHPRA. So we gave them an in-service about what we were to do for them. The responsibility to fill out that form is up to them. So we did this ... all my nurses have a current CV and they all have current registration and they all have the courses they have completed at the college or university and then they have the performance appraisal. So we look back on what you really wanted to do, so look really you have achieved this and this and that. Like we have when you first started here, the skill tree. And then I usually highlight what they need to achieve by the next appraisal so then we do this ... (Jane)

In addition to AHPRA and compliance requirements, the folders were a focal point of Jane’s discussion of staff development and she prioritised having an organised system in place that enabled efficient monitoring of staff progress. Folders were kept in her office and were not freely accessible to staff. Ownership and control of these staff development activities by the NUM was characteristic of the participant group.

In seeking the participants’ perspectives on goal development, beyond the tasks of managing documents, I gained a deeper understanding of their role in influencing learning. Fiona valued goal development particularly during induction, where learning needs were most intense:

when people start here we have a lot of goals and we need to achieve all these things to get your skills up to where we need them to be and then it’s all, “Ok now you’ve done that now you’ve achieved all these things”. And that’s when you’re sort of in a bit of limbo so you just work, which is good for a while because you just want to sort of put your head down and put all that into practice but ... I don’t want people to get ... complacent or ... feel that there’s nowhere else to go when there’s other things that they could be doing to achieve more and to give them sort of a sense of belonging to the team and “We want you now to do this” and “These are the goals that we’d like you to try and work towards now”. Instead of sort of staying stagnant and I think that’s important. (Fiona)

Similar to Jane, Fiona took control of goal setting and viewed new staff as passive participants in this process. Fiona clearly valued goal setting within the skills pathway, but also the utility of the process as a means for checking off achievements. This practice tended to focus on outcomes rather than on the processes involved in their achievement. Fiona used goals to motivate staff to achieve advanced practice.
Of interest in Fiona’s account was her concern that, after achieving their goals and applying their learning to their practice, staff might then become complacent, and associate learning with ‘stagnation’. She was aware of the need for staff to embed their skills within the temporal space between learning one set of skills and another, and seemed to have a feel for the length of that intervening time, perhaps a tacit understanding of the point where staff are ready for more learning.

However, not all participants were positive about goal development within performance management. Jack was particularly unsupportive:

I think it’s a waste of paper if you ask me. I mean, it can be if it’s used properly. You can see if there’s any progress ... I mean in that respect I think it’s a useful tool. But I mean a lot of people have difficulties filling them in. I think they’re making it too complicated. So that’s how I see it. I think, that’s why I think it should be used differently because everybody’s afraid of it. (Jack)

Jack viewed performance goal development as a bureaucratic process of form filling, useful for measuring conformity but otherwise associated with compliance and fear rather than with learning and development. Jack’s views contrasted with those of other participants who emphasised their control of the process and saw it as a catalyst for learning and team participation. Jack did not perceive a role for himself in controlling goal development, apart perhaps from overcoming the complicated nature of the form, the fear it engendered and seeking to use it more effectively. Perhaps his views had been formed by the culture on his unit and by his own history of professional development.

The participants’ explication of their perspectives about learning were most comprehensive and focused in relation to staff induction. This intense period of learning demanded the participants’ oversight of precepting relationships and goal development. The participants valued preceptors who were able to empower new staff, by presenting themselves as partners in learning, modelling good practices and guiding new staff through the ambiguities of clinical care. The participants valued goal development as a means to guide staff development and monitor progress. They valued the motivational aspects of goal achievement and the growth in capability that supported confidence and participation in the wider team.
6.3.3 Caring as a stimulus for learning facilitation

Beyond discussions about the utility of skills pathways and goal development, the participants’ accounts revealed caring and supportive approaches that underpinned and motivated their learning facilitation practices. Descriptions of their interactions with staff who had particular learning needs, including during induction and when matters of underperformance arose, provided interesting and deeper insights into their perspectives on learning in their workplaces.

The participants viewed mastery of clinical skills as an avenue for gaining team acceptance and developing a sense of belonging. This was demonstrated by Fiona in the previous section. I found this somewhat surprising as participants had otherwise expressed an interest in compliance as a key motivator for their learning facilitation practices. Lisa also explicitly expressed the view that a desire for belonging provided motivation for staff to develop their skills:

*we’re very big on advancement and they watch their peers advance, especially when we take a whole group together. They’ve all gone to uni together and they kind of compete with each other a bit I think. So they do set goals because it’s like, “Okay, I want to get to triage, I want to do the next level and I want to be resus trained and I want to hold the MET page” … So it’s really big here otherwise you just get left behind and that’s the point where you’ll often leave or you just, you won’t want to be here because all your peers have advanced so high.* (Lisa)

Lisa perceived a degree of competition between new staff, especially new graduates, as a motivating force for advancement and goal achievement. While the team provided a means for social learning, the participants also identified the influence of the personal need for peer group acceptance as a significant driver of skills development. Lisa’s comment “We’re big on advancement here” suggested this was a norm, perhaps embedded in the culture of her workplace. Both Lisa and Fiona were sensitive to the impact of learning and progression on a sense of belonging to a team. Sally’s perspective was also concerned with team belonging, but she viewed goal development as an assurance that all staff had an equal opportunity to achieve that status:

*if there’s no plan, no goal, there’s no objective then the ones who are keen and motivated will approach us and speak up and want to do this, want to do that. The quiet achievers, the quiet ones will just sit*
back and become neglected. I feel that I’m so-o-o conscious of that because we’ve got such big units the personalities are so varied, so different. We have the very quiet ones who are keen to learn but won’t speak up ... and before you know two years later they haven’t stepped up, they’re capable, just not step up because they are actually being neglected. (Sally)

Sally identified differences in the dispositions of staff members, between those who were more dominant and able to articulate their own learning needs, and those who were less so, and of the effect that this had on opportunities for learning and achievement. The standardisation of performance goals removed any privilege created by dominant personalities, provided a reference point and prevented ‘neglect’ of staff learning and advancement needs. Sally was acutely aware of the emotional impact of learning and skills development on staff and on their relationship to the wider team.

The participants’ perspectives on goal development were largely positive, from both practical perspectives and also as avenues for staff to develop competence as a means of gaining team acceptance. This was an interesting finding that demonstrated strong sensitivity, emotional intelligence and caring for staff in relation to their learning experiences. The participants’ caring attitudes towards staff who were learning was also revealed in conversations that went beyond goal development. Jane explained how she provided emotional support to new staff:

So we build them up slowly, practically and in theory. And then what I usually do at the end of the day, especially a big day, I call them here and say, “How was your day?” (Jane)

Jane was aware of the challenges her unit presented to staff, and of the need to ensure they felt supported and aware of the emotionally intense nature of the work. Her supportive attitude underpinned her design of an incremental learning experience. I considered her caring and supportive approach to be essential for staff learning, and for their development of confidence in their clinical work. The high priority given to supporting staff was also reflected in the participants’ accounts of how they prevented and managed underperformance, as Rosa explained:

Because we are every day, not playing with life, but we work in their life. So to me it is very important that if, that’s why I said today, “If you don’t feel comfortable let me know straight away please”. Because in that case I will move mountains for you to feel comfortable
and to actually give the proper care to. I don’t want to come back the next day and find that, because it is a terrible thing for you to lose a patient or put a patient in danger. How you going to feel? You not doing those things because you like to do those things. It’s very, very important. (Rosa)

Rosa was concerned not only for the standard of patient care but for the emotional consequences for the staff member. She recognised that error was not deliberate and emphasised her open support to staff to prevent errors from occurring. Fiona also demonstrated understanding of the emotional consequences for staff who were underperforming:

I say “how do you think you’re going?” Because they’re feeling it, and this has just happened very recently, she was feeling it, and I get a lot of feedback [about the staff member’s performance] so I want to address that very quickly. So, we had her on a plan probably within two months of being here to support it, and that’s the idea of it, to support through education so their performance improves. (Fiona)

Fiona also recognised the feelings of staff who were not performing well. She identified a learning need and acted to support development of their skills. Similar to Rosa, Fiona’s sense of empathy towards staff who were not performing motivated her support of their learning. These responses were characteristic of the participant group, and contrasted with earlier conversations that focused solely on policy compliance.

Participants’ concern with the learning needs of new and underperforming staff was inherent in their accounts. Of particular importance to Rob was the experience of Assistants in Nursing (AINs), who were not only new staff members with unknown skills, but who occupied a new position that was not well understood by the wider nursing team. Rob was sensitive to the needs of the AINs, and focused his support, perhaps understated in his account, on development of her skills and capability as a means for harnessing her acceptance by other staff on the unit:

we've been very fortunate with our AIN. She struggled under a great deal of prejudice which is not the right word but it'll do, um and I think only through her strength of character and the support she was given and... to some very small extent, my determination that she was going to stay no matter what bitching and carrying on went on. After about four or five weeks people realised that she was actually able to do these sorts of things and the world did not end, the patients did not die and it all actually worked out. (Rob)
Robs support for staff acceptance of the AIN was also demonstrated during my observational visit.

_During the next item of general business, staff raised their concerns about the appropriateness of having AINs working with such acute patients in their unit. The NUM listened and advocated for the AIN, declaring his evaluation of her skills as being of a high standard. He suggested that staff lodge a grievance if they felt strongly about the issue._ (Field notes: Rob’s unit)

My fieldwork observation suggested continuation of support and advocacy for the AIN was necessary in order for Rob to sustain staff acceptance of her skills and capability as a member of the nursing team. Rob recognised that acceptance of the AIN by other unit staff was not only based on level of skill, but also on their openness and trust of an unknown nursing role. Rob was instrumental in enabling that process. Rob drew on positional power, referring staff to the grievance policy, if they had any concerns indicating the value he placed on acceptance of the AIN by the nursing team.

Participants recognised and supported staff emotional and learning needs, including dependence of new staff and staff in new positions, as newcomers to their units. Conversely, new staff were also valued as a source of learning for participants’ units. Samantha’s perspective represented the views of several participants:

_Usually when there’s a new staff coming in and they’ve got some other information that will help the unit, it’s always been welcomed, like that’s the way we’re running the unit…. Like I always ask them “What do you think about it” like “Can you suggest any way to improve it?” I tell them what the concern is and then we get some information and feedback from them._ (Samantha)

Samantha’s approach highlighted her respect for new staff experience, skills and knowledge. In seeking advice on clinical work, Samantha sought to empower new staff, to facilitate confidence and a collegial relationship by reducing the impact of power that was inherent in their relationship. Her approach also demonstrated caring and awareness of the feeling of staff who were new to the unit.

The participants in this research were deeply aware of the influence of individual skill level and capability on staff emotions. They considered individual capability important for gaining a sense of belonging to the team, and supported learning
opportunities that enabled this to occur. The participants’ awareness of individual emotions influenced their approach to staff who were new to the unit, or who were experiencing performance issues, and emphasised their role in providing unlimited support to enable staff to progress.

In this section, the participants’ perspectives on learning in their clinical units, and how it is best achieved, have been explored. The participants valued and supported learning as a means to achieve safe and quality care in their units. They also valued learning as a means to facilitate staff compliance with policies. Learning opportunities met the learning interests of staff, developed a qualified workforce, and aided in retention. The participants generally valued formal learning and the systems they had created to monitor compliance with formal learning activities. Most participants valued the formality of goal development as a means to establish shared responsibility for staff performance and compliance, and considered goal achievement as instrumental in enabling staff competence and engendering a sense of belonging to the team. However, the participants recognised the constraints imposed by formal processes. The participants were deeply aware of the emotional needs of learners, and emphasised their own roles in providing support for their staff, drawing on personal and positional forms of power to facilitate and influence staff learning.

6.4 Understanding staff performance

In exploring the participants’ perspectives about staff learning in their units, I sought a deeper understanding of how they developed knowledge of staff capability and performance, given the disconnection that sometimes arose when their management responsibilities separated them from the work of the unit. This was important because the participants’ responsibilities for the safety and quality of patient care in their units included being accountable for the standard of staff performance. Being well informed about the standard of individual staff and team performance was essential to this undertaking. The participants in this research routinely undertook formal monitoring activities such as auditing that yielded information about their team’s compliance with policy. Audit data was valued by participants, perhaps owing to its direct relationship to policy. However, during deeper discussion, participants also described less formal practices they used to develop their
knowledge of individual staff member’s capabilities. In this section, the range of approaches used by the participants to develop their understanding of staff capability is explored.

6.4.1 Understanding staff performance through audit processes

Within the policy and procedure rich environment of the hospital, controls were in place to measure compliance. Control, a process that involves monitoring and feedback on progress toward a given end (Robbins, Bergman, & Coulter, 2018), is strongly associated with quality management processes, and in healthcare specifically relates to such structures as clinical governance and accreditation. Control also occurs through organisational structures, professional registration, culture and external regulation. I interpreted control within the participants’ work contexts as being underpinned by policy and procedure. The elements of control – familiarising staff with standards, monitoring compliance, giving feedback and planning for improvement – impacted heavily on the participants’ roles and priorities.

The most frequently discussed and observed control during the fieldwork component of my research was the audit, an activity that seeks to monitor, measure and verify the work that is being done according to predetermined standards. Audits were largely policy driven and aimed to measure compliance. Numerous audits were undertaken across the organisation, and within each clinical unit, each with its own focus, and all feeding into a larger system that monitored the overarching audit process. During unit meetings I observed participants speaking about many and varied audits including those relating to handwashing, documentation, equipment, medication charts, and environment. Some audits, such as handwashing, required auditing staff to undergo a training program on how to perform the audit, itself a subject of an audit. Audits were carried out by unit staff, CNEs and the participants, who also oversaw the process, interpreted results, gave feedback and made recommendations for improvement to staff performance. Audits were quite prominent in the participants’ discussion of their work. Amanda detailed her meticulous approach to undertaking this activity:

I do drug audits and of those drug audits I audit the charts and the documentation on how the doctors prescribe it, how the pharmacist
provided those prescriptions and how the nurses dispensed those prescriptions, administered it and then document their actual occurrence. And that’s monitored every month. And I write a report on it all about that, an outcomes statement. (Amanda)

Amanda was quite direct and placed great emphasis on her role in completing audits, detailing each component and emphasising formality: “I audit”, “I write a report”. This activity, as a formal process driven by the hospital auditing schedule, was identified by the participants as a task associated with hospital compliance rather than with learning. However, during unit meetings the participants presented results of audits, used visual representation (graphs) to interpret and explain the results, and recognised work well done. Where there was an issue of low performance, the participants explained the practice implications of the relevant policy and emphasised strategies to improve, as observed during my visit to Kate’s unit:

During the meeting, the participant presented a report on routine unit audits, including hand hygiene, documentation, handover, patient identification bands and medication charts. She presented charts of results and interpreted trends. Where deviations in performance were identified she gave examples, and emphasised correct procedures. Handwashing practices of doctors were highlighted as trouble spots and NUM gave staff instructions on how to speak respectfully but assertively to a doctor to remind about handwashing protocol. (Field notes: Kate’s unit)

Audit results contributed to the participants’ understanding of the work of the team in complying with policy within the process of care delivery.

Audits, as mandated by hospital policy, were not always relevant to each clinical area. The participants expressed an interest in developing audits that were more relevant to aspects of quality that were particular to their units. As an example, Jane had developed her own informal auditing routine in relation to blood transfusions, as she felt this was an important standard to be enforced in her unit:

Sometimes when we have many blood transfusions, I go around because I check the bloods with that nurse who is treating the patients and then I see the sticker of the blood transfusion because one sticker must remain on the back, other ones goes into the patient’s notes to prove that we have given that blood transfusion. So sometimes I find them floating somewhere there. So I go over there and I gently say, “Do you have time to put the sticker in the progress notes or did you want me to do it now?” But it cannot be floating because it’s going to get lost. (Jane)
Jane was clearly concerned about the patient safety risks associated with administering blood transfusions. She participated in unit work to assess compliance, and was able to determine and address non-compliance when it occurred. Jane also echoed the importance of compliance and being able to defend practice, “To prove that we have given that blood transfusion”, a theme that was noted in the participants’ responses across the fieldwork phase of this research.

The practice of developing audits locally also enabled participants to make their own judgement about what was important and relevant. In so doing it provided participants with an opportunity to become engaged in unit work in a practical way, to work in the space that was unique to their unit and to develop information that could be used to enhance staff performance. This was evident in Jenny’s account of audit development:

"It’s a service that we’re giving. So I say, “Look, we’ve got to get together. We’ve got to talk about this. We have to work on this. We’ve got to do audits, we’ve got to look at our audits, reflect on our audits. What can we do better to make this practice better?” Like, even just checking on a resus [resuscitation] trolley. “OK, this is the percentage that we do, so what can we do to make it better? Because we’ve got to make it better and if it’s not getting better then why isn’t it? So how can we do that?” (Jenny)

Jenny’s repeated use of “we” inferred teamwork and her presence in the team’s practice space. Their shared purpose was reiterated in her reminder to staff of their unit’s service identity. In the quest for improvement, she asserted her expectation of their participation and guided the team towards critical reflection on practice. The audit was central to this process, as the audit could yield information about their practice that could be used to inform improvement. By supporting a collaborative team interaction to transition a formal compliance-driven process into a useful practice change, Jenny promoted an opportunity for learning within the team.

In a policy and procedure rich environment, participants had a key responsibility for ensuring staff compliance with those policies and procedures that were directly relevant to patient care and staff job roles. Audit results contributed to the information needed to gauge where non-compliance or misunderstanding was occurring. This opened up an opportunity for participants to understand staff learning needs, and to facilitate educational interventions to address any shortcomings.
6.4.2 Informal approaches to determining staff performance

The nature of less formal approaches taken to understand staff performance varied between participants. This variation was largely dependent on unit speciality, hours of operation and number of staff responsible to each participant, as these factors directly influenced opportunities available for participants to monitor staff performance. Furthermore, staff skill and knowledge levels were not only determined by nursing qualifications, for example, Registered or Enrolled Nursing qualifications, or Assistant in Nursing qualifications, but also by the nature and extent of staff experience in nursing (including their current workplace), the specialty area they were working in, and their individual propensity for the work. Strategies the participants used to assess staff performance included participation in clinical care, being aware of each staff member’s contribution to the overall performance of the unit, and observation of staff interactions within team activities such as handover, routine meetings and case presentations.

Assessment of staff performance was a complex task, compounded by challenging unit contexts with more than one speciality, each requiring a specific skill set, by a frequent undersupply of experienced staff, and by staff turnover. This meant that for many participants the staff mix on any unit at any particular time was difficult to assess and was often less than perfect. Fiona prioritised ensuring that the staff mix enabled safe care, although she acknowledged that the combinations were not always ideal:

*I have two quite different specialities that exist on this ward so it’s a matter of having skill to cover both specialities. And ideally, you’d like senior and junior staff on each shift, which doesn’t occur all the time, but its allocating appropriately so it’s a safe workplace ... because it’s a limited number of senior staff and more junior staff so it’s just a matter of making that fit to cover two specialities as well.*

(Fiona)

Unit specialisations were generally constant. However, a portion of the unit’s beds were sometimes allocated to other specialisations according to need. Participants, like Fiona, needed to be able to adapt to the demands that these decisions placed on their work. Fiona described frequent changes that had been made to the focus of her unit, such as the re-allocation of half of the beds on her medical unit to specialised surgery, and the challenges involved in ensuring staff had the skills to meet the needs
of these different patient groups. To roster appropriately, it was essential for Fiona to understand the capabilities of her staff to care for patients within these specialisations. This was a challenging task as skill levels differed between staff, and assessing capability involved understanding their propensity for work, their skills and attitudes, as well as their capacity to adapt to change. During shift allocation, the skill sets of multiple staff were ‘pieced together’ to ensure the final skill mix met the needs of the unit in terms of quality of care and patient safety. Keeping abreast of staff capabilities in a changing context was a challenging task.

The participants described how they assessed their staff’s ability to perform their work through routine management tasks, for example, by monitoring incident reports, responding to staff and patient care issues, and maintaining awareness of activity occurring in the clinical area. I was particularly interested in how they acquired this knowledge, as I was aware they spent only limited amounts of time working closely with staff. Opportunities to acquire this knowledge varied between participants owing to the time available to maintain a presence in the clinical area. Some participants worked closely with staff while others worked from a distance, leaving clinical supervision up to the Clinical Nurse Educators and Team Leaders. Those who worked closely with staff felt more confident in their ability to directly appraise staff performance. For example, Jane was able to spend more time with staff as, owing to the nature of her unit, all staff worked the same hours and she was closely involved in patient care:

*My role here is that I am on the floor with them. I am checking therapy with them ... and when I’m checking I know how they cannulate, how the nurses are going along with the patients. I check the order; I check that all the signatures are there. It doesn’t take long.* (Jane)

The unit’s structure enabled Jane to develop and maintain awareness of staff skills and ongoing level of performance as she was physically close to the unit’s work. Furthermore, as her unit was highly technical and specialised, Jane spent a lot of time working alongside staff and ensuring standards of care were upheld. Jane also incorporated compliance checking as a means of assessing staff skills and identifying learning needs. While checking staff compliance was a fairly standardised process, which generally involved a formal process of watching staff perform treatments, checking against doctors’ orders and signing to validate the process, at the same time
Jane was able to assess more subjective aspects such as “how” staff performed procedures and interacted with patients. These qualitative aspects of nursing work, which included such characteristics as the nature of their communication, kindness, respect and emotional intelligence, are challenging to ascertain away from ‘the bedside’. However, as a participant in the process of care, Jane was able to use a formal checking process and engagement with associated “artefacts” (i.e. sign sheets, treatments and orders) as trigger points for action, decision making and conversation, which provided her with leverage to develop understanding of these more subjective practice dimensions. This approach contributed to her overall assessment of her staff’s ability to deliver this aspect of patient care in a safe and effective manner.

Kate also emphasised working with staff as an effective way to learn about their level of performance, but was more deliberate in assessing their level of knowledge:

*I work with them ... There’s plenty of opportunities in any week to say, “I need a hand” and ask them what their understanding is of particular ... procedures, how drugs work. Like, I often go and help them to give drugs and I will say to them, “Do you remember what this is for?” And just to get an understanding of what they actually know or whether they just give them because they’re prescribed.*

(Kate)

Kate indicated that working with staff was a regular activity, and was based on helping rather than on checking up. Kate’s willingness to immerse herself in clinical work and to help fostered a familiarity that enabled staff to feel comfortable asking her for “a hand”. The act of “helping” was a positive act of caring, which gave Kate access to staff members’ space in a non-threatening way, reducing the effects of power on their interaction. The power to admonish for incorrect performance was inherent in Kate’s relationship with staff and it was necessary for her to modify the effects of power to be able to positively influence their work. By questioning staff as she partnered with them in delivering care, drawing on referent and expert forms of personal power, opportunities for informal and incidental learning arose and gave her a sense of the knowledge and skill basis that underpinned their work. Kate’s learning facilitation practice was embedded in her assessment of staff performance.

Similarly, Fiona emphasised the importance of working closely with staff, but privileged observation of practice, rather than direct engagement. She was more
interested in the way the unit was running, which she saw as an outcome of effective individual practice:

> By o-b-se-r-v-at-io-n ... [slow, pensive, appeared to be thinking] 
> because I spend a lot of time out there and see what’s going on and I suppose it’s the team leaders really. It’s how the day is running or if someone’s falling behind [beeper], you know, if they’ve fallen behind in their workload then I sort of judge their performance on the day to day. I do performance appraisals to make that a formal process but it’s really the day to day ... I might get complaints from a staff about a staff member, obviously I take those seriously, and if patients are complaining [small laugh]. But mostly it’s just my observations and seeing what’s going on and how the day’s running. (Fiona)

Fiona did not work directly with staff as Jane and Kate had described, but rather valued understanding less tangible, holistic aspects of their performance, “how the day’s running”, as well as receiving feedback from other staff and patients. She valued timely and efficient work, and contributions of staff to the whole operation of the unit. Fiona observed staff performance from some distance to their clinical work, trusting her relationships with staff and patients and her interactions with the day’s unfolding events to generate any information about staff performance that she needed to know. Her understanding enabled her to act to support or provide education for staff who were having difficulty acquiring the necessary skills to be able to perform effectively in their team roles.

The participants also used team gatherings to gauge staff understanding of relevant unit practices. Formal team gatherings included scheduled ward meetings and handovers, and informal gatherings included impromptu meetings called during the day or meetings that occurred during breaks. Rob deliberately used regular staff meetings to develop his understanding of staff knowledge of particular practices from questions asked of him and from the discussions between staff that ensued:

> So by having a meeting you have a sense that they didn’t get it [meaning not understood] or did not follow through and read up on it. (Rob)

Rob’s focus was on what staff did not know rather than on what they did, perhaps reflective of his focus on ensuring compliance rather than on recognising its achievement. Meetings provided an opportunity for interaction between staff on nursing care issues. Staff interacted freely on points of interest, and deliberated over
important issues. Rob provided support during these interactions by using openended questions and providing feedback to the group on their contributions. The
discussion gave an opportunity for staff to build on their understandings, and for Rob
to reflect on and ‘process’ staff responses, an activity that contributed to his
understanding of the level of staff knowledge on various unit practices. By
deliberately fostering effective team relations that enabled deliberation on relevant
topics during meetings, drawing on expert and referent power, the participants had
an opportunity to better appreciate staff understanding of unit practices.

During ongoing discussion, Rob identified handovers to be a particularly useful way
to gain insight into nurses’ practices and knowledge. A handover is a meeting that
occurs between incoming and outgoing nursing staff during a shift changeover.
During a handover, nursing staff come together to exchange information and to
interact purposefully within a team. Through communication of patient care, and of
the basis of decisions made during the shift, it is a time when individual performance
becomes explicit:

*It [handover] gives me an idea of how aware people are in the way
that they talk about their patients ... as whether they’ve been given
their medication and that identifies issues and problem-solving skills.
But also in going through a patient’s chart and whether someone’s
identified a problem and said what they’ve done about it.* (Rob)

Handover provided an opportunity for Rob to gain knowledge about staff
management of patient care, as well as their ability to comply with policy and
engage in problem solving. Verbal handover provided a means to assess non-
physical aspects of patient care, where knowledge, skills and experience were
applied to clinical problems; in short, clinical reasoning. Clinical reasoning is
fundamental to nursing practice. It traverses the boundaries set by clinical procedures
and policies and moves practice capability to a cognitive domain. These cognitive
processes are less readily observed but can be made explicit through dialogue. The
language used by his staff also taught Rob about their attitudes, and this seemed
important to him: “the way they [nurses] talk about their patients”. Patient charts
used during a handover also contributed to his assessment of staff performance,
triggering dialogue about specific events. Handover and patient charts were
important mediating tools that facilitated dialogue and enabled Rob’s assessment of
staff performance. Patient charts captured the history of each patient’s progress as
well as many of the programmed and non-programmed interventions carried out by staff during each shift. As a tangible representation of patient care, they were open to interrogation; a process that gave the participants insight into staff compliance as well as their reasoning behind non-programmed care decisions.

Case study presentations, organised primarily to enable collaborative decision making and learning around patient care, also provided participants with an opportunity to gauge staff understanding of clinical knowledge and unit practices. Case study presentations involve a staff member presenting details of a patient’s history, including problems, treatment and ongoing care needs, and provides an opportunity for the healthcare team to contribute to problem resolution in a collaborative way. Case presentations simultaneously provide opportunities to assess staff performance, staff learning and enhancement of patient care. During such case study presentations Kate formed an impression of staff knowledge and understanding by being receptive to the nature of their questions, particularly those initiated by more junior staff whom she considered to be less knowledgeable and experienced and therefore more interested and likely to raise questions:

*Once a week we have a session where a senior or seniorish gives a case study of a patient they’ve looked after ... we use the [patients who have had a particular type of surgery], we start at the beginning about the drugs they use and what they’re for, the care of the patient as they come back. And it’s sort of an education session but it’s also a session to, I guess, let people ask questions that they might feel silly asking ... So it’s an opportunity and that’s a really good place to identify the younger, or not necessarily younger, but junior staff [level of understanding] because they’re interested and they’ll ask questions and they’ll come to me and they’ll ask questions.* (Kate)

In supporting case presentations in her unit, Kate created opportunities for team interaction that formed a basis for her to observe responses from staff as a means to understand their knowledge, as well as to provide feedback. She valued an atmosphere where staff could ask even “silly” questions, to encourage learning and reduce any misunderstandings. This activity also triggered ongoing enquiry and reflection as staff who were not comfortable in asking “silly” questions or who thought about the case afterwards followed up with her at a later time, providing additional opportunities for feedback and information gathering. These meetings and
follow-up conversations fostered Kate’s ability to develop a fluid understanding of staff knowledge of clinical care.

In summary, the participants, as managers of specialised and complex patient care units, were responsible and accountable for the safety and quality of care provided to patients in their units. The participants sought opportunities to understand the capabilities of staff to perform safe, quality clinical work in their units, by completing audits, through direct observation and participation in clinical work, by maintaining awareness of staff contribution to the performance of the unit and by observing staff interactions within the wider team. The participants engaged with various ‘practice artefacts’ that provided tangible histories of decision making and formed the basis for conversations about care and clinical reasoning; they sought to communicate effectively with individual staff about care, and worked with teams to enable conversations that revealed less tangible capabilities, such as organising and problem-solving skills. Participants drew on personal forms of power to enable meaningful and non-threatening engagement with staff during these interactions. Participants’ holistic understanding of staff performance facilitated awareness of the learning needs of both individuals and groups, as a basis for development and implementation of their learning facilitation practices.

6.5 Conclusion

The participants in this research identified their roles as nurses and as managers, and did not immediately identify an educational role beyond organising staff attendance at formal learning events and monitoring work practices in the interests of patient safety. However, during deeper exploration, particularly during times of intense learning for staff such as induction, participants’ perspectives on staff learning became more apparent. The participants valued formal tangible learning experiences; the provision of information; their own knowledge, understanding and modelling practices; mentoring; providing opportunities to interact with a supportive manager; and a team environment as enablers of learning. These values served as a source of motivation for their learning facilitation work. The participants were aware of the emotional experiences of learners and described caring and supportive practices that enabled learners to progress. The participants actively sought to understand staff performance through formal sources of information such as audit results and
informally by participating in the work of the unit. However, the educational potential of participants’ own practice in fostering learning through their engagement in these activities was not always a conscious part of their work routines. On deeper exploration and interpretation of the participants’ responses, I was able to gain insight into a range of activities performed within the course of their management work that supported deeper engagement with educational practices. These activities are explored more deeply in Chapter 7.
Chapter 7: Learning facilitation strategies

In this chapter, I present key findings from my deeper interpretation of the participants’ learning facilitation practices, situating my interpretation within the contextual and practice foundations explored in Chapters 5 and 6. This chapter concludes the findings section of this thesis and foregrounds the discussion and the model of NUMs’ learning facilitation practices presented in Chapter 8.

In Chapter 5, I explored contextual factors that shaped the participants’ learning facilitation work. The key influences on their learning facilitation practices originated from within the health system and hospital environments as well as more locally from within individual units. Broader influences included the policy context, formal systems of monitoring and compliance requirements, and local influences included the unit specific factors such as clinical specialisation, hours of operation and staff mix. Understanding these contextual dimensions was important as their influence was embedded in hospital and unit practices and shaped and sustained the participants’ learning facilitation practices.

In Chapter 6 I presented the participants’ views on their learning facilitation roles, including their perspectives on staff learning in their clinical workplaces. The participants valued formal learning activities and did not perceive themselves as educators. However, following exploration of the participants’ perspectives on practices they deemed conducive to learning in their workplaces, their learning facilitation practices became more deeply known. The participants’ strong sense of awareness of staff emotions emerged as a key influence on their learning facilitation practice. The participants also explained in detail strategies they used to develop their understanding of their staff’s capabilities and learning needs. Their unique use of power to facilitate learning and understanding was illuminated in these accounts. By exploring the participants’ perspectives about learning, and how they developed their awareness of staff performance and capability, and learning needs, I developed a solid foundation from which to more deeply understand their learning facilitation practices.

The findings discussed in this chapter answer the following research sub-question:
4. What activities do Nursing Unit Managers undertake to facilitate staff learning?

In this chapter my interpretation was guided by Mintzberg’s people and action ‘planes’, Kemmis et al. (2014) relatings and doings, and Eraut’s (2004, 2012) contextual and learning factors. Consistent with these frameworks interpretation revealed that NUMs’ learning facilitation practices occurred within work routines and teams. The participants’ facilitation of individual learning within work routines included their design and use of learning resources, their facilitation of incidental learning, their support of reflective learning approaches and precepting, and their development of individual team leader skills. The participants’ facilitation of learning within teams included activities conducted within work routines, and within team meetings. These findings are then coalesced to holistically represent NUMs’ learning facilitation practices in Figure 7.1, which concludes this chapter.

7.1 Facilitating individual learning within work routines

In seeking to more deeply understand the participants’ learning facilitation roles, I explored their accounts of activities they performed to bring about change in individual and team performance. Routine work activities that facilitated staff learning included staff induction, performance review, incident management, roster development and management of day-to-day clinical issues. My interpretation of these accounts enabled a deeper understanding of embedded learning facilitation practices that were inherent in the participants’ work. These practices were included in a range of activities such as supporting learning with learning resources, facilitating incidental learning, supporting reflective learning approaches, supporting learning through precepting, and developing selected staff members’ team leadership skills.

7.1.1 Supporting learning with learning resources

As reported in Chapter 5, the context and nature of the participants’ clinical units was complex and diverse. Staff learning needs in each clinical unit were only partially met by centralised educational activities. This placed an onus on the participants to provide learning opportunities that were unit specific. Common to
many participants were accounts of resources they had created to enhance staff learning of locally defined clinical practices. The participants did not identify this aspect of their work as a discrete learning facilitation role, but rather revealed these activities through discussions of other dimensions of their work. I conceptualised these activities as learning facilitation practices as these resources were purposefully designed by the participants with learning in mind, and in response to their understanding of staff members’ particular learning needs. Examples of learning resources included training packages, worksheets, checklists and resource manuals.

The participants’ use and development of specific resources to facilitate learning was exemplified in their development of training packages. Jane’s unit was highly specialised; the clinical procedures were complex, and the learning needs of staff intense. As there was no CNE allocated to her unit, Jane and the Clinical Nurse Consultant (CNC) provided staff education. This included the development of a unit- based staff orientation program that incorporated a training package and worksheets for staff to complete, demonstrated in Jane’s quotation:

Then we give them worksheets. And they need to go through chapter by chapter [of the training manual] according to what you’re learning. I prefer them first on the floor to get used to the ... [treatment names] ... how it is ordered, how we troubleshoot, how we do this, specific clinical skills, how we interact. Because as you can see in our big area how we interact with the rest of the patients and the relatives or how you are going to be if you are two on the floor and there’s five pumps screaming and the patient is looking at you and ringing the bell. After they have passed [had their completed worksheets assessed as satisfactory by the Clinical Nurse Consultant] that within one or two months they are used to that. (Jane)

Jane sought to enable consolidation of learning from practice experiences and study of clinical learning resources by providing worksheets that she together with the CNC had developed. These were then “marked” by the CNC, suggesting a level of formality, and perhaps reinforcement of existing power relationships between participant/CNC and junior staff. Jane’s perspective on learning from this activity was confined to worksheets that reflected specific and measurable aspects of knowledge and skill. In contrast to this formality, Jane valued staff understanding of the context in which clinical tasks were performed as being foundational to learning the theory that was addressed by the training package and worksheet. Her approach suggested she understood the relationship between theory and practice, the value of
experiential learning and of strategies for embedding theory into practice for a new staff member, although this was not explicit.

Similarly, Fiona described a training resource she had designed to enable team leader development. Team leaders were experienced Registered Nurses, deemed by participants to be capable of managing unit operations during each shift. While hospitals offered a short team leader training course, it was held infrequently, and was separated from clinical units. At the unit level, team leader training was carried out by the participants rather than by CNEs. The participants developed their own team leader training program, which included mentoring, support for staff members’ ongoing professional learning and development of learning resources. This was a rich activity in terms of the participants’ engagement in learning facilitation, as it was directly relevant to their own work. Fiona’s learning resource consisted of a manual of information about the unit, policies and procedures, and communication strategies. Also included were activities that required learners to apply their new knowledge. Fiona described this resource and emphasised its grounding in specific unit practice in the following quotation:

so they take it home and read it, answer questions. One of us [the NUM or another experienced team leader] goes through the answers to the questions and it’s, you know, incident ... when this happens or something happens with a patient what do you do? Who do you call? Who do you contact? If this happens who do you call? How do you manage this situation? – It’s those sorts of things and getting down to disasters. If there was a disaster in the hospital and you got a yellow page and what do you do? (Fiona)

Fiona described her training package as consisting of realistic case scenarios, accompanied by questions that provoked decision making on clinical and other problems and provided an opportunity for learners to apply their knowledge of policies and procedures. The focus on policies and procedures was, however, largely confined to ensuring compliance, and was limited in its capacity to develop problem-solving skills within the uncertain space of healthcare.

The participants commonly referred to resources they had created including manuals, informal lists, signs and notices to support staff activity. I observed many of these myself in staff meeting rooms during observational visits. Jenny’s ‘how to do’ manual reflected her memory of her own learning needs when she arrived in the unit:
Jenny drew on her own experiences to justify and inform her approach to learning facilitation in developing her ‘how to do’ manual. Her manual included procedures and processes that were not included in hospital policies, and yet essential for unit operations. Examples of topics included patient transfer procedures, and equipment ordering strategies. Her manuals also included translation of hospital policies and procedures into a form that was localised to the clinical area, such as communication strategies and networks.

The participants constructed learning resources to promote staff learning of clinical work and confidence for new and relieving staff. Manuals and worksheets reflected the participants’ understandings of staff learning needs, knowledge of clinical work, interpretation of policy and procedure, as well as what was valued and important. Explicit articulation of practice in these resources may have enabled the participants’ tacit understandings in these areas to become explicit and thereby enabled those practices to be known by staff. Furthermore, these artefacts provided a medium for sharing and discussion of clinical matters between staff, an activity that I considered conducive to learning in each clinical area.

Other resources constructed by the participants to facilitate staff learning included libraries, which typically consisted of books, journals and DVDs on nursing and clinical topics, that were housed in bookcases in unit tea rooms. I observed these resources during observational visits:

_I sat in the next to a book case, away from the group. I could see what was in the book cases which included education folders: infection control, privacy, “interesting articles” as well as books and journals. There was a notice board, just a small one, with College of Nursing Courses and a [clinical specialty] nursing course. (Field notes: Sue’s unit)_

Jane spoke of the library she had developed:
And then we also created a library. We bought books and all that when I was first put here and new nurses are also allowed to borrow those books and take them home. (Jane)

In developing a library Jane reflected approaches taken by other participants. Having professional nursing resources available for staff to refer to was important to the participants, especially when access to online resources was often limited. In naming the collection of books a ‘library’, and welcoming staff to use it and to take the books home, Jane communicated her view that knowledge was a part of their workplace, and access was important. However, there was an assumption that staff would learn from having a library and, other than by making staff aware of the library, she did not elaborate on how she could enable their engagement with it and how it would inform their practice, or how often they engaged with it.

Enabling staff access to current research reported in journal articles was also particularly valued by participants. Maintaining journal collections was among the roles several participants described. Sally actively supported a journal club on her unit as a means for staff to engage in discussion about research.

*Journals, it’s good because it’s the most up to date, it’s current trends, current thoughts, yes we encourage that. We’re running journal articles and journal clubs*

Other participants were aware of journal clubs and regretted the lack of time to organise these events in their workplaces. They were however committed to ensuring staff had access to current research resources that were relevant to their specialisation.

In this section, I have demonstrated participants’ learning facilitation practices in their development of learning resources. Learning resources represented the participants’ understandings of staff learning needs, their manner of learning, the nature of clinical work, and constraints on learning inherent in other learning activities. Worksheets and problem-solving created opportunities for participants to provide feedback and aimed to engage staff actively in theoretical aspects of practice. Information repositories, including manuals, libraries and training packages, were valued as supportive learning aids; however, the participants did not identify what strategies they would use to enable their application to practice. In developing learning resources, the participants were able to share their tacit
understandings of practice with staff and to create a medium that promoted interaction on aspects of practice.

7.1.2 Facilitating incidental learning

Opportunities for the participants to facilitate incidental learning emerged within the routines of unit work as the participants became aware of staff members’ needs for knowledge or instruction on how to perform clinical skills. In this section I examine occasions where the participants engaged in unplanned or incidental education, which usually involved direct instruction at the point of patient care.

As discussed in Chapter 6, the participants did not immediately identify a learning facilitation dimension of their work beyond organising staff attendance at formal education. However, when asked about how they influence staff performance in specific areas of clinical work, participants’ learning facilitation roles became explicit, and visible in their everyday work activities. An example of this was participants’ roles in enabling staff to become competent in using computers. Use of computerised systems was more frequently becoming an important part of patient care, and the participants often spoke of emerging challenges as staff were required to work with new and unfamiliar systems. Centralised computer training was offered infrequently, leaving units with the task of facilitating staff competence in computer use. Such training tended to occur as required, rather than as a part of a formalised educational plan. Jack provided a detailed account of his approach to ‘teaching’ computer skills when a need arose:

So I usually sit down and spend maybe an hour with them and they drive the computer and I have to sit next to them and I say, “Look, press here and press there”. And you have to be very patient, you can lose your patience you see. I mean, it’s easy for us. It’s just click, click, click, done. But someone who’s never used it they click there. “No, not there”. You have to be very patient because otherwise they lose track and you’ve lost them. (Jack)

Jack worked directly with staff in an instructional manner. While his account implied that past impatience with staff had been counterproductive, he had reached a point where he viewed the nature of his interaction with staff learners as being important to learning. He specifically identified time and patience as factors central to facilitating learning. Jack’s account was confined to time spent with staff at the
computer and he did not detail how this learning was transferred to practice. I also understood that enabling staff to become independent with this task was important to him, and motivated his actions, as the complex and fast-paced nature of his role would have made it impossible for him to continue this level of involvement. He effectively modified the organisational constraints imposed on staff learning of this task. Spending time with staff engaged in this activity also provided opportunities to give feedback to staff about their performance.

The participants also provided incidental facilitation of learning in other circumstances, particularly where issues of patient safety were involved. As an example, Lisa stepped into a teaching role when learning needs were medication based, leaving more complex clinical skills to CNEs:

> If it’s medication based we will show them how to look it up and look up all the protocol, how to look up the protocol of actually administrations. So then they know how to do that. Which they generally would have been shown before but you forget. So if it’s an actual procedure, if we can be by them to show them how to do it, great. Often we can’t because it’s so busy. That’s where the senior staff will step in and they’re more than happy to go in and show them. (Lisa)

By “showing them”, Lisa aimed to develop her staff’s skills in information searching, so that they could develop knowledge of procedures and become more independent. She was also empathetic to learners’ tendency to forget some things. This level of support and empathy was important in enabling staff to develop confidence, and important for ongoing learning and participation in unit work. Her continual reference to ‘we’ rather than ‘I’ gave an impression that she saw herself as a member of a team and that there was wider and consistent agreement about how things are done. I interpreted her account of these relationships as a cultural norm, one that enabled and maintained staff learning of unit practices, and invited interaction from staff when incidental learning needs arose.

The participants described responding to staff needs for information or direct instruction as a normal part of their role. Lisa’s focus was on preparing staff to become independent and resourceful, whereas Jack focused on the task. Both empathised with staff who were in need of learning: Lisa towards the difficulty experienced in remembering previous instructions, and Jack with the need for
patience in learning a new task. They both drew on referent and expert forms of power to facilitate a conducive learning relationship to occur. Amanda had also anticipated having to respond to incidental requests, and deliberately sought to provoke opportunities for this to occur. She worked with staff during particular activities so that she could provide feedback and address emerging learning needs:

*I work with the staff. Like, we don’t have enough staff to cover all the bases and I say, “Right, we’re having vaccination clinics. I’ll be the nurse, so you be the vaccinator for the first five patients and I’ll do the last five.” So staff can see and sometimes staff will say, “Can you come and do this? I don't feel confident.” And so you put a tourniquet on a patient and you say, “Right, now tell me what you feel,” And they feel the cubital fossa and say, “I don’t feel anything.” And I’ll say, “Feel again. It feels like a water-filled balloon. Feel again. Can you feel this?” So I take their hand and I put it over. So it’s all training.* (Amanda)

Amanda took an opportunity to facilitate learning while participating in unit work and chose role reversal to transform vaccination practices into a learning opportunity. She used direct language with staff in communicating this plan, drawing on her legitimate power as unit manager. However, in working as ‘the nurse’ (assistant to the vaccinating nurse) she sought to modify the power relationship, seeking to empower the staff member and cultivate confidence and skill in managing clinical work. Her approach was deliberate in enabling learning. While there was potential here for staff to feel threatened by this situation, perhaps having any weaknesses exposed, her account indicated a pre-existing relationship of trust, as she quoted: “staff say, ‘Can you come and do this? I don’t feel confident’”, modifying any dissonance brought about by the power relationship, and better countenancing the conditions for learning to occur. Her account also included physical touch – “I take their hand” – an action she deemed appropriate and necessary for learning to occur, a level of familiarity that was perhaps an outcome of a comfortable relationship. Amanda was able to enable learning in this situation, by working closely with the staff member, and using Socratic questioning – “tell me what you feel ... Can you feel this?” – to aid learning, focusing the staff member’s attention on the task, while also gauging his/her level of understanding.

The participants’ units were busy and their time was limited, but staff learning was essential for safe patient care. The participants in this research explained their
responses to incidental learning needs that arose during the course of their day. My interpretation of the participants’ work uncovered accounts of situations where they were able to directly and immediately facilitate learning in response to staff members’ incidental learning needs. Their educational work was largely incidental, unplanned and reactionary and they generally worked in a one-on-one situation, providing feedback and responding to individual staff learning needs. Underpinning their educational work was a desire to develop the confidence, knowledge and skill needed for staff to work independently and safely. Their use of personal power complemented the legitimate power held as the senior partner in the learning interaction.

7.1.3 Supporting reflective learning approaches

The participants were well aware of reflection as a professional learning practice. The participants spoke of their use of reflection as a tool for developing team-based learning in relation to incidents and cases, and to facilitate individual learning during management of incidents or underperformance. Their appreciation of reflection as a learning strategy is perhaps unsurprising as reflective practice is embedded in nursing education.

In recognition of the centrality of reflection to nursing practice, I sought to better understand how the participants encouraged reflective practice in facilitating staff learning of clinical work. I explored their understanding of reflection as a process, their views on its role in learning and how they encouraged reflection as a learning facilitation strategy in their units.

The participants were generally aware that new staff and students were expected to engage in reflective practice, although they did not actively promote individual reflection as a routine learning activity with unit staff. They thought that reflective journals were important evidence of reflection and that nurses should include them in their professional portfolios, as required by the national registering authority, AHPRA. Amanda took action to enable staff to develop their journals. Her description provided insights into her view on reflection:

You need the reflective journals, which I don’t do well, and never did. I hate reflection, but people say “in hindsight”, but you don’t get that without reflection and a lot of times you do that subconsciously. But
it’s that conscious reflection that drives me insane. So I don’t do that well and I procrastinate with the reflection part. So I feel that I needed somebody else to show them that. So I brought in somebody else to do that. And so we actually developed, but even now, after all that, I can guarantee it probably in my 13 staff I probably have 3 that have portfolios because they think it’ll [being audited by AHPRA] happen to someone else. (Amanda)

Amanda’s awareness of her own dislike and lack of skill in reflective practice influenced her decision to arrange education for staff on reflective writing. I interpreted her actions and perspectives largely as a response to registration requirements, rather than as a commitment to enhancement of learning of professional practice. Her response demonstrated the priority given to learning in response to regulatory requirements. While other participants did not express Amanda’s disdain for reflection, they were generally ambivalent towards it in relation to their own practice or that of their staff. Their support for reflection was driven by AHPRA requirements. This is consistent with the influences on practice that I came to understand as I developed Chapter 6.

Fiona’s views were representative of the participants:

The new staff do, so the new grads, and that’s a really important part of their ... transition to practice is to use journals and reflect on their practice. But I think as you get out of that first year of uni it drops off a lot. And I know that we’re all meant to do that [laugh] but no, it doesn’t ...

Fiona recognised that reflection is a learning tool for new graduates but was of the opinion that once staff had moved beyond the novice stage they were not likely to continue. She did not perceive it as part of ongoing practice and was aware that she and many others did not engage in deliberate reflection, although perhaps with some reservation. As a personal and private activity, reflection was difficult to enforce in the workplace, and there was a sense that it was seen as an activity associated only with meeting university requirements. It was interesting, however, that Fiona saw it as useful for staff to use during workplace transition, but not in transitioning within the dynamic circumstances of professional practice that she had described as characteristic of her workplace.

The participants did not rate reflective practice highly as an individual learning strategy, despite its strong presence in nursing education and registration. However,
they did encourage staff to reflect in particular situations, including management of performance, resolution of critical incidents and team development. As an example, Kate guided staff to reflect when managing underperformance:

> When we’ve got an instance of issues with performance, so, “What did you think you did well today?” “What did you find difficult today?” and … “That worked quite well.” Because then people realise that they’re having problems and also when we have an incident. But like as a general basis I don’t have time for them to come and reflect on. But look if anything happens, it doesn’t have to be a catastrophic incident, then it might be, “How do you think we could have done it better?” (Kate)

Kate used open questions to stimulate staff reflection on their work, and to steer them toward recognition of aspects of their practice that could be improved. Kate was able to guide staff through a process of self-assessment by relating to them in a non-accusing manner, using open-ended questions that aimed to trigger reflection. Her approach was empathetic. She deemed reflection as a strategy for considering performance and mediated this process. Guiding staff through self-reflection in a constructive and empathetic manner was characteristic of the participants’ accounts of managing performance issues.

Jenny’s perception differed from other participants, who considered reflection a means for learning about clinical practice. Jenny underscored the value she placed on reflection as a team development strategy through her assertion that possession of reflective skills was a prerequisite for effective teamwork. Jenny identified interdependencies between reflection, teamwork and leadership, with reflection being essential for teamwork, and learning experiences and leadership essential for team growth. She saw the team as a place for sharing and nurture, a place of strength with a capacity to engender positive change.

During our interview, Jenny showed me a model she had created to demonstrate her perspective to staff. The model consisted of a black cube, open at the top. Inside was a globe of the world, reflected in three inwards-facing mirrors on three of the four vertical planes. Each mirror revealed something different about the globe depending on which one you viewed.

Jenny explained the significance of her model:
So, to me, that’s why I think reflection’s important because you need to have a good look at yourself... as especially within a team environment. Like because your behaviours and how you practice at work can really affect the whole team... I bring it [the model] out often when we have in-services or we need to talk about reflection and that, and I wanted to get it put into a perspex cube so it could be shared by anyone. (Jenny)

Jenny’s view of reflection differed from that of other participants. She visualised it as a means for enhancing individual practice within a team, through learning about ‘self’, rather than as a tool for learning from incidents or experiences. She considered that each team member had an obligation to reflect on themselves as a member of the whole team, in the same way that the mirrors in her model reflected the different properties of the globe that fit together to make a whole. She valued the model as a resource to explain her view of reflection and teamwork to staff.

John’s view of reflection as a resource for ‘unit learning’ also differed from that of other participants. He was aware of the benefits of reflection for individual development and meeting AHPRA requirements, but emphasised its value in harnessing staff engagement with unit policies and procedures:

I want them to be reflecting on our practices but I don’t want them to have, how are we doing it, how can we improve it and how is it difficult to do things? ... Like I’ve been telling them, “Why aren’t we doing these things correctly? Like, we know this is the goal. What’s stopping us? Go and work out what’s stopping us.” So that’s reflection in a way. (John)

As a new NUM, John was concerned about raising standards of care. He was keen for staff to be involved in processes that influenced their work, and felt that reflection on unit processes was a valuable activity. John viewed staff as sources of information and welcomed and used staff meetings to encourage sharing of critical thoughts about unit processes. By encouraging staff to challenge and justify current practices and assumptions and to consider the constraints that inhibited practice performance through reflection, he opened avenues for deeper thinking around work routines and practices. John’s approach engendered possibilities for learning and the creation of innovative responses to practice issues, as well as an ongoing evolution of practice.
The participants were familiar with reflection in nursing practice, and its relationship to registration. They used reflection in quite different ways, although usually in relation to underperformance, incidents or practice issues. I considered the participants as brokers, using questioning to bring staff and incidents together, stimulating reflection and learning from focus on and exploration of relevant issues. Their use of referent power enabled this process. However, the participants’ role was largely reactionary, and their influence did not extend to professional practice development, or to activities that drew meaning from an ongoing reflective dialogue. The participants guided staff through a reflective process that enabled them to learn from incidents and personal performance when needed.

7.1.4 Supporting learning through precepting

The purpose of precepting was to familiarise new staff with a unit’s purpose, physical layout, clinical practices, staff roles and relationships, routines and culture. Precepting was supported by a general hospital induction program of two to three days, where new staff learned about hospital policies and employee matters, as well as requirements for ongoing completion of mandatory training. Precepting fostered development of social relationships, as staff were introduced to team members and inducted into social practices which formed a basis for development of ongoing working relationships. Cultural awareness was enabled as preceptored staff learned about the practices and norms that were accepted and valued by the team.

The period of time in which new staff were inducted demanded a focused response from the participants. In some units, Clinical Nurse Educators conducted precepting, although the participants provided oversight of this activity. The participants selected appropriate preceptors, ensured their rostered shifts coincided, communicated precepting requirements to the CNE, and monitored the progress of the precepting relationship. At the level of each unit, the period of precepting was developed in accordance with each new staff member’s need and the unit’s induction practices.

As the participants organised and provided oversight of precepting relationships, they drew on their experiences and conceptions about the qualities of a successful preceptor, and the value of precepting relationships in enabling new staff to learn. In exploring their experiences in managing precepting I was able to appreciate the
participants’ learning facilitation views and practices as they engaged in this aspect of their roles. Their perspectives relating to precepting are discussed in Chapter 6.

The participants held quite diverse views on precepting, how it should be carried out and the qualities of a good preceptor. Each unit’s complexity and each new staff member’s entry skills impacted on the extent of the participants’ involvement and the nature of the precepting relationships. Jane’s technically complex unit, which was challenging to any new staff member, required intensive induction and precepting. She outlined a structured, incremental approach to learning within the precepting relationship:

*The first week they’re just observing. They’re observing and follow the nurse because our treatment chart is very complicated so that nurse needs to start to become familiar with how to read that chart. Then we progress them the second week to the clinical skills practical which is IV cannulation and accessing lines. Then we slowly progress them to, I send them to a full day of xxxx therapy safety. So they go to that xxxx therapy safety and they come back and they’re more at ease now ... and all that. (Jane)*

In developing this structure for new staff, Jane had considered the time it would take for staff to learn each procedure. She chose a sequence of experiences that she believed would enable staff to learn: observation of the preceptor, followed by practical application, and theory. In ‘slowly progressing’ staff to more complex learning activities, Jane engaged formatively in the learning process, providing opportunities for new learning based on her understanding of learners’ progress. Jane was aware that staff found the unit to be confronting to begin with, and that gaining familiarity by observing, learning about basic tasks, and completing relevant training were supportive activities that enabled new staff to adapt to specific unit demands. This early level of comfort was important to the development of confidence, an important basis for ongoing learning.

In some units, the pace of work made it difficult for participants to oversee and structure precepting processes. Fiona’s account of precepting provided a relevant example. She described a rather ad-hoc process of setting up a precepting relationship that occurred in her unit:

*... but really we kind of ... thrown in there ... “Well here, so and so ... she’s starting today and you’re her preceptor.” That’s really where it
Fiona was open in her description of the reality of the situation where staff, including preceptors, were “thrown in”, and it was “hoped” things would work. She did not seem to have much control over the experience, despite her role in organising it, and clearly trusted each preceptor to provide a quality experience for the new staff member. Fiona hoped that, despite the brief introduction, rapport would develop. This was important for building trust, as a basis for providing new staff with support as they take on more challenging tasks.

Within each clinical unit, usually several experienced nurses had been prepared by hospital precepting courses to undertake precepting roles. The participants generally chose a single preceptor to induct a new staff member, and rostered both staff members on the same shifts to enable the relationship to develop. Sometimes this arrangement was not possible and more than one preceptor was allocated to a new staff member. More broadly, team approaches to precepting were not generally favoured. However, in Lisa’s unit, a busy acute care department, ongoing precepting as a team activity was understood:

Well they [nursing staff] do it through buddying. When they [new staff] come on, … they usually have three supernumerary days where they’re buddied completely with a staff member so they’re not, they don’t look after any patients on their own … So once they’ve done their supernumerary and they then obviously get their own bed load. But usually we do it as teamwork here, so usually, a new staff member might get, OK, they work in bed 4–11 but they will only look after four of those patients and then the other staff member … on the other four patients so they are still working as a buddy even though they’ve got their own four. So, they can rely on that staff member and that staff member will generally overlook them to make sure that they’re okay. (Lisa)

Lisa valued “buddying” relationships as important means for learning to occur. Lisa was one of a number of participants who referred to “buddying”, a term that inferred friendliness and mutual benefit, and one that dispersed some of the power imbalance conveyed by the terms ‘mentor’ and ‘mentee’, presenting learning as a peer rather than a didactic activity. She considered it important for new staff to be able to ‘rely on the buddy’, valuing a relationship of trust. Lisa also referred to the ‘post-buddy
period’, a time where transition to independent practice was enabled through confidence-building strategies, including being able to work independently within a supportive team.

The participants saw precepting as a valuable social learning strategy that enabled staff to develop the skills needed for successful unit transition. The participants had developed a deep understanding of the learning that was possible within precepting relationships and were active in designing learning experiences for new staff within those relationships. They particularly valued rapport and trust engendered by precepting relationships as instrumental in enabling learning.

7.1.5 Developing team leadership skills

The participants’ learning facilitation practices extended beyond development of clinical skills and knowledge to include the development of more advanced capabilities such as those required for team leadership. Team leaders were experienced registered nurses who were selected by participants on the basis of their ability to organise each shift’s work and provide oversight to care delivery and patient flow. These team leaders were integral to staffing structures throughout the hospitals. They provided oversight to clinical activities and relieved participants from operational work, which enabled them to focus on less clinical aspects of management work. Team leaders also managed units after hours and on weekends when participants were absent and received an ‘in-charge’ allowance at these times. Experienced team leaders also relieved the participants for more extended periods, for example when they took leave. I was interested to understand how the participants selected and prepared team leaders for this important role, and where in this process their learning facilitation practices were most visible.

Qualities of team leaders

In selecting staff for team leader roles, the participants valued particular qualities. Staff who were being considered for a team leader role required experience and clinical expertise in the unit specialisation. In order to organise and resource unit work, team leaders needed to be able to understand hospital systems, policy and procedures, implications for nursing work of different clinical conditions,
management of complications and complex treatment regimes and dealing with the preferences of patients, relatives, and medical and other staff.

The participants’ reports of traits considered essential for effective team leadership were highly contextual. For example, in John’s complex fast-paced unit, the ability to communicate was considered to be the most desirable trait in a team leader:

\[
\text{and then dealing with the upper management, which is where they would sort of step up. And the biggest thing I want from them is communication and that’s mainly the attribute to look through them, you know, people who can confidently and calmly communicate with people around them. And again the team leader role is the main role where you see that in action. (John)}
\]

Team leaders in John’s unit were required to communicate with administrators and physicians in a manner that was respectful, convincing, succinct and informative. Within his unit’s environment, communication often occurred during a crisis, demanding a calm and confident approach. As a consequence, John valued strong communication skills in staff he selected for leadership work.

Jenny also valued communication, but more specifically the ability to escalate issues that could not be resolved in the clinical unit:

\[
\text{It's about if you have a resus and you need to escalate that for more help there's always escalation processes, there's a niche thing that we do. So, and even in your communication, so ISPBAR [communication framework] is about escalating things in the appropriate manner. (Jenny)}
\]

The NUMs explained that staff, and especially team leaders, need to be able to escalate matters of clinical importance. This was emphasised as a response to the growing concern in hospitals about the safety and quality of patient care.

When Rob described team leader skills, he also emphasised safety as the central focus of clinical care:

\[
\text{But they eventually get to that stage where they are safe to be a team leader, safe to be in charge of the ward and they are mentoring [precepting] and they are providing the correct guidance and leadership for the junior staff. (Rob)}
\]

Rob identified team leader skills in guiding less skilled staff as a focus of practices designed to enhance the safety of clinical care. A focus on safety, as a key contextual
influence on NUMs’ learning facilitation practices, was evident in their approach to selecting staff for team leader roles in their units.

Developing team leaders

In exploring the participants’ views on meeting the learning needs of team leaders, or aspiring team leaders, as part of the management team, I was particularly interested in how they facilitated staff members’ transition into this role. I was interested in exploring how participants facilitated their staff’s transition to the different approach to decision making that characterises management work. Nurses’ decision making usually focuses on meeting the care needs of individual patients during each shift. Management decision making has a wider focus on meeting the care needs of a larger group of patients, and staff. Decision making can be challenged when the needs of individuals conflict with those of the group (Walshe, 2011), for example, when the care needs of patients conflict with the training needs of staff. Managers often need to consider the wider hospital context in making decisions about patients, whereas nurses generally need only to relate their decision making to the immediate unit. In developing nurses’ capability to undertake management work, the participants need to help them transition from one level of thinking (nurse) to the other (team leader/manager).

The participants in this research expressed a view that team leadership requires an ability to think differently and more broadly than when undertaking nursing work. As an example of the increased breadth of thinking required from team leaders, Jenny and John spoke about developing team leaders who needed to appreciate the whole hospital and not just their own unit:

whereas I’m trying to get them to grasp they are part of a big hospital ... we’ve got to improve the whole flow ... we’ve got a responsibility ... whereas they’re only fussed about what’s happening right in front of them rather than sort of working out ... we’ve got to make the best of what we can. (John)

So I have found that, the girls have found that, even the old ones, have a different understanding about how the whole system works and what supports are there and why it’s important to have a bit of an understanding and why it’s important to deal with these issues. Like, if you can see a situation and diffuse it before it escalates and it basically blows up in your face then it’s that awareness of your workplace. (Jenny)
John was able to visualise the ‘whole flow’ and saw his unit as part of a wider system that needed all parts functioning synchronously to be able to work and improve. Jenny argued that an understanding of the whole was required to be able to identify and manage issues that had the propensity to “blow up”. Participants did not immediately articulate how they would facilitate trainee team leaders’ development of this understanding, which I considered to be based on non-propositional knowledge, which is not visible and difficult to articulate. Their views surfaced through targeted discussions of team leader development.

The participants’ perspectives on how best to develop team leaders varied and reflected their experiences in the NUM role as well as their personal management styles and preferences. They valued working alongside other team leaders, attending team leader training courses, and working through learning packages. Rob felt that staff development of team leader skills occurred naturally and incrementally:

*I mean there’s things such as the team leader and mentoring\textsuperscript{14} and other things that are clinically based but people are getting recurrent and regular learning opportunities. Most of them take part in them at some point or another and it is an incremental development, incremental learning. Maybe it needs to be repetitive for some of them. But they eventually get to that stage where they are safe to be a team leader, safe to be in charge of the ward and they are mentoring and they are providing the correct guidance and leadership for the junior staff.* (Rob)

Rob valued regular formal learning experiences conducted by the hospital, but also felt that attendance over time enabled staff to develop the knowledge and confidence that was needed for a team leader role. He referred to ‘recurrent’ learning experiences: mandatory learning experiences that were repeated at various intervals to ensure staff were ‘refreshed’ periodically. Rob valued the repetition of these experiences, which enabled experienced staff to keep up with clinical skills, as an important resource for team leading. Rob also valued incremental learning, which demonstrated his awareness of ‘scaffolded’ approaches to learning and development. He also emphasised unit safety as a valued outcome of quality team leader performance, a view that was shared among several participants. Rob trusted that

\textsuperscript{14}Mentoring refers to ongoing career-focused support of a staff member by a more experienced staff member. Unlike precepting, it is not confined to the induction period.
clinical experience, supported by formal learning opportunities, would produce team leader competencies. However, he did not identify the nature of the learning that occurs through experience, and how it relates to formal learning.

Other participants spoke of more active approaches to team leader development. Fiona felt that experiencing the role with her support was the best way for staff to learn about team leader work:

*ideally I’d like them to do work in hours as a TL*[team leader]. There’s a TL on the shift right now while I’m here just to manage the things that occur day to day ... what do you do when this happens … *(Fiona)*

Fiona’s approach enabled staff to learn about team management by allowing them to experience the role and the challenges inherent in management decision making and in organising and managing staff and clinical processes, without having ultimate responsibility. This experience enabled staff to ‘practise’ team leading, with the aim of enhancing their confidence and autonomy. Fiona valued having oversight of the learning process, arranging for trainee team leaders to work within her working hours, which enabled her to provide support for and feedback on their performance.

When they were preparing to take extended periods of leave, the participants were responsible for organising a temporary replacement. Replacement NUMs were usually already working as team leaders and had the experience and expertise to be able to perform administrative tasks and manage staffing, unit operations and patient care issues that emerged each day. In some cases, experienced team leaders had relieved previously and needed no preparation. Where the appointee was new to the position, a more focused preparation was required, including one-to-one induction and mentoring, and development of written instructions. John anticipated developing a manual to guide staff who may relieve his NUM position:

*So that will be most of it, and then I’ll have a fairly hefty document that I’ll have to provide where I’ll just spell out just basics of how you get through the day and even the steps of how to access the computer and how you run this report. And obviously after they do it a few times, but four weeks is fairly short, so they’ll just be getting up to speed by the time … Like, I’d say they will still be using the instruction manual at the end.* *(John)*
John expected to develop the manual as a resource with the relieving NUM’s learning needs in mind. The manual had learning potential in providing support and enabling a self-directed approach to development of the practice-based knowledge required to perform the role. The manual would complement learning available from interactions with other senior staff in the unit, including the Clinical Nurse Consultant and Clinical Nurse Educator. However, the messiness of management work, and how to work in an environment characterised by rapid change and competing demands, could not be articulated in the manual. John relied on the support available within the unit, and the replacement’s ability to seek guidance as a means for overcoming this challenge.

Fiona also referred to an instructional approach to preparing staff for NUM relief roles. She outlined the induction she intended to provide a trainee relieving NUM:

*It’s just about, “This is what you need to do and this is what’s required. You need reports on this and you need to access this computer program and that’s the sort of thing we’re doing.”* (Fiona)

Fiona’s approach was to give instruction on various tasks that her replacement would need to perform. She created a checklist approach to the work. As with John, there was some tension between establishing the replacement’s ability to secure routine work practices according to standards and facilitating competence to deal with uncertain and unique situations that had no clear solution, as is typical of healthcare workplaces (Maddern et al., 2016). She did not explain how she would develop these skills.

During deeper discussion with Fiona, she clarified the different approach she would take for staff who were interested in becoming a NUM rather than in simply working in a relief or team leader capacity:

*I think I’d talk more about maybe the philosophy that I follow instead or like I think ... my philosophy on why I’d do things or how I like to run the ward, or my vision for the ward. So I think that would be different and maybe it would give us a bit more time because that person would have a genuine interest, and want to learn, those other things about the role, not just the bare bones.* (Fiona)

Fiona identified sharing with interested staff her ‘philosophy’ of management rather than simply providing a list of tasks. She felt that new staff would learn more if they
were genuinely interested and she was prepared to invest in that. She felt it was important for staff to understand her reasons and preferences for managing the ward. Fiona’s intentions suggested a willingness to consider an interested staff member as an equal in this endeavour, referring to ‘us’ and sharing personal views that were not shared with others.

I was interested in gaining a deeper understanding of her philosophy, which she was happy to share:

*to be a good leader, to be seen as a good leader but to be accessible.*

*Like, I want them to think, “Gosh, she doesn’t just sit in the office and produces the roster and that’s sort of the end of the story.” And I think that I’ve most achieved that ... and I don’t need to be their friend but I need to be the person that, if there’s a problem they can go, “I’m going to go and speak to her because she going to be able to fix this for me.” ... but lead the way in good leadership, good clinical knowledge and good practices, so it flows down the line to them and we all follow the same model.* (Fiona)

Fiona was concerned about her staff’s perceptions of her management work and wanted her staff to see her as an accessible manager who is able to “fix” their problems. Fiona’s account suggested she welcomed a degree of dependency of staff on her. She valued leadership coupled with clinical knowledge as important attributes of a NUM. In referring to good practices, I understood her to mean practice that is compliant with policy and procedure, and also ethical and just. Fiona believed that good leaders enable uptake, which I deemed as learning, of these practices by others. Her comment suggested she perceived her own modelling of desirable practices as important for team performance. She also valued uniformity and expected leaders to follow a course that enabled staff to “follow the same model”. Fiona valued order and standardisation, a perspective that was also identified among other participants, and that was useful in communicating valuable practices.

Well-prepared team leaders who had relieved in the NUMs’ position could provide valuable support to NUMs and to the quality of their unit’s practices. John spoke of his own experience prior to appointment as a NUM and felt that there was great capacity for relieving NUMs to influence staff when they return to their usual nursing roles:
when you’re back nursing on the floor you can still be an advocate for understanding the system. Because when you’re on the floor everyone complains that everyone but the NUM doesn’t care, but you just realise that there is a bigger system out here. It’s not just that you’re part of a bigger organisation, there’s outcomes you have to have and it’s all about making the organisation run smoothly as far as patients and that sort of thing so … (John)

John felt that relieving NUMs, when back in their usual roles, could influence staff and advocate for NUM and unit priorities. This type of peer learning could potentially moderate tensions that might exist between NUMs and their staff and enable staff to understand the participants’ role and the context in which care was provided and how their roles related to the wider workplace.

In developing staff for management work, whether at team leader or acting NUM level, the participants drew on their own experiences, routines, conceptions about staff learning and practices to shape learning experiences. Their work in developing staff as team leaders was different to their work in developing clinical staff, as they were more directly involved. They saw this as a discrete and non-delegable domain of their own practice. As they explained their perspectives, conceptions about staff learning and approaches to developing team leaders, I was able to gain an appreciation of the qualities they valued as pertinent to performance of their own roles. In working to develop staff as managers and leaders there was scope for deeper consideration and appreciation of opportunities for informal learning to complement formal learning approaches that are limited to the development of procedural knowledge.

7.1.6 Conclusion

In this section I have explored the participants’ facilitation of individual staff learning within the ordinary routines of their unit’s work. The participants actively designed and promoted various learning resources including training packages, ‘how to do folders’, and worksheets to support staff learning of new skills and procedures and to support team leader development. They selected and maintained learning resources to support ongoing professional development. The participants facilitated incidental learning, responded to individual learning needs as they arose, and engaged in focused clinical instruction with individual staff and trainee team leaders to support their skills development. The participants encouraged reflection largely to
meet AHPRA standards and to manage underperformance: a surprising finding given the focus on reflection within the nursing profession. The participants also had an active role in designing and overseeing precepting and induction for new staff, and a direct role in developing staff for team leader roles. They use personal forms of power to establish rapport and enhance staff acceptance of learning encounters. These findings were revealed during discussion with the participants on their roles, routines and interactions with staff, but were not identified by them as educational work.

7.2 Facilitating learning within teams

As I interpreted the participants’ accounts of how they facilitated individual learning, I became aware of their learning facilitation practices within the wider team. In Section 6.4.1, I illuminated participants’ interactions with teams as a means for understanding staff performance. Participants also worked directly to facilitate learning within team meetings that occurred within the ordinary routines of work. In this section, I explore participants’ interactions with staff to facilitate learning within the context of informal and formal team meetings.

7.2.1 Learning within informal team gatherings

In this research, teamwork was seen to form the mainstay of hospital operations. The participants advocated for teamwork and interacted with unit shift and wider healthcare teams during the course of each day. They used formal and informal team gatherings to communicate matters of importance in relation to their unit’s work. Beyond these team gatherings, opportunities arose for staff to learn within their unit’s routines. In this section I explore how the participants used these often informal and unscheduled opportunities to facilitate learning within the team.

At the commencement of a typical day in most units, the participants met with unit staff to discuss patient matters, staffing, work flow, general ‘housekeeping’, and communication from hospital management. These meetings were generally collaborative and focused on ensuring everyone was clear about expectations for the shift and how they were to work together as a team. Jenny referred to her unit planning meetings as ‘huddling’ together. Jenny explained the range of learning needs addressed during ‘huddles’ that needed to be accommodated:
so with the team, we huddle together and I say “OK”... I ask them what their needs are in education because we have a lot of student midwives. I have some new grads, I have new staff who have started who follow like a career pathway, a skills pathway and they’re given a lot of things that they need to work on. So it’s planning for the day, for their educational needs for growth. Sometimes its experience for other people who are up and coming team leaders. Sometimes it’s a student midwife. Sometimes you have casuals that need support. So we have to look at what models of care that we’re working with so can we delegate or do we need to team nurse for that shift, depending on the type of patients. (Jenny)

The term ‘huddle’ is recognised in nursing work as a framework for bringing staff together at intermittent times during a shift in meaningful conversation around patient care, primarily for the purpose of enhancing safety (Provost, Lanham, Leykum, McDaniel & Pugh, 2015). Aside from the theoretical basis of the huddling practice, Jenny frequently referred to ‘huddling’ as core communication that was valued in her unit. Jenny’s use of ‘huddle’ conveyed a sense of informality, belonging, warmth and security, in relation to work and learning, reflecting something of her team leadership style. During huddles she embedded plans for meeting staff learning needs within overall plans for the day. In inviting staff to identify their own learning needs, she enabled them to take individual responsibility for their learning. Jenny accommodated the practical aspects of staff learning by matching their self-identified needs to the skills, knowledge and abilities of other staff, and to patient needs. When patients’ needs changed, Jenny guided staff to ‘huddle’ again to regroup and revise the day’s plans. Her approach was fluid, responsive, and embedded in the relationships that underpinned the unit’s work.

In seeking a deeper understanding of Jenny’s role in enabling learning, I sought clarification of learning opportunities that were available within the speciality area. Jenny explained how she supported staff to attend weekly educational sessions organised and attended by medical staff:

We religiously do the rounds at 8 o’clock every morning. The only day we don’t is Tuesday because the medical staff have an education session ... they might get in guest speakers for a [particular topic]. And it’s predominantly medical staff get there but what I try to achieve is to get as many people or nursing staff off the floor to attend. So one week they’ll do X-ray meetings and we’ll discuss X-rays and findings on that, another one we’ll review cases from the previous month and actually what did we do, what could we do better
… So often I’ll work on the floor and send some of the other nursing staff. So the educator and I, like yesterday we worked on the floor and sent two other people off to go to the X-ray because it’s about, I think you’ve got to give everyone opportunity, otherwise … if I know about it or the educator knows about it, then nobody else, we can teach them but I think they’ve got to feel valued in the team and given that respect to have those opportunities. (Jenny)

While I had perceived the participants’ practice of arranging for staff to attend learning events as a routine learning facilitation role, from Jenny’s account I became more deeply aware of their membership of professional networks as a resource to aid staff learning. By leveraging her positive relationship with the medical team – a relationship that made it possible to modify the power dynamics that are characteristic of nurse–doctor relationships – Jenny was able to facilitate team learning experiences for nursing staff. Her support of their participation not only facilitated opportunities for learning, but developed relationships within the wider team. These relationships had the potential to foster ongoing learning and development of skills required for future effective inter-professional communication and collaboration.

Jenny’s perspective was also underpinned by a desire to advocate for staff, to enable them to feel valued as members of the wider multidisciplinary team and entitled to the same learning opportunities as other team members. Her advocacy role was enacted by relieving staff from their duties so that they could attend learning opportunities, substituting her work for theirs. In this way, her actions directly supported nurses’ learning, and communicated the value she placed on learning to the unit’s work.

Jane also undertook the work of staff in her unit so that they could attend educational events:

_We have calendars for education and all the topics that we do. So xxxx [CNC] and myself, we send all the nurses to the tea room … and then we stay out between 8–9, we bring patients in so they aren’t waiting, we take obs [observations], we set up the lines [intravenous lines]. CNC checks the bloods, we advance as much as we can with those patients, we explain to the patients who say, “Where are the nurses?” “Oh”, we say, “they’re learning”. I need to educate them more and more._ (Jane)
Similar to Jenny, Jane also facilitated opportunities for staff to attend learning events by actively working in their place, together with the CNC. She was committed to this practice, and by stepping into nurses’ roles she reduced the power disparity between herself and her staff, as she valued opportunities to learn as a resource that should be distributed equally. In relieving staff so they could attend educational sessions, the participants were not simply filling a gap, but were fostering a rich learning culture through modelling supportive team practices.

The participants nurtured and orchestrated social relationships with members of nursing and wider healthcare teams within their work routines. These relationships provided important resources for their learning facilitation practices. The participants organised regular shift meetings, which facilitated learning about the nuances of the day’s work and supported individual learning needs. They worked with the wider healthcare team to facilitate nursing staff participation in ward rounds and interdisciplinary case presentations. The participants also regularly relieved staff so they could attend in-service education, a practice that supported individual learning and team development through modelling effective practices and modifying constraints imposed by structural power relationships. Their networked status was an important resource for facilitating learning within teams.

7.2.2 Formal and incidental team meetings: Collegial spaces for learning

Further to ‘huddles’ and attendance at medical rounds, the participants also organised more formal team meetings, held less often, and usually away from the unit. During the fieldwork phase of this research, following the first interview, I observed most participants’ interactions with staff during each unit’s routine staff meeting. I found that the participants used team meetings to present new knowledge and clarify staff understanding of clinical issues, explain routine changes to practice, and to engage the team in discussion on workplace issues, patient cases and incidents. Within each of these activities, the participants’ interactions with their team actively facilitated individual learning, through knowledge exchange and, more deeply, through deliberation that enabled deeper consideration of practice.

Formal unit meetings were scheduled by participants on a regular basis, generally every two to four weeks. Meetings were conducted usually at about 2.30 in the
afternoon, when the morning and evening shifts overlapped. Meetings were generally held in staff tea rooms or other non-patient-care spaces. The participants chaired all meetings, following an agenda that they had prepared prior to the meeting.

During my observation of unit meetings, I found participants engaged in informal instruction on a range of clinical matters. For example, in response to staff queries during a meeting, Lisa spoke in detail about the development of sepsis in an acute patient, and then justified and reinforced the nursing care procedures that staff were required to undertake to ensure the safety of the patient. In another meeting, Rob modelled and justified appropriate language for staff to use when speaking to others, such as how to speak to and engage with an angry colleague in resolution of a conflict. Kate explained her information-seeking behaviours, and shared literature she had found to support staff queries about a revision previously made to a clinical procedure. Jenny referred to innovative practices that could be embedded in their clinical work that she had discovered from networking with other hospitals.

Participants had a central role in these meetings, drawing on their expertise to facilitate learning, and to convene discussion.

The participants particularly valued teams as sites of collaborative discussion on unit matters; however, the nature of their interactions varied. From my field notes, Sue’s approach demonstrated her learning facilitation practices as she convened staff participation in unit meetings:

*Sue [NUM] seemed relaxed and the meeting was quite interactive. Staff, and Sue, were talking to each other informally prior to the meeting, and the mood seemed happy. During the meeting I noticed Sue asked questions, often presenting uncertainty or a desire for information from staff or increased understanding on certain things to stimulate discussion. For example, there was a new policy that they had to obtain patients’ signatures on Medicare forms from now on and Sue said, “this will be a logistical nightmare” [based on the patients’ clinical conditions]. Sue supported ongoing discussion on solutions [and] was receptive to their responses. What appeared to be a deliberate challenge to staff was observed during discussion of other agenda items. This contrasted with meetings in other units where the NUM, although very nice, came across as being the source of all knowledge. The expression of uncertainty seemed to evolve into participative discussion, decision and action. (Field notes: Sue’s unit)*
Sue’s meeting was collaborative, interactive and productive. Her approach stimulated discussion and thought and appeared to extend staff discussion into critical and creative solutions, rather than simple opinions. I considered this activity to be deliberate and an important means by which deeper understanding of practice was enabled. In other meetings, the participants approached their staff in a friendly manner, but their positions of power were apparent and influenced the interactions. They appeared to draw on less formal sources of power when interacting with staff on less formal occasions.

Samantha’s perspective on her use of team meetings also revealed the value she placed on having an opportunity to work with the team to discuss unit matters:

Because when I started here we had a lot of changes ... All the, there were no clear processes on doing things the way they should be. And we started implementing that slowly. We have to have a clear process with admissions. What are the things when we see a concern? We discuss that. And then we look for solutions as a team and I’m in there all the time. I guide them; I assist them. Because I think leading by example is the best way of convincing the staff as a role model. If they can see it in you, then it’s easier for them to follow. (Samantha)

The team meeting offered Samantha an opportunity to lead discussion of relevant workplace issues and to model desirable, achievable practices. In being ‘in there all the time’ Samantha indicated her strong presence as a team member. Team activity in her unit provided a means for collective decision making and staff learning through her own modelling of desirable behaviours. While Samantha valued these meetings as an opportunity to directly facilitate individual staff members’ learning through collaboration, there was a suggestion that she had a dominant presence in these interactions. Her account partly resonated with my observation of her during the unit staff meeting. She asked her staff for their opinions on a range of matters and, while she seemed to be less skilled at challenging their thinking than Sue, the atmosphere was friendly and participative. Much of the meeting involved communication of information about clinical changes, use of graphs to explain audit results and acknowledging unit achievements.

The participants valued staff participation in team meetings. Sue and Samantha used approaches that encouraged their staff to interact and to deliberate on clinical issues and learning was considered an outcome of the deeper or extended thinking that was
encouraged during their meetings. Fiona also valued meetings as a time for interaction but used the power of her position to a greater extent, as described in my observational field notes:

*It was very much directed by her [the NUM] as I had expected it would be. She was pleasant but clearly the boss, using directive language such as “won’t”, “can’t”, “no way” and “that’s a mega no”. The ward had changed its purpose and bed numbers, a hospital policy directive, and the NUM had to redo all the rosters to accommodate the change. She told the staff this was not nice but was a given ... The staff did not say much about this change. I thought it was significant and wondered why there was no protest or concern expressed – maybe it was because I was there or maybe they had already had the thumbs up on that. (Field notes: Fiona’s unit.)*

The nature of the meeting that I attended was not particularly collaborative, other than when the topic of the upcoming Christmas party arose. This discussion seemed to create interest, with all staff including Fiona contributing equally. I felt this was important and seemed to reflect a shared interest in spending time together. I considered this a positive outcome of the meeting, as opportunities to establish relationships outside of work were likely to offer support for learning and collaborative practice within the workplace. Staff engagement with the Christmas party discussion was, however, at odds with their participation in discussion on work matters.

I gained a deeper understanding of Fiona’s perspective on her role in staff meetings during our follow-up interview.

*I do a lot of problem solving and so I come [to the meeting] with the solutions and I might open it up to them to give me some input. But I probably have done some problem solving and go in with an issue and maybe this is what’s going to happen and it’s not set in stone, what I say is not set in stone and I’m happy for input and a lot of people don’t have input, a lot of people just go with the flow and I say that’s what we’re going to do now but, ... and sometimes I’ll go in and I’ll say this: “I need you to tell me what you think about this.”* (Fiona)

Fiona maintained control by undertaking problem solving independently, while being open to staff perspectives. Fiona used her position to enlist engagement: “I need you to tell me what you think of this”. She used ‘power’ to ‘empower’. Her intention was to provide staff with an opportunity to deliberate as a team on alternatives; a process that I deemed had the potential to facilitate learning, as
understanding was shared, acknowledged and extended. Fiona valued staff perspectives on unit issues and sought to foster participation, although from my observations of the low participation of staff, I suspected that most probably accepted her decisions without comment.

Sue and Samantha both worked with staff teams to deliberate on unit matters but shared quite different perspectives on their role in influencing learning in these collaborations. Sue convened and guided deeper discussion by offering up challenge, and Samantha viewed her role as a model and guide in the process of deliberation. In both cases, the participants worked closely with the team to support learning as they deliberated on meaningful patient care issues. Fiona used power to a greater extent although her intentions were similar. Across the participant group, they interacted with staff during meetings to communicate information about practice and workforce issues, and to engage staff in discussion and deliberation on important aspects of practice. The participants used different strategies to engage staff in discussion. Their use of power was a significant influence on the nature of their engagement with staff during unit meetings.

*Incidental meetings: Case and incident discussions*

Meetings were also arranged outside of regular meeting times to facilitate case discussions, sharing of staff learning from attendance at courses or conferences, communication on policy changes, workload arrangements or other matters as they arose that were deemed relevant by each participant. Jenny emphasised the value she placed on team decision making and how she engaged staff in discussion on clinical matters when the need arose:

> And if we find that we need something then we come together as a team so we have what we call ‘working group meetings’. So if we have an issue or we see some aspect of care that we need to look at for the patient and we want to improve it then we get together as a team and work it out together as a group and not as individuals. Because we’ve been taught that it’s no good me telling people what to do, they’ve got to own it. So they’ve got to come up with their ideas of what they want to do. (Jenny)

Jenny viewed team discussion as being important in developing staff ownership of decisions which aimed to resolve particular issues. In giving her team meetings the name ‘working group meetings’ she created an identity which signalled that these
interactions were routine team events. These strategies created a space that engaged the team in testing ideas and collaborating about patient care. Using the team in this way was instrumental in enabling learning and in fostering and sustaining a learning culture and highlighted participants’ role in facilitating learning through their everyday work.

Kate used case discussions to enable individual staff to learn within the team, but also to give those who had attended courses an opportunity to have input:

> So I encourage people that have got new or interesting stuff to actually participate in in-services. Even if they’re not going to give a full in-service it might be totally different when you’ve got an audience there. The other thing that we do, which is working really well and actually gives the staff the opportunity to demonstrate what they’re learning, is we’re doing a case study. And, there’s one today, a case study of a patient that’s here that they’ve looked after. So … staff … sit down and present what they did and why they did it and it educates the other staff. And it also gives people the opportunity to talk about the drugs that we use because we found … a lot of people … just gave the drugs not really understanding what they were for and the immune suppressant drugs, but they knew that they were to immunosuppress patients, but just a bit better understanding of what we’re doing and what we do. And that’s working really well too.

(Kate)

Kate’s commitment to ensuring staff who attended courses shared their learning with the team, was typical of the participant group. Kate supported and facilitated team discussion during case presentations. In requiring staff to describe what they did and why, she encouraged them to think more deeply about the knowledge that underpinned their clinical work, enabling them to identify and challenge any underlying assumptions that may impact on their practice. This could be a relevant and powerful authentic learning activity, as learning was enabled through team reflection and deliberation on and discussion of practice issues. Team discussion can stimulate individual learning through reflection on knowledge, skills and practices, and can release knowledge that is bound in tacit understandings (Eraut, 2007). To enable learning in this way, NUMs need to develop an effective and trusting learning culture where staff can test ideas and talk about practice in a safe and respectful environment. Kate’s approach to knowledge sharing and case discussion reflected these ideas.
The participants also assembled team meetings to support individual reflection and learning in relation to clinical incidents. Amanda, who was not supportive of individual reflection, was more enthusiastic about reflection in a team context:

> Often we do it in meetings and it’s like we’ll have an incident, we’ll have a medication error or a documentation error, and I’ll talk to the individual staff and say, “This is the issues I’ve got with you. We are now going to use this issue as a learning tool and I’m going to bring it to the meeting.” And so we will then actually just bring that issue to our staff meetings and say, “Right, we have this issue.” And I put it on the table and I say, “Can you see where the mistake is here?” And I get the nurses to look. I don’t tell them where the mistake is and often it will take them a long time to go through all the steps because they look at surface and often it’ll take them ... they’ll say, “Oh, look” and you say, “yes, look.” And it might have taken them half an hour to pick out that one issue but if I’d pointed it out that’s meaningless. They’ve got to find it themselves. (Amanda)

Amanda promoted team integrity by taking care not to identify the erring staff member. Her view of reflection was that ‘faulty’ documentation provided a stimulus for reflection, so that staff could apply their own knowledge to detect the error. However, while the event was deemed to be a useful learning activity, one that enabled her to provide feedback and foster team relationship building, it was not accompanied by any ideas about the context of the error, and how to apply the learning to future practice. Her intentions, however, were bound to the facilitation of learning and prevention of future error.

Fiona also valued team-based reflection as a means for enabling team-based learning, and drew staff together to reflect on incidents:

> If there was an incident, that’s when we ask someone to reflect on what happened in that incident and that’s when we might do a case study. So you reflect on, “What did I do when this abc happened? I did this and then maybe the medical staff did this ...” So we use that to reflect on, but I don’t think we do that a lot anymore unless it’s for incident, revolving around incident. (Fiona)

Fiona engaged in a process of guiding staff to reflect on incidents by articulating the circumstances and nursing interventions surrounding the incidents. This approach enabled individuals to engage in social deliberation about the challenges presented by the case. There was potential for this activity to enable individual reflection within the collective discussion, and to develop a knowledge basis on which to build
future practice. The formation of social relationships from sharing of ideas and knowledge during this process could further develop the team’s capacity for ongoing mutual support and informal learning and development the team’s confidence. Articulating perspectives about a case can also enable release of tacit understanding. Similar to Amanda, Fiona did not discuss the implications of the reflective activity for future practice.

The participants embedded team meetings within the routines of their clinical units. They supported individual staff learning during meetings as they shared information and supported collaborative and reflective discussion on clinical matters. Their support of team collaboration also enabled staff to learn from each other and to deliberate on practice, and facilitated articulation of tacit understandings.

7.3 Key dimensions of NUMs’ learning facilitation practices

In this chapter I have examined the participants’ learning facilitation practices undertaken to influence learning in their clinical workplaces. These learning facilitation practices occurred within three key dimensions: directly with individuals, within teams and through artefacts. These dimensions are represented below in Figure 7.1: Key dimensions of Nursing Unit Managers’ learning facilitation practices. The participants facilitated individual learning by providing individual and incidental instruction, and by organising and supporting precepting, mentoring and professional development. Individual learning also occurred naturally through the social nature of nursing work, but also during team interactions that had been purposefully convened by participants to facilitate learning, including regular meetings, case discussions and reflections on incidents. The use of artefacts, such as ‘how to’ manuals and other clinical resources, was revealed to be an important learning facilitation practice that facilitated individual learning of local unit practices and enabled important practices to be reproduced and developed. These three dimensions of participants’ learning facilitation practice that seek to facilitate individual staff learning are represented in Figure 7.1.
Figure 7.1. Key dimensions of Nursing Unit Managers’ learning facilitation practices

7.4 Conclusion

This chapter explored the participants’ learning facilitation practices within the contextual and practice environment of their work. The participants’ accounts of their interactions with staff during the ordinary routines of their unit’s work revealed their facilitation of learning with individuals, within teams and through their use of artefacts. The participants engaged in direct facilitation of learning with individuals, often incidentally, within precepting relationships, and by developing and mentoring staff for team leader roles. The participants facilitated team learning by negotiating opportunities with the wider healthcare team, by directly supporting staff attendance at learning events, and by organising and convening team deliberation on clinical issues and collaborative problem solving. The participants developed and utilised learning aids to support staff learning of unit-specific activities, to augment learning for new staff and to support professional development. These three dimensions of participants’ learning facilitation practice – with individuals, within teams and through artefacts – are represented in Figure 7.1. Together with the findings reported in Chapters 5 and 6, this chapter forms the basis of the final synthesis and model presented in the following chapter of this thesis.
Chapter 8: A Living Systems Model of NUMs’ Learning Facilitation Practices

The primary aim of my research was to develop a deeper understanding of Nursing Unit Managers’ (NUMs’) practices in influencing learning in clinical workplaces. The overarching research question that guided my research was: How do NUMs facilitate learning in clinical workplaces? My research focused on practices undertaken by NUMs to influence the performance of a range of nursing practitioners including Registered Nurses (RNs), Enrolled Nurses (ENs) and Assistants in Nursing (AINs). To answer my research question this chapter draws together the findings presented in Chapters 5, 6, and 7.

In this chapter, the key research findings are represented in a Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1). This model coalesces the complex ways that context, practice foundations and power combine to shape NUMs’ learning facilitation practices within a holistic representation of both the practices NUMs use to facilitate staff learning and the factors that shaped development of those practices. NUM’s use of power is integral to their learning facilitation practices. The participants in this research drew from a unique blend of personalised and positional forms of power to influence learning with individuals, within teams and through artefacts. The participants’ particular use of power emerged from their conceptualisation of the learning that was required, shaped by their conceptions of staff learning, knowledge of staff performance, motivations and identity. This research highlighted the substantive, significant and embedded nature of NUMs’ learning facilitation practices. The participants’ limited awareness of the scope of their influence on learning signals an opportunity for a focus on learning facilitation in educational programs and ongoing research. This is important as NUMs’ learning facilitation practices in clinical workplaces have significant implications for development of staff performance to provide safe and quality care for patients in hospitals.
8.1 Chapter purpose and scope

In this chapter I synthesise my key research findings into a Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1). This model draws together three key influences on NUMs’ learning facilitation practices: context, foundations and power. An analogy of a tree as a living structure is used to highlight the dynamic and complex interplay of systems, processes and unique traits that shape NUMs’ learning facilitation practices within the healthcare context. The key influences – context, foundations and power – alongside the dimensions of NUMs’ learning facilitation practices, and their link to the analogy of a tree, are described below.

- Context: The context of NUMs’ learning facilitation practices, foundations and sources of power are represented in the model (Figure 8.1) by the tree’s external environment. Contextual factors that influence NUMs’ learning facilitation practices include the interplay between factors arising from the hospital’s external and internal environments. Contextual factors also shape NUMs’ foundational identities, conceptions of staff learning and motivation, the focus of their practices, opportunities for networking, and ultimately the nature of their learning facilitation practices.

- Foundations: The foundations of NUMs’ learning facilitation practices, including their identity, conceptions of staff learning, knowledge of staff performance, and motivations are represented in the model (Figure 8.1) by the tree’s roots. This explicates how these foundations merge to uniquely nurture, support and sustain NUMs’ learning facilitation practices.

- Learning facilitation practices: NUMs’ learning facilitation practices are represented in the model (Figure 8.1) by the tree’s foliage, supported by three dimensions of activity – with individuals, within teams and through artefacts – represented by the branches. This represents the nature of NUMs’ learning facilitation practices, with reference to their use of power.

- Power: The key mechanism of influence, power, is represented in the model (Figure 8.1) by the trunk of the tree. Power, which is inherent in NUMs’ personal relationships and positional status, is presented as the central
influence on NUMs’ learning facilitation practices. NUMs’ use of power in shaping staff learning draws on their practice foundations: their identity, knowledge of staff performance, conceptions of staff learning, and motivations.

These three dimensions – context, foundations, and power – combine in unique and fluid ways to determine the nature of NUMs’ learning facilitation practices. These individual dimensions as well as NUMs' learning facilitation practices are explored in more detail in the following sections.

Figure 8.1. A Living Systems Model of NUMs’ Learning Facilitation Practices
8.2 Context

In this research, influences arising from the general context of healthcare and professional nursing, the organisation (hospital), and the specific unit(s) where NUMs’ work created ongoing need for change to clinical practice. Context is represented in the space surrounding the tree in the model (Figure 8.1). This is because of the expansive and continual nature of context that affected all parts of NUMs’ learning facilitation practices. This section explores the nuanced and dynamic way that context shapes NUMs’ learning facilitation practices. Similar to most health service organisations, the socio-political context of the hospitals in which NUMs work is dynamic, complex and contested. This environment demands continual adaptation and renewal of workplace practices to achieve strategic and clinical outcomes, including a high standard of safe, quality care. While many factors arising from the socio-political environment, including technology, regulation, policy, and stakeholder demands are known to influence hospital work (Duckett & Wilcox, 2015), a more nuanced understanding of specific socio-political influences, more particularly on NUMs’ learning facilitation practices, not previously reported, is examined in this section.

Among the many nuanced and dynamic influences revealed by my research, this section focuses on key contextual factors found to influence NUMs’ learning facilitation practices. These key contextual factors were identified during text interpretation, guided by my theoretical framework. The key factors include those originating within the broad context of healthcare such as professional regulations, government policy, and the wider nursing profession; as well as those from within the hospital such as the context of the unit, including opportunities for networking, the nature of the specialisation, and hours of operation. These factors are represented in the space surrounding the tree in the model (Figure 8.1).

8.2.1 The influence of the broader context on NUMs’ learning facilitation practices

Contextual influences arising from both the wider healthcare environment and from within the hospital influence the nursing profession, the work of the hospital, the environment of the clinical unit, and ultimately NUMs’ learning facilitation practices. Influences on hospital work that have been identified in previous research,
including an increase in chronic disease, a focus on safety, quality and efficiency, ongoing and rapid technological advances, demands arising from community public hospital access, and the strength of consumer expectations were explained in detail in Section 2.2.2: Focus on safety and quality. Further specific factors that influence NUMs’ learning facilitation practices were identified during text interpretation, guided by my theoretical framework. In this section, I discuss specific contextual factors identified in this research that influence NUMs’ learning facilitation practices.

The Australian Health Practitioners Regulation Agency (AHPRA), the national regulating body for nursing, is one of the most significant contextual factors that shapes NUMs’ learning facilitation practices. In particular, AHPRA’s mandate that Registered Nurses meet continuing professional development standards in order to maintain their registration (Nursing & Midwifery Board of Australia, 2016a) was of critical importance to NUMs. This was because staff who do not meet professional development standards lose their registration and are unable to undertake nursing work. NUMs are therefore greatly motivated by these high-stakes AHPRA regulations, with many of their formal learning facilitation practices, including enabling staff attendance at professional development activities, designed to ensure staff meet AHPRA requirements.

Apart from AHPRA, the Ministry of Health also exerts significant influence on NUMs’ learning facilitation practices through its policy focus which reflects broad political and technological changes as well as an ongoing commitment to safe and quality care. As an example, a recent hospital-level policy, “Recognition and management of patients who are clinically deteriorating”, was a hospital response to a Ministry of Health policy developed as a consequence of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals 2008 (Clinical Excellence Commission, 2013). A centralised hospital education program was included among the strategies for implementation of this policy. Although their role in implementation has received little attention, NUMs have a significant role in facilitating the transfer of this learning to meet the particular practice needs of unit staff. Enabling their staff to translate policy to practice is an important part of NUMs’ learning facilitation practices and is discussed in more detail in Section 8.4.
Continual technological and healthcare practice change also impact policy development and implementation across the healthcare sector, creating an ongoing need for NUMs to engage with staff learning. NUMs’ learning facilitation focus in response to these changes includes ensuring staff attend mandatory learning events, undertaking audits and giving feedback to staff, ensuring staff have opportunities to develop mandated skills, organising educational responses to incidents, and managing underperformance issues or changes in treatments. These activities, determined by organisational policy and procedure that specifies and communicates the standards required to achieve safe care, not surprisingly form the basis of a significant portion of NUMs’ learning facilitation practices. These practices, represented in the Living Systems Model of NUMs’ Learning Facilitation Practices by the foliage of the tree, are discussed in more detail in Section 8.4.

Further to contextual influences arising from the healthcare regulatory and policy environment, there are influences arising from within the nursing profession. Sources of contemporary nursing knowledge including conferences, courses and journals provide important resources for nursing staff learning and enhancement of patient care. While hospitals have formal processes, such as clinical governance, for considering practice implications arising from external sources (Spigelman & Rendalls, 2015), this research revealed a more nuanced nature of NUMs’ roles in this process. NUMs actively harness new knowledge brought to the workplace by staff who have attended conferences and courses and from new staff to the unit who sometimes bring different perspectives on care. NUMs are open to multiple sources of clinical knowledge and develop strategies to consider and embed contemporary nursing knowledge into the practices of the unit. They work to span the boundaries between the wider field of professional nursing practice, and the work of the clinical unit, facilitating the learning required to achieve evidence-based good practice.

Contextual influences arising from the hospital and wider healthcare environment that influence NUMs’ learning facilitation practices are generally bound to policy and regulation. Hospital responses to government policies include generation of local policies and procedures that specify how government policies will be implemented. Together with the requirements of AHPRA, these hospital policies and procedures are a significant influence on NUMs’ learning facilitation practices.
8.2.2 The influence of the specific context of the clinical workplace

As the immediate context of NUMs’ learning facilitation practices, the clinical unit is replete with influences that shape those practices including patient acuity, the skill level of staff, and the availability of other opportunities for staff learning such as formal education and unit resources. In this section I discuss three key local contextual influences on NUMs’ learning facilitation practices: the nature of the unit specialisation, the hours and routines of work, and the availability of professional networks.

Unit specialisation

Consistent with nursing care in hospital contexts more generally, NUMs work in diverse and specialised units (Duckett & Willcox, 2015). Nursing care within each specialty area is underpinned by general and specialist nursing knowledge and skills. While nurses develop a set of portable skills and knowledge through their education and experience, learning in new clinical contexts presents a challenge (Conway & McMillan, 2013) and has implications for NUMs’ learning facilitation practices. These practices are determined by the specific nature of each specialisation including technical complexity, and the foundational knowledge and skill that underpins the nursing activity performed there. To achieve this, NUMs working in highly specialised and technically complex areas are committed to ensuring staff followed a structured program over a long period of time. NUMs drew on their own knowledge of the clinical area and a tacit understanding of staff development to justify their approach to staff education offered in their units. NUMs are also committed to developing their own clinical skills in their specialist area, to ensure they are sufficiently well informed about the relevant clinical work to be able to guide new staff, and to be generally perceived as a resource for learning by nursing staff in the unit.

Further complicating and challenging NUMs’ learning facilitation practices are frequent changes to unit specialisations. Such changes often occur through policy mandates decided at higher levels in the hospitals. For example, one research participant described the short notice given to convert half the beds in her cardiology unit to urology. The nature and demands of an unstable patient base on nurses’ skill
level has been recognised (Chiarella & Roydhouse, 2011), and has been associated with adverse events (Duffield, Diers, O’Brien-Pallas, Aisbett, Roche et al (2011). The role of NUMs in managing staff learning in this environment includes developing skills in managing clinical complexity and liaising with clinical nurse educators (Duffield, Roche, Dimitrelis, Homer & Buchan, 2014), but their practices in enabling learning of nursing staff in this context has not been reported. NUMs’ ordinary responsibilities to ensure an appropriate skill mix on all shifts, by developing their knowledge of staff competence, facilitating learning of new skills and procedures, and seeking and drawing on available resources, are much more challenging in this rapidly changing and unpredictable clinical environment. This has implications for their ongoing development as unit managers/leaders, advocates for staff learning as well as for their own knowledge and skill in facilitating staff learning.

*Hours of operation*

Hours of work are another unit-based contextual influence on NUMs’ learning facilitation practices. Some units operate within business hours (9 am – 5 pm) and provide short-stay or day-only care for patients. NUMs who work in these units work the same shifts as all nursing staff. Consistently working alongside nursing staff facilitates NUMs’ ability to develop a deep knowledge of staff skills and capabilities. NUMs particularly value opportunities to interact with staff on clinical matters. It has been reported in the literature that, where nursing staff and NUMs work the same hours, staff are better able to master clinical skills and routines and all staff are more likely to be aware of the capability of team members (Duffield, Roche, O’Brien Pallas, Catling-Paull, & King, 2009). Consistent with this understanding of the influence of concurrent hours of work on staff capability development, participants of this research described how their ability to monitor and influence the nature of the team, sense the climate of the unit, assess the capability of staff to perform their roles and take measures to develop staff performance when necessary was enhanced by their coinciding hours of work. They were able to plan for learning facilitation experiences, and to develop team relationships as a basis for influence. NUMs are better able to understand their staff’s capabilities, and responses to changes in
practice, and to facilitate learning as it is needed when they work the same hours as the staff in their unit.

Such opportunities contrast with the experience of shift workers who have limited contact with NUMs (Gifkins, Loudoun, & Johnston, 2017). Where participants in this research did not work the same hours as unit staff, they were more reliant on team leaders to manage staff. They developed artefacts to guide staff performance in completing some unit tasks, and gave attention to asynchronous forms of communication such as memos, read and sign sheets and minutes of staff meetings to provide oversight to staff practices. Opportunities to understand the performance of staff who worked outside business hours were included in patient notes, handover and sometimes reports from other staff. However, as nursing staff employed in the field work hospitals worked a rotating roster, their shifts coincided with those of the participants periodically and provided some opportunities for deeper interactions and knowledge of practice to develop.

*The availability of networks*

NUMs’ relationships with wider teams of health professionals are another important contextual factor that influences their learning facilitation practices. Each unit is networked to a wider team of health professionals including medical, allied health and administrative staff. The primary purpose of these networks is to enhance patient care through multidisciplinary collaboration. NUMs play a key role in developing interprofessional relationships to coordinate collaborative endeavours and support the development of the wider team (Heale, Dickieson, Carter & Wenghofer, 2014). Importantly, NUMs value their investment of time in nurturing these relationships. While current literature has identified NUMs roles in interprofessional work as “brokers” to enable transfer of information between health professionals (Tasselli, 2015, p. 866) this research found that NUMs purposefully supported relationship development as a means for opening opportunities for staff learning. Importantly, NUMs value their investment of time in nurturing these relationships. Good interprofessional relationships open up opportunities to advance staff members’ learning needs and access to learning events, including clinical rounds and medical staff case reviews. These opportunities are deliberately initiated by NUMs for the purpose of staff learning and team development.
The frequency and magnitude of change in the healthcare context creates an ongoing need for adaptation and learning of new or changed practices. NUMs play a pivotal role in facilitating staff learning in this dynamic context.

8.3 Foundations

NUMs' learning facilitation practices are established on four key foundational dimensions: identity, conceptions of staff learning, knowledge of staff performance, and motivations. NUMs are motivated to ensure staff provide care that is safe and of high quality, and to ensure that the work of the unit complies with policy. NUMs also exhibit a deep and altruistic commitment to staff development. These foundations reflect the personal and professional perspectives NUMs bring to their work, tempered by their experience and knowledge of nursing practice and the context of their work. These foundations, represented by the tree’s root system in the Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1) underpin NUMs’ learning facilitation practices and decisions, and serve to sustain these practices over time.

8.3.1 Identity

In this research, the participants acknowledged that they had well-formed identities as nurses and as managers. This is not surprising given they were all experienced nurses. However, they did not so readily articulate an identity related to education, although they were aware of their general responsibilities to ensure a skilled workforce. This finding is consistent with conclusions presented in the literature review (Chapter 3). The core of the participants’ nurse and manager identities was revealed in their accounts of dual nursing and managerial work, including involvement in managing and overseeing patient care, communicating and representing nursing within multidisciplinary teams, and being a resource for nursing care clinical matters.

Factors that are known to reinforce professional identity (the sense of self in relation to job roles and influence) include recognised job roles, the expectations of others about the job role and the self-knowledge acquired from reflection on one’s position in relation to one’s wider social network (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). These factors, embedded in NUMs’ work contexts, shape their
identity. Their conspicuous positions as managers of their units establish expectations of their job role to staff, whose responses, behaviours and patterns of communication reinforce NUMs’ identity as managers. Furthermore, NUMs’ membership of a wider social network of NUMs provides a basis for developing self-knowledge as a part of their identity formation, and their membership in this network further defines their NUM identity to others.

NUMs’ identities as nurses and managers shapes their approach to their work, their use of language, their interactions with staff and their actions. The sometimes dominant and authoritarian nature of the participants’ management identity was revealed through their use of language, such as ‘policy speak’ that consolidated their allegiance to the authority of the organisation (hospital) and accentuated their dominance over unit staff. NUMs’ identity as managers enables familiarity with sources of available power and how power can be used in their work.

Despite the presence of multiple factors that reinforced their management identity, the NUMs in this research also demonstrated a strong allegiance to the nursing profession. Their identities as ‘nurses first and managers second’ emerges from a strong and personal sense of belonging to the nursing profession (Pegram et al., 2015). The qualities of empathy and emotional intelligence, which are central to therapeutic communication, which is important in nursing (Potter, Perry, Stokert, & Hall, 2012), were retained by the participants following their transition to management work, and underpinned their interactions with staff. The participants’ empathy and emotional intelligence were observed in their expressions of concern for staff, caring and commitment to staff welfare, and attention to staff members’ individual needs to learn and become confident within very challenging hospital workplaces. The participants’ use of language that demonstrated ownership or matriarchy, for example “my staff”, and their justification of activities that “built them up” further demonstrated empathy and emotional intelligence, and a curious mix of positional and personal power in an identity that was simultaneously ‘bossy’ and kind. NUMs’ complex and unique nurse-manager identity provides an important foundation on which their learning facilitation practices are built.

While the participants acknowledged the management and nursing basis of their identity, they placed limited emphasis on the learning facilitation dimension. The
presence of others who were formally charged with educational activities, for example, CNEs and the hospitals’ centralised education department, likely shaped NUMs’ perceptions of their own role, i.e. as managers and not as educators. This possibility is consistent with known socially constructed sources of identity (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). This was evident in the participants’ views that it was the CNE who “does the education” and their emphasis on the functions of the centralised education department. Furthermore, the need to be a good ‘fit’ with organisational expectations, identified as an influence on identity development (Swann, Johnson, & Bosson, 2009), was another likely influence on the low value the participants in this research placed on the educational aspects of their roles, as specific educational activities were not formally articulated in their job roles (NSW Industrial Relations Commission, 2018). The participants did not openly acknowledge an educational role in meeting learning needs, other than in relation to consulting with CNEs or arranging formal learning activities.

This research identified a learning facilitation role that extended the participants’ identities beyond managers and nurses to include an implicit learning facilitation identity. This significant finding makes a unique contribution to knowledge of nursing management work. The participants’ accounts of specific activities they undertook in response to learning needs that arose during their day demonstrated a learning dimension to their work not previously described. These activities that aimed to facilitate staff learning individually, within teams and through artefacts are detailed in Section 8.4.

NUMs’ identities as managers and as nurses provide an important foundation for their learning facilitation practices. As managers they ensure mandatory learning is available and engage other staff and resources when a learning need becomes apparent. As nurses, NUMs are able to use their expertise and empathy to influence the work undertaken by staff. However, the participants’ identities as managers and as nurses, and not as educators, was inconsistent with their accounts of work undertaken to influence performance during the routines of the workplace. These implicitly understood learning facilitation practices and NUMs’ purposeful and selective use of power in influencing staff performance are explained in more detail in Sections 8.4 and 8.5.
8.3.2 Conceptions of staff learning

Building on the influence of NUMs’ core identities, as nurses, managers, and facilitators of learning (as established in the previous section), this section further explicates the nuanced and complex nature of NUMs’ learning facilitation practices through an exploration of how NUMs’ conceptions about learning significantly shape those practices. In this research, the participants’ conceptions of staff learning included their views on how staff learn, the learning facilitation strategies and outcomes they most valued, and their role in facilitating staff learning. It has been long acknowledged that the aspects of practice that are most highly valued by NUMs include efforts to achieve quality care and to provide support to others, including staff and patients (Aitamaa, Leino-Kilpi, Puukka, & Suhonen, 2010; Orvik, Vågen, Axelsson, & Axelsson, 2015). These valued practices are characteristic of the human and caring dimensions of NUMs’ professional nursing identity (Bergin, 2009). This research builds on this general understanding of NUMs’ valued practices to provide a more nuanced understanding of their conceptions, including their valued practices, specifically in relation to staff learning. These conceptions of staff learning underpin NUMs’ learning facilitation practices. NUMs’ conceptions of staff learning are represented in the Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1), as part of the root system, as structures with the capacity to adapt to changing conditions. NUMs’ conceptions of staff learning underpin and shape the decisions they make about learning, how they use power, and ultimately how they act to facilitate learning in their clinical units.

NUMs’ conceptions of staff learning that most influence their learning facilitation practices comprise their personal dispositions and understanding of what their job entails, their priorities and how they aim to achieve workplace objectives. The individual perspective that managers bring to their work has been explained by Mintzberg (2009, p. 47) as the ‘frame’ that they bring to their job, a view that recognises the unique nature of management work and the personal contributions that each manager brings to their work. My research extends Mintzberg’s concept of the ‘frame’ brought to a job by identifying and describing how each participant’s unique history, experience and conceptions of staff learning shaped their managerial and, in this case, their NUM work and more specifically their learning facilitation...
practices. Each NUM has a unique history of being a nurse and a manager, a unique journey from student to registered nurse and from registered nurse to NUM. These prior professional experiences significantly shape the formation of NUMs’ understanding of how staff learn. The participants referred to their past experiences when justifying the actions and conceptions of staff learning that guided their own current practices. These experiences precipitated their commitment to support staff learning of their job roles and reflected the value they placed on this activity.

The participants particularly valued opportunities to engage with staff in clinical work, although they did not explicitly associate this practice with a learning facilitation role. They valued having a presence in the clinical area: directly by participating in the delivery of care, and indirectly by designing routines, processes and structures that shaped the context of that care. The participants’ clinical presence was also enabled by the relationships and rapport they cultivated with staff, and their strong commitment to being available and approachable. They valued being perceived by nursing and medical/allied health staff as key resources, as ‘reservoirs’ of information about the unit and the clinical work carried out there. Many expressed a view that their staff’s performance was influenced by their role as a knowledgeable leader who modelled good practices. While NUMs’ roles in influencing staff performance through modelling, particularly in relation to communication skills, has been recognised (Anons on et al, 2014), the nature and influence of their modelling roles on learning have not been explored. In this research, participants’ presence in the unit provided opportunities for modelling, and their design of work routines that reflected their people-oriented beliefs, enabled them to strongly and consistently influence learning. However, the participants’ explicit understanding did not recognise the full extent of this influence.

The participants’ conceptions of staff learning were most clearly evident in their interactions with their staff during staff induction, a unit activity with an intense learning focus. During staff induction the participants emphasised the importance of their role in establishing compliance requirements and communication channels. They also perceived themselves and other team members as role models and prioritised modelling good practices to facilitate learning. The participants also particularly valued early goal development within the ‘skills pathway’, a scaffolded arrangement of clinical skills that guided the participants’ support of new staff to
progressively achieve a higher level of performance. They believed that the skills pathway motivated staff learning and considered goal achievement as key to developing a sense of belonging to unit teams. They also valued the formality of the skills pathway that guided their interactions with staff but also aligned staff induction and development with policy compliance.

An important learning facilitation activity valued by participants, beyond induction of new staff, was organising and monitoring staff attendance at mandatory learning events. This activity, considered a formal, tangible strategy to resource the work of the unit is common to NUMs roles (Anthony et al., 2005; Everson-Bates, 1992; Skytt et al., 2015). However, my research revealed deeper understanding of NUMs engagement with this aspect of their practice. The participants sought input from CNEs on specific unit learning issues and arranged education in response to incidental learning needs. The participants valued formal learning, information sessions and training in clinical competencies as sources of learning for staff, and considered staff engagement with these resources as evidence of performance and compliance. The value they attributed to these activities was also reflected in their philosophy about compliance with policy and the importance of following policy to avoid possible consequences of non-compliance, such as not being supported by the hospital if harm should arise.

The participants primarily viewed education as a vehicle to enhance performance and underpin safe patient practice. They primarily viewed and valued education as a didactic and formal activity, separated in time and place from workplace routines, for example in centralised learning departments. As NUMs work to influence staff performance, with individual staff, within teams and through artefacts, as explained in Section 8.4, their understated and tacit conceptions of staff learning become more deeply known. This extends current knowledge of NUMs’ learning facilitation practices that are limited to formal practices, restrained in their exploration of less tangible approaches.

8.3.3 Understanding staff performance

Central to NUMs’ learning facilitation practices is ongoing development of their knowledge of their staff members’ capabilities to carry out unit work safely and to
expected standards. Understanding of staff performance, represented in the Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1) within the roots of the tree, is an important foundation of their learning facilitation practices. As NUMs seek to understand staff performance, they develop both propositional and personal knowledge about staff performance. Propositional knowledge, explicit knowledge that can be described, measured and shared (Eraut, 2000), was developed from audit results and other formal sources of information about specific tasks carried out by nurses such as handwashing or patient documentation. Personal knowledge, which is sometimes tacit, is developed from experiences, memory, skills and the history of their use as well as personalisation of propositional knowledge (Eraut, 2000). Examples of personal knowledge development in this research include having a sense that the unit is operating smoothly, or that an underperforming staff member is ‘feeling it’, without necessarily being able to articulate the basis of that knowledge. While propositional measures of performance are often espoused as key sources of management knowledge (Bresnen, Hodgson, Bailey, Hyde, & Hassard, 2017), personal knowledge is considered to be used by managers more frequently (Mintzberg, 2009). These perspectives around the use of propositional and personal knowledge to facilitate learning in workplaces are consistent with the findings from this research. However, while NUMs’ roles in conducting staff appraisals as a measure of performance has been recognised (NSW Industrial Relations Commission, 2018) few studies have explored how managers, and NUMs in particular, develop and sustain their propositional and personal knowledge of staff performance, beyond this process. This research contributes a unique and nuanced understanding of this dimension of management work in general and NUMs’ work in particular.

The participants in this research highly valued the development of propositional knowledge about staff performance as it enabled them to monitor staff compliance and provide appropriate feedback to staff. Folders that contained records of staff attendance at training, incident reports and audits provided the participants with a valuable source of propositional knowledge that was indicative of staff compliance with standards. Knowledge of staff performance developed from these sources provided the participants with an authoritative basis for provision of feedback to staff. They provided staff feedback for multiple reasons including to explain unit
progress in this area of compliance, to recognise work well done, to reinforce good practice and instil confidence, to plan education, and to remind staff of areas where improvement was needed. The tangible, measurable and perhaps indisputable knowledge that is generated by these routine activities is valued by NUMs, and forms an important basis for their learning facilitation practices.

While the participants placed most emphasis on propositional sources of knowledge about staff performance, they also relied on implicit personal knowledge, although, consistent with contemporary understanding of implicit knowledge, they were less able to articulate how this was developed. Their accounts of developing knowledge, for example, of a staff member’s leadership performance, reflected ‘sense making’, a process that occurs through language and talking/deliberating and is continuous, as deliberative dialogue and action interact to build meaning. Within this process, the streaming of ‘cues’ fosters understanding and forward action (Weick, Sutcliffe, & Obstfeld, 2005). The participants’ ongoing receptivity to ‘cues’, such as the nature of staff questions, influenced the development of their personal knowledge of staff performance. They actively sought cues from which knowledge of matters that were not typical or expected could be acquired. Opportunities for harnessing cues included listening in to a handover, seeking to understand how issues were managed, or regularly doing unit rounds, asking staff details about patient care. In these ways the participants formed a sense of the depth and quality of their staff’s work. The participants’ presence in the unit and their continuous dialogue with staff sustained ongoing deliberation and knowledge development about staff performance.

Opportunities to understand staff performance arising from propositional and personal sources of knowledge are often interrelated. For example, the participants described how they managed a nurse’s medication error: being alerted to the incident, reinforcing policy directly with the staff member involved and directly observing the staff member’s performance. At the same time, the participants were able to observe staff interactions with patients and other staff, although this may not have been the original intention, thus furthering their understanding of a staff member’s performance. Opportunities for understanding staff performance sometimes occurred simultaneously, and in the context of other routines, and reflected the complex nature of the clinical workplace and of management work. For example, as the participants listened to a handover, they were able to gain a sense of
a staff member’s knowledge and decision-making skills as well as finding out about the patients they had cared for during that shift. Explicit sources of knowledge, for example, incident reports and handover, were infused with tacit forms of knowledge gained from their impressions of staff responses to workplace activities.

NUMs’ understanding of staff performance is an important foundation for their learning facilitation practices. Opportunities for developing propositional and personal knowledge about staff performance are embedded in clinical work routines. NUMs’ work with staff, and leveraging their close proximity to the unit develops personal and propositional knowledge, often in tandem, of how individual staff and teams are performing.

8.3.4 Motivation

This research revealed three key motivating factors that drive NUMs’ learning facilitation practices: provision of safe, quality patient care; unit compliance with organisational policies; and fulfillment of staff professional development and advancement needs. These priorities are reflected in NUMs’ identity (discussed in Section 8.2.1), conceptions of staff learning (discussed in Section 8.3.2), actions undertaken to develop knowledge of staff performance (discussed in Section 8.2.3), and their accounts of daily work routines. Within the uncertain and challenging unit context, NUMs’ motivation, defined in the management literature as actions, determination and resolve to achieve an aim (Robbins et al., 2018), provides a strong driver of their learning facilitation efforts. NUMs’ motivation together with their identity, conceptions of staff learning, and perspectives, and knowledge of staff performance, shapes the development and implementation of their learning facilitation practices that are intended to realise unit priorities.

NUMs’ motivation is represented in the Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1) within the root system of the tree. Motivation gives strength to the foundations of NUMs’ learning facilitation strategies and provides an impetus for action. Similar to NUMs’ identities, conceptions of staff learning, and their knowledge of staff performance, their motivation is dynamic and sensitive to changing priorities and environmental conditions that impact on the
organisation. This finding adds to knowledge of NUMs’ practice foundations, as
there is a dearth of literature that explores factors that motivate NUMs’ work. One
study identified the nature of interpersonal relationships as a key motivator for
NUMs’ work engagement (Warshawsky, Havens & Knafl, 2012), but no studies
identified drivers of their learning facilitation practices. This research found that
motivation to achieve safety and quality, to ensure policy compliance, and to meet
staff development and human needs influences NUMs’ learning facilitation practices
(foliage) and their use of power (trunk and branches), as represented in the model
(Figure 8.1), to achieve the aims of the unit.

Safety and quality

NUMs’ responsibility for ensuring safe and quality care is firmly embedded in their
position descriptions (Industrial Relations Commission of NSW, 2017) and forms a
primary driver of their learning facilitation practices. However, while the academic
literature is replete with recommendations for NUMs practices in developing safe
and quality care in their units (Abdi et al., 2015; Ammouri et al., 2015; Chiang et al.,
2011; El-Jardali et al., 2010; Lyman Hammond & Cox, 2018; Merrill, 2015), studies
do not explore safety and quality as motivators for NUMs learning facilitation
practices. This research contributes to understanding of this aspect of their practice.

The participants emphasised their accountability for staff knowledge, capability and
performance in their job roles, and their responsibility for the quality and safety of
care provided to patients on their units. To meet these responsibilities, they
purposefully created a context where safe practice could occur, and acknowledged
the vicarious nature of their own relationship to patient care. As the participants
could not be present at every clinical encounter, they were reliant on other sources to
inform their understanding of staff members’ capabilities and practices, particularly
staff members’ ability to be safe. The participants overcame their temporal and
physical distances from staff, through remote actions such as organising and
monitoring staff attendance at formal education, which they believed to be
foundational to safe practice; ensuring documented unit practices were safe;
conducting audits; and maintaining a clinical presence when possible. The
participants’ presence also provided an opportunity to provide direct oversight of
staff learning of particular clinical procedures they considered to carry a high degree
of risk, for example cardiac arrest management, fire safety, blood transfusions, and medication administration procedures.

A significant issue that motivated the participants’ learning facilitation practices was their concern about the capability and confidence of staff to ‘escalate’ issues that arose during their shift to senior nurse managers. Recent studies have identified constraints on nurses’ ability to escalate concerns about deteriorating patients to medical staff (Massey, Chaboyer, & Anderson, 2017; Mohammed Iddrisu, Hutchinson, Sungkar, & Considine, 2018); however, few studies have identified constraints on nurses escalating issues to more senior nurses. In this research, ‘escalating’ was sometimes necessary when nurses felt a need to challenge decisions made by medical staff, for example, the transfer or discharge of a patient whom the nurse did not consider to be well enough. The participants commented on the challenge of teaching staff to communicate ‘upwards’ in an assertive manner on these occasions, and how important it was to ensure patient safety. Many emphasised ‘escalating’ as an important role of team leaders, whom they considered instrumental to the provision of safe care owing to their close proximity to the clinical work of the unit. The participants in this research identified strategies they used to teach escalation capabilities to nursing staff such as modelling, and including escalation skills in team leader training routines. The participants concern about communication between levels of nurses signalled an area of learning need that had implications for their learning facilitation practices.

The provision of safe quality care, as a primary responsibility, motivates NUMs’ work and strongly shaped their learning facilitation practices. NUMs undertake many and varied practices to achieve safe, quality care in their units including shaping a clinical environment that supports safe practice, arranging education, ensuring policies and procedures are evidence-based, carrying out audits, maintaining a presence in the unit, engaging in focused teaching, developing competent shift teams and ensuring staff are capable of patient advocacy. This range of patient safety-related learning facilitation practices NUMs undertook highlights the importance they place on patient safety and quality care. Many of NUMs’ learning facilitation practices are underpinned by their motivation to achieve safe and quality care.
Compliance with policy

The participants viewed activities undertaken to ensure compliance with policies and procedures as another core aspect of their learning facilitation practices and privileged them almost to the same extent as safety and quality. The participants’ emphasis on policy compliance was demonstrated by their use of policy language including words such as ‘mandatory’, ‘compliance’, ‘regulations’ and ‘authorise’. These terms were embedded in the participants’ descriptions and explanations of their learning facilitation practices. They justified many of their actions and routines in terms of policy compliance, and their roles as ‘peddlers’ of policy were reflected in their identity and conceptions of staff learning, as discussed in Section 8.3.1 and Section 8.3.2. Formal learning opportunities were aligned with policy compliance, and actions taken to influence learning in less formal situations, for example in response to a staff member’s need for information on a medication, were often explained in relation to an associated policy or procedure.

This research revealed that NUMs’ motivation to ensure compliance with policies and procedures is closely aligned with their motivation to achieve safe, quality care. This finding resonates strongly with the requirements of NUMs’ position responsibilities (Industrial Relations Commission of NSW, 2017), and recent research that has identified NUMs’ roles in influencing safe and quality patient care (Merrill, 2015; Murray, Sundin, & Cope, 2018). It is widely acknowledged that policies and procedures generally aim to achieve high standards of performance in clinical and non-clinical areas (Australian Commission on Safety & Quality in Health Care, 2017). In clinical areas, the dominant focus of policies and procedures is to achieve safe, quality care in a range of specific activities that pose a risk of harm to patients, directly and indirectly. Policies and procedures also communicate organisational values and expectations of staff. Furthermore, the substance and authority of policies and procedures in determining practice standards often substitutes for direct supervision (Bowditch, Buono, & Stewart, 2008).

The participants’ motivation to ensure their staff complied with policy was a significant influence on their learning facilitation practices. Examples of the participants’ commitment to ensuring policy and procedure were understood, contextualised and implemented by unit staff include their design and development
of ‘how to do’ manuals and checklists. These activities were accompanied by others that monitored compliance, for example performing audits, competency assessments and monitoring records of staff attendance at formal education. These very visible, formal, policy/safety-driven activities informed the participants’ understanding of their staff’s capabilities and formed important dimensions of their learning facilitation practices.

This research revealed that NUMs’ focus on policy compliance encompasses evaluation of its relevance to unit work. Policies can be developed in response to external requirements with limited relevance to those who need to know; are often developed away from the workplace; and do not always reflect the variation that exists in the contexts where they are to be applied (Wears & Hunte, 2014). NUMs encourage staff to critically evaluate policies and to participate as a team in appropriately adapting policies to the specific needs of their unit. This aspect of policy implementation, although rarely considered in healthcare (Wears & Hunte, 2014), was described by the participants as one of the realities of their role in influencing and shaping clinical work and consequently learning.

Achieving staff compliance with policy and procedure is a significant motivator for NUMs’ learning facilitation practices. The desire to secure staff compliance with policy and procedure also motivates NUMs to engage critically in establishing the meaning and relevance of policy and procedure documents to unit work. NUMs’ roles in translating policy for their staff, and in facilitating staff adaptation of policy/procedure to specific contexts is discussed in more detail in Section 8.4.

Fulfillment of staff professional development and human needs

The participants in this research were intensely committed to staff welfare and wellbeing and demonstrated empathetic and caring attitudes in accounts of their learning facilitation practices. The participants were committed to enabling learning and staff development as a means to enhance staff confidence and feelings of belonging to the wider team.

The participants’ accounts of their interactions with staff, and their justification for supporting staff learning, provided insight into their unique use of empathy within their management roles. Empathy has been identified as an intrinsic nursing trait,
along with caring, advocacy, responsibility, intentionality and respect (Burhans & Alligood, 2010), and is considered an essential leader behaviour (Shirey, 2009). Recently, an association between NUM empathy and nurse wellbeing, engagement and learning was identified (Mortier, Vlerick, & Clays, 2016). My research builds on this understanding through identification of NUMs’ empathetic desire for staff achievement as a motivation for development and implementation of their learning facilitation practices.

The participants’ empathy toward staff was revealed particularly in their accounts of interactions with staff during induction and discussions about underperformance. On these occasions, the participants sought to develop or restore staff self-confidence and generate more positive feelings by working closely to progress staff skills and knowledge of unit work. The participants were also aware of their staff members’ need for belonging, of their need to feel clinically competent and to feel part of the unit team. The participants were also aware of the impact of low self-confidence on performance. The participants’ empathy and commitment to staff wellbeing and capability motivated their efforts to facilitate learning, and to enable staff to provide safe, quality care within the unit’s team environment.

The participants’ support for staff was also evidenced in their direct participation in unit work. They sought opportunities to personally relieve staff of their clinical caseloads so they could attend a learning event, a practice that explicitly demonstrated caring for staff and an interest in their learning. The participants also actively pursued networks within their units’ interprofessional healthcare teams and advocated for nurses to attend medical ‘rounds’ and case presentations. These actions actively communicated to staff the NUMs’ care for staff and commitment to their ongoing learning.

The participants’ commitment to staff was further demonstrated by their development of learning artefacts. These resources were specifically designed to enable staff to practice autonomously when there was no other source of guidance on local unit procedures, such as on weekends or after hours. The participants were sensitive to staff needs when working after hours, and acknowledged that in these circumstances staff may become stressed about not knowing how to complete a task. Learning artefacts developed by the participants, such as manuals on clinical matters
and ‘how to do it’ instructions, effectively transformed organisational policies and informal rules into a resource that was meaningful to unit staff, supported their work, and addressed the lack of support that can occur after hours. NUMs’ roles as translators of organisational information into a form that is meaningful for staff is significant and is discussed in more detail in Section 8.4.

NUMs’ commitment to staff motivates many of their learning facilitation practices. Their commitment to staff development is evident in their expressions of empathy and many of their learning facilitation practices.

8.4 Learning facilitation practices

Since the move of nursing education from hospital-based training to the tertiary sector, NUMs are no longer responsible for directly teaching student nurses (Bradshaw, 2010). In contemporary health workplaces, NUMs’ learning facilitation practices are perceived as being largely indirect, and focus on development of the learning context, for example, providing resources and supporting opportunities for professional development for Registered Nurses (Bradshaw, 2010; Duffield & Franks, 2002). The findings from my research, which identify NUMs’ active involvement in direct facilitation of learning, challenge these assumptions and provide a more nuanced understanding of how NUMs facilitate learning in clinical workplaces.

Earlier sections of this chapter presented four key foundational aspects of NUMs’ learning facilitation practices: their identity, conceptions of staff learning, understanding of staff performance, and motivation. Together, these foundational factors, represented in the Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1) as the roots of the tree, shape NUMs’ understanding of what is important in relation to staff performance and their own capacity for influence.

This research revealed that NUMs facilitate learning in their clinical workplaces in three key areas: with individuals, within teams and through artefacts. These practices are represented in the model (Figure 8.1) by the tree’s three branches. The following section explains in detail activities within each of these three key areas that constitute NUMs’ learning facilitation practices.
8.4.1 Facilitating learning by working with individual staff

NUMs facilitate learning for individual staff in many and varied ways including providing direct instruction, albeit often incidentally, on aspects of clinical work; developing new staff and preceptors; and mentoring experienced staff for team leader roles. Their practices in facilitating learning with individual staff are represented in the model (Figure 8.1) within the foliage that stems from the tree branch ‘with individuals’.

Providing direct instruction

Responding to incidental learning needs forms a significant part of NUMs’ learning facilitation practices with individual staff members. Incidental learning needs arise during the ordinary routines of each day when staff seek advice from NUMs on specific issues, often related to clinical care, or where NUMs encounter a staff learning need during their routine work. These incidental learning needs are many and varied and include occasions where NUMs provide direct unplanned instruction or demonstrate skills such as finding information about a medication, operating a computer, or performing a clinical skill.

The participants’ approaches to staff learning on these occasions included being open and inviting, and being receptive to questions and accepting errors or lack of skill or knowledge. While these participative and non-threatening approaches are considered essential for clinical educators’ and mentors’ guidance of learners in clinical work (Scott & Spouse, 2013; Sweet & Broadbent, 2017), the use of these practices by NUMs has not previously been identified. The participants in my research built their learning facilitation practices on a firm platform of their own clinical competence and their staff’s perception of them as resources on clinical matters. As the participants described their engagement with staff during these incidental learning facilitation encounters, they expressed a desire to empower staff, to ensure they gained confidence and felt able to work autonomously. Previous studies have identified the positive value that NUMs place on staff empowerment (Skytt, Hagerman, Strömberg, & Engström, 2015; Van Bogeart et al., 2015),
although few identify NUMs’ roles in empowering staff through their own direct learning facilitation practices.

NUMs also actively seek opportunities to facilitate individual learning by being present and visible in their units, carrying out rounds and participating in care. Having a presence in the unit, in the clinical space where staff worked was important to the participants, who believed this opened up opportunities to act as a resource and model for staff. These occasions, discussed in Section 8.3.3, also enabled the participants to gain an understanding of staff performance as a basis for individually tailored learning facilitation practices.

*Developing staff through preceptorship*

NUMs’ learning facilitation practices with individual staff also include developing, organising and monitoring precepting relationships. The participants understood a preceptor to be an experienced staff member who is paired with a new staff member to guide the new staff member’s workplace transition. The participants considered the work of preceptors to involve working or ‘buddying up’ with a new staff member, coaching, modelling accepted practices, and enabling socialisation and a sense of team membership. These activities are common in nursing preceptorship (Ulrich, 2012). In recognition of the complexity of nursing work, and its potential to cause harm to patients, precepting aims to ensure staff are prepared to deliver safe quality care (Ulrich, 2012); an outcome (discussed previously in Section 8.3.4) that motivated the participants’ engagement with the precepting process. Precepting relationships complement a formal orientation process offered by hospitals; with its duration dependent on the learning needs of the new staff member and the time made available. While the participants also used the term ‘mentoring’ to define the process of new staff induction, mentoring was more specifically used to refer to a relationship between an experienced nurse and another nurse for the purpose of career development. This traditional perspective on mentoring (Woolnough, 2017) does not confine the relationship to the induction phase.

Literature on NUMs’ practices in overseeing precepting as a means of facilitating learning is limited to general recommendations about provision of oversight and selection of preceptors (Ward & McComb, 2017) with few details about the nature of
this role. Preceptors’ perspectives on NUMs’ lack of involvement or recognition of staff working in precepting roles have also been reported (Hjälmhult, Haaland, & Litland, 2012). Contrary to these reported preceptor views, my research found that NUMs value and seek opportunities to influence precepting, and that they adopt well-reasoned approaches to selecting preceptors and monitoring precepting relationships in their units.

The participants in this research demonstrated deep appreciation of how new staff learn, and the characteristics of experienced staff that best foster new staff members’ learning, such as “being a learner”. In overseeing preceptor relationships, NUMs advise preceptors about what is required of the role and what they believe is most important for each learner, and monitor the effectiveness of the precepting relationship and its effects on staff learning. The intensity of their role is more focused in units where patient care is more technically complex, such as critical care and emergency areas. Through oversight of preceptor relationships NUMs are deeply involved in anticipating learning needs and shaping the learning experiences of new staff. They influence the role of preceptors by providing structure and oversight to precepting relationships, and by working with preceptors to enable new staff to effectively transition into their roles.

*Mentoring experienced staff for team leader roles*

While NUMs work indirectly through preceptors to facilitate learning for new staff, this research also revealed that NUMs work directly as mentors to facilitate the preparation of experienced staff for team leader roles. The role of the team leader, discussed in Chapter 2, is to assign patients or tasks to nurses within a shift, to communicate with staff, organise group discussions around patient care and problem solving, support staff who may be stressed, and maintain morale and effective interrelationships (Nagi, Davies, Williams, Roberts, & Lewis, 2012). Team leadership has been strongly associated with quality and safety of care (Mannix, Wiljes, & Daly, 2013), as well as increased job satisfaction and retention (Duffield et al., 2011; Roche, Duffield, Dimitrelis, & Frew, 2015). Recognition of the need for nurses to be prepared for leadership roles in the Australian healthcare context has influenced governments to offer training, for example the Foundational Clinical Leadership Program (Clinical Excellence Commission, n.d.) and the NSW Health
Leadership Program (Health Education & Training Institute, 2018). Other responses to team leader training in the Australian healthcare context include university courses in leadership and management, as well as in-house training (Dignam et al., 2012). While mentorship has been included as an adjunct to these learning experiences, current research has been limited to understanding the experience of mentees (McCloughen, O’Brien, & Jackson, 2009). In exploring NUMs’ roles in facilitating staff learning for team leadership, my research makes a unique contribution to understanding the key role NUMs have to play in influencing leader development in the clinical workplace.

The participants in my research were familiar with preparing staff for team leadership, and were able to clearly justify and articulate their ideas about how it should be undertaken. Unlike their practices in facilitating staff learning of routine clinical work, facilitation of learning for team leadership enabled the participants to more readily share their own current specific job-related skills and knowledge. Team leaders worked within the participants’ ‘space’. Participants also had a vested interest in facilitating team leader learning, as competent team leaders were able to share some of the tasks and responsibilities associated with the delivery of safe quality care to patients.

The participants in this research held well-formed views on a broad range of capabilities required for good team leadership. They considered the following capabilities to be particularly important: knowledge of clinical work; ability to manage complex clinical situations and interact well with other health professionals; ability to communicate; ability to understand the ‘bigger picture’; ability to be assertive with senior nursing and medical staff in representing the unit’s needs if required; and ability to model good practice for other staff to follow. The participants developed knowledge of staff performance in these areas by maintaining a presence in the clinical area and by gaining a sense of how well the unit as a whole was operating, as a reflection of how well it was being managed by the team leader. The participants’ understanding of their staff’s capabilities in these areas informed their selection of staff for team leader roles and mentoring in preparation for those roles.

Having identified appropriate staff for mentoring, the participants engaged in multiple practices to facilitate development of team leadership capabilities. Their
approaches included organising staff attendance at team leader professional development days; developing a training package and assessing staff responses to embedded learning activities; and working alongside staff as they acted in the team leader role. The participants purposefully rostered staff to work as team leaders during their rostered hours, so that they were available to provide support and oversight as needed, while keeping enough distance to enable trainee team leaders to have opportunities to learn. In contrast to these more widely held views, some of the participants in my research felt that experienced staff eventually develop the confidence and expertise to work as the team leader without any special oversight, and identified repeated exposure to unit challenges as conducive to learning. These NUMs were less aware of the supportive influence of their own presence in the unit, and of the opportunities they provided to staff to develop team leader skills. For some, their identity as a manager, rather than as an educator, appeared to restrict their appreciation of their role in this respect.

Interestingly, the participants viewed their role in facilitating team leader learning differently to their role in preparing staff for a relieving role, that is, to relieve the NUM for extended periods of leave. Staff who were chosen to relieve the NUMs were required to assume a greater degree of responsibility for the unit over an extended time period. The role included understanding and participation in administrative networks that were specific to the NUM role, requiring more intense preparation than that required by team leaders. The hospital allocated very little time to this process. The participants expressed regret over this constraint, which prevented sharing of their views on the full scope of management work beyond team leadership and completion of basic tasks. The participants inducted relieving NUMs into their role during normal shifts, and relied heavily on resources they had developed, which included lists of instructions and schedules of routine tasks to be completed, to provide guidance. The participants also described their role in preparing relieving NUMs to develop and submit reports and operate within the computerised administrative environment. The participants facilitated relieving NUMs’ learning by teaching them how to complete various routine computer-based reports, for example on daily staffing and patient occupancy status, and by preparing manuals and checklists to enable staff to become autonomous with administrative procedures. The participants’ focus in preparing staff to undertake NUM roles was
primarily task oriented, with little or no attention given to development of interpersonal skills, team leadership or managing the complexity of the clinical area. However, as discussed in Section 8.3.3, the participants’ tacit knowledge of staff clinical skills and capabilities, and ability to work within the team provided an indication of the skills the chosen staff brought to the relieving role.

In this section I have presented NUMs’ practices in facilitating individual learning within the clinical unit. NUMs engage in one-to-one instruction to meet individual incidental learning needs, and deliberately seek opportunities for this to occur. They think deeply about learning through precepting, preceptor qualities and the time required for new staff to learn, and are closely involved in developing preceptors, and planning and providing oversight to preceptor relationships. NUMs also play a key role in team leader development; they are familiar with team leader qualities and mentor suitable staff to aid their transition. However, other than during direct teaching encounters aimed at meeting incidental learning needs, the participants were largely unaware of the potential of their role to influence learning. Learning from informal approaches such as conversations with staff about performance was not fully recognised and was considered to be less valuable than formal approaches such as skills checklists, training programs, and efforts aimed at tangible skill development. This finding indicates that NUMs could be encouraged to better recognise and harness the value of informal learning facilitation practices that are inherent in their roles and daily work.

8.4.2 Facilitating learning within teams

Working in teams has long been considered a vital component of effective healthcare work, one that is associated with leadership; collaborative and effective interpersonal relationships; and more recently with enhanced patient safety (Healy & Sampford, 2011). The ability of nurses to function in a team is also emphasised among the competencies for health professional registration (Nursing & Midwifery Board of Australia, 2016b). The teamwork focus that is inherent within the healthcare system was reflected in the organisation of patient care delivery processes in the hospitals that were the sites of this research.
Central to teamwork in healthcare is collaboration, a process of team interaction that is dependent on having common aims, shared decision making, responsibility and power, respect and trust for members, and knowledge of each other’s roles (Petri, 2010). Effective communication is essential for collaboration to occur. However, while current literature abounds with studies of nursing collaboration within inter-professional teams (Bookey- Basset, Markle- Reid, Mckey, & Akhtar- Danesh, 2017; Gausvik, Lautar, Miller, Pallerla, & Schlaudecker, 2015; Piers et al., 2017), there is a dearth of literature that explores intra-professional team collaboration within nursing, and how it is enacted (Moore & Prentice, 2015; Moore, Prentice, & Salfi, 2017). Scant mention is made in the literature of the value of team meetings for staff collaboration and learning (Moore & Prentice, 2015) and, while NUMS’ roles in enabling team communication and feedback on clinical problems has been recognised (Ammouri et al., 2015), the manner in which NUMs enact and influence learning within these interactions has not been explored. This lack of exploration of NUMs’ learning facilitation in team meetings is somewhat surprising, given the regularity of nursing staff team meetings that occur in hospital routines. In portraying nursing team meetings as central places for collaboration and learning, and importantly of NUMs’ practices in enabling these processes, my research makes a significant contribution to contemporary understanding of the enactment of nursing team collaboration and learning in clinical workplaces. NUMs’ learning facilitation practices within teams are represented in the model (Figure 8.1) as part of the foliage of the tree, that extends from the branch “within teams”.

The participants in this study used the concept of ‘team’ in describing different aspects of their work. Working as a team and ‘teaming up’ referred to a way of organising work, for example through team nursing, as well as to a type of moral code that represented a shared understanding of unit aims, and a willingness to support each other in a collegial way. The participants referred to working with ‘the team’, including broader teams and specific shift teams, to disseminate information, to engage in discussion and problem solving around incidents and cases, and to re-prioritise the activities of the day. This occurred through regular team meetings including scheduled staff meetings and incidental meetings used for case discussions and incident analysis. These team meetings provided valuable/rich opportunities for participants to facilitate staff learning.
Routine team meetings

Routine nursing staff team meetings, which occurred every 3–4 weeks, provided the participants with an opportunity to meet formally with nursing staff to share new information and to convene discussions on other unit matters of interest. The participants did not describe these meetings as learning occasions, rather as opportunities to disseminate information. However, during the observation of staff meetings carried out during the fieldwork phase of this research a range of learning facilitation practices undertaken by participants during these meetings was observed. Participants’ nuanced use of power in different and blended forms to facilitate learning during these meetings highlighted the centrality of power in participants facilitation of staff learning both in these meetings and more generally. Participants’ use of power will be explored in more detail in Section 8.5.

The participants held a central role in convening staff team meetings. Consistent with their views on their role during meetings as disseminators of information, they informed staff on a wide range of changes in processes, policies and procedures, as well as results of audits and surveys that were relevant to nursing work. The participants also reminded staff to comply with various procedures, sometimes drawing on coercive power\textsuperscript{15} to strongly influence nurses’ performance. For example, one participant told staff: “breach the policy and be sacked”, and another: “if you have a problem then fill out a grievance form” and “if you don’t comply a checklist will be instated”. The participants’ roles as unit figureheads, and as the source of positional power\textsuperscript{16}, was most apparent during staff team meetings.

These transactional and didactic interactions that were characteristic of unit meetings are consistent with ‘process’ interactions, one of two dominant forms of nursing team interaction, that focus on matters of procedure and patient care routines (Timmermans, Van Linge, Van Petegem, Elseviers, & Denekens, 2011). Many of these interactions provided opportunities for the participants to facilitate learning. For example, in response to staff queries during a meeting, one participant spoke in

\textsuperscript{15} Coercive power is power to discipline others who do not conform (French & Raven, 1959)
detail about the development of sepsis in an acute patient, and reinforced the nursing care procedures required to ensure the safety of the patient, another modelled and justified appropriate language for staff to use when responding to an angry colleague and another shared innovative practices she had discovered from networking with other hospitals. By drawing on their own knowledge, explaining clinical foundations of practice, referring to cases and modelling appropriate practices, the participants used expert power to influence learning as they interacted with staff about clinical matters during staff team meetings.

In agreement with Timmermans et al. (2011), this research found that NUMs value and seek to engage staff in procedural interactions considered to be conducive to learning facilitation through information exchange. However, the participants also engaged staff in more collegial and open discussions during team meetings, on clinical issues and problem solving. These discussions were consistent with Timmermans et al.’s second form of nursing interaction, developmental interaction, which focuses on clinical challenge, change and matters of ongoing interest, inviting innovation and critical thinking. I considered developmental strategies to facilitate a deeper level of learning owing to their influence on active rather than passive engagement. The participants also employed a number of strategies to engage staff in problem solving. In most meetings, the participants used open-ended questions to seek input from staff, who generally responded with ongoing questions and discussion. The participants also employed asynchronous approaches, which enabled the whole team to engage in developmental team discussions without time constraints. As an example, policies, procedures, processes and other matters that the participants felt required staff critique were stored in a folder for staff to access outside of meeting times. Comments were then collated by the participants and reported back to staff at the next meeting. Some participants were quite firm with their staff, for example, “I need you to provide feedback on this by next meeting”. Again, they were drawing on positional power to ensure staff participation. The participants’ commitment to staff critique of unit processes stimulated staff engagement and development of knowledge of the processes, and was considered a learning facilitation practice. However, while Timmermans et al. concluded that the majority of nursing interactions were process-oriented rather than development-oriented, my research found that NUMs value and frequently seek developmental interactions.
NUMs’ practices in engaging staff in case presentations provide further examples of their use of development-oriented approaches, as defined by Timmermans et al. (2011). In addition to regular team meetings, the participants organised impromptu team meetings to specifically facilitate staff learning from case presentations and incidents as they arose. The participants often encouraged staff to present case histories of patients they had looked after, and nominated staff to present a topic of interest such as their learning from a conference or course they had attended. The participants actively guided discussions, and valued having an opportunity to determine the knowledge of other staff, through their interactions, questions and responses to the discussion. The participants valued discussion and sharing of perceptions about correct practice and potential constraints on adherence to clinical standards. During these discussions the participants facilitated group reflection to enable understanding and development of practice implications. Unlike routine staff meetings, the participants explicitly viewed these case presentations as learning events.

The participants’ practices in organising, convening and guiding discussion during case and incident management meetings were exemplars of significant learning facilitation strategies. The participants were committed to facilitating group reflection on clinical work. While nurses are familiar with individual reflection, which is included in the Registered Nurse Standards for Practice: “develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice” (Nursing & Midwifery Board of Australia, 2016b, p. 2), practice development through group reflection is dependent largely on opportunities provided in the workplace. NUMs had a key role to play in shaping these opportunities.

Group reflection has been demonstrated to be valuable in clinical learning as it has the capacity to enable tacit knowledge, held by staff, to become explicit during reflective discussion (Yip & Raelin, 2011). While NUMs’ practices in enabling learning by encouraging team reflection have been recognised (Matsuo, 2012), few studies have explored NUMs’ perspectives on this aspect of their practice. In exploring NUMs’ personal accounts of their influence on staff performance, my
research has illuminated NUMs’ use of team reflection as an important and deliberate learning facilitation strategy.

NUMs’ learning facilitation practice within teams has not been explored previously and represents a new contribution to current understanding of NUMs’ learning facilitation practices. NUMs facilitate learning during routine meetings by explaining clinical matters, drawing on cases and clinical knowledge, modelling information-seeking behaviours, and modelling and demonstrating communication strategies. They engage staff in problem solving, and invite discussion and critique of cases and clinical matters. The participants’ interactions with staff during routine meetings were richly interspersed with learning facilitation activities, and yet their perception of their influence on staff was limited to dissemination of information and did not include a learning dimension. Work with teams during case and incident discussions, acknowledged by the participants as a learning event, included encouraging and convening discussion and reflection and shaping staff preparedness for future practice. The participants in this research drew on personal and positional forms of power as they facilitated staff learning within teams.

8.4.3 Facilitating learning through artefacts

My research revealed that NUMs’ use of artefacts, represented in the foliage of the Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1) as an extension of the branch: “through artefacts”, is among their core learning facilitation practices. The NUMs in this research utilised and created a range of artefacts to support their learning facilitation practices. Artefacts are physical objects that, in workplaces, mediate practices and interactions between workers (Sheehan et al., 2017). Artefacts in clinical environments can include manuals, rosters, noticeboards, equipment, learning spaces and uniforms. The presence and use of artefacts communicates to staff what is valued and provides sources of non-verbal communication (Rose, Spinks, Canhoto, & Reid, 2015) as well as providing staff with opportunities to learn during their work routines (Billett, 2014). Artefacts also stimulate verbalisation of tacit knowledge, which enables this level of knowledge to be known and understood (Eraut, 2007). Artefacts also represent a history of practices associated with their use, and provide a basis for practice development (Kemmis et al., 2014). For example, procedure manuals, as artefacts, communicate
current practice norms, enable them to be reproduced, and serve as a basis for their reconstitution and continuation, as dynamic temporal representations of what is important in achieving unit aims.

The widespread availability and use of artefacts, which are known to facilitate clinical learning (Sheehan et al., 2017), was reflected in the participants’ learning facilitation practices. Artefacts they used to facilitate learning included policy and procedure manuals, computer programs, reference books, journal articles, minutes of meetings, and case reports. My research also revealed participants’ emphasis on policy and procedure manuals and associated documents that support monitoring and compliance activities, including audits, incident reports, checklists, mandatory training attendance charts, patient charts and skills pathways. Portfolios developed for each staff member that contained training records, performance appraisals and AHPRA registration status provide an example of a formalised compliance process undertaken to facilitate staff learning. These compliance artefacts also communicate standards and are frequently referred to during routine work discussions with staff. For example, the participants privileged the management of incident reports when describing the routines of their day. Incident reports provide a means for staff to communicate anomalies in the process of care, including the application of policy to practice, and bring together (Sheehan et al., 2017) the people who were associated with the incident and its management. Incident reports and related artefacts draw on the language of policy, and provide a means for the legitimate power\textsuperscript{17} associated with policy and procedure to be shared and embedded in work practices. The knowledge produced from interactions generated by incident reports also contributes to NUMs’ knowledge base of staff performance, identified previously (Section 8.3.3) as a relevant foundation for their learning facilitation practices.

While the value of workplace artefacts as learning tools is widely acknowledged (Billett, 2014; Sheehan et al., 2017), less is known particularly about NUMs’ development of artefacts to facilitate staff learning. One of the artefacts most commonly cited by the participants in this research was the ‘read and sign’ sheet, a document created by participants for staff to complete once they had read a policy or

\textsuperscript{17} Legitimate power: power that is attributed to position in a hierarchy (French & Raven, 1959)
procedure. The presence of ‘read and sign’ sheets communicated the importance of the policy document to staff, and staff engagement with it to the participants, forming a ‘paper trail’ in case compliance became an issue. The prominent location of ‘read and sign’ sheets with other work documents such as communication books and rosters brought staff together, providing opportunities for interaction and deliberation about the policy’s practice implications. These artefacts facilitated learning of valued practices beyond NUMs and CNE’s normal working hours. Participants valued the ‘read and sign’ sheet for its power to ensure their staff read the policy/procedure, with the expectation that staff would apply the new policy or procedure to practice.

NUMs’ obligations to ensure staff apply policy to practice are among the defining roles of their work (NSW Health, 2010b). Strategies undertaken by NUMs to enable this to occur beyond basic communication are less well recognised. My research found that NUMs actively translate policies and procedures into meaningful terms to facilitate learning and application to practice in their individual units. In particular, they develop artefacts as tools to support this process. Policies and procedures which are general in nature often require adaptation to achieve relevance to each clinical area. For example, some participants extended the ‘read and sign’ sheet by developing ‘how to do’ manuals that clearly explained how various policies and procedures were to be applied to practice in their specific context. These artefacts were designed to facilitate learning and application of practices within the local context, and drew on language and routines that were familiar to staff to facilitate learning of new practices. Other informal artefacts that aimed to assist staff to transform policy to practice were found in informal memos, checklists, and notes which were observed on meeting room whiteboards and noticeboards. While these artefacts are common to workplaces (Sheehan et al., 2017), their use by NUMs as a means to facilitate staff learning and application of policy to practice is not recognised in the academic literature or in professional sources, for example the Public Health System Nurses and Midwives State Ward 2017 (Industrial Relations Commission of NSW, 2017).

Other artefacts were designed specifically with learning in mind. The participants’ priorities and perspectives on staff learning and performance were reflected in these artefacts. They developed resource folders for trainee team leaders that included
information, case studies, questions and worksheets that promoted learning of hospital and administrative routines. They also developed worksheets, induction programs, resource libraries and folders to support staff learning. In addition to developing these resources, the participants also evaluated, maintained and encouraged their use by nursing staff. Development of these resources, as artefacts, reflected the participants’ identities as managers concerned with compliance, and as nurses who cared about enabling staff development and fostering staff confidence to provide safe quality care to patients. They did not, however, clearly identify these practices with an educator identity.

As a central artefact that carried significant implications for learning was the unit roster. While a tool for organising work, the unit roster also mediated team composition, including skill mix and ratios of experienced to less experienced staff. In developing a roster, NUMs created opportunities for learning, as work was divided between staff according to level of skill, and opportunities were provided for staff to learn from others, and from challenges that were inherent in the work allocated for each shift. NUMs were aware that the roster mediated team composition and shift relationships that yielded a real potential for learning.

Research on the process and implications of rostering is not new. Rosters in hospitals have been identified as cognitive artefacts: refined representations of what is valued in workplaces, and as tools for reducing uncertainty (Nemeth, O'Connor, Klock & Cook, 2006); as exerting a profound influence on unit and hospital performance as well as nurse retention and attraction, (Silvestro & Silvestro, 2008), as associated with the development of an effective staff culture, teamwork and standards of care (Lemke, Brennan, Soo Hoo & Shutke, 2017) and as a place to list clinical skills and needs and teaching responsibilities of staff (Henderson, 2011). However, these studies did not identify the roster as an artefact of learning, as a tool for developing teams that communicate and enable opportunities for social learning. In illuminating the role of NUMs in creating learning opportunities through roster development, my research contributes uniquely to the existing body of literature.

This research revealed NUMs’ frequent use of artefacts to influence learning within daily workplace routines. Development of artefacts is complex, and is influenced by
NUMs’ identity, conceptions of staff learning, unit requirements, and personal and positional forms of power. NUMs use policies and procedures, and associated controls such as audits and checklists, to influence staff performance, drawing on the power that is embedded in these items and processes. NUMs draw on more personal forms of power to develop artefacts designed to transfer the meaning of formal polices into a form that facilitates staff learning and application to practice, often at the point within the routines of care that the learning is required. NUMs also draw on their knowledge of staff performance to develop specific artefacts that facilitate learning in their clinical workplaces as the need arises.

In this section I have presented the complex and unique nature of NUMs’ learning facilitation practices in clinical workplaces. Three key dimensions of learning facilitation practices were discussed: with individuals, within teams and through artefacts. A summary of key findings from this section is included below in Table 8.1: NUMs’ Learning facilitation practices: Key findings. NUMs are motivated by policy requirements, and draw on policy and related documents as key resources for their learning facilitation practices. Within this formalised policy environment, NUMs’ learning facilitation practices are justified and shaped by their identity, conceptions of staff learning, understanding of staff performance and motivations. Power was identified as a key resource used by NUMs to enact their learning facilitation practices. Power, in its positional and personal\textsuperscript{18} forms, is used in individual and complex ways by NUMs to shape learning opportunities for staff within each clinical workplace.

\textsuperscript{18} Personal power is associated with individual attributes regardless of their position (French & Raven, 1959).
Table 8.1: NUMs’ Learning facilitation practices: Key findings

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Existing research evidence</th>
<th>Contribution from my research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitating learning with individual staff</td>
<td>Confined to clinical instruction practices of CNE and mentors (Scott &amp; Spouse, 2013; Sweet &amp; Broadbent, 2017) NUMs support of individual learning as empowerment (Sklitt, Hagerman, Strömberg, &amp; Engström, 2015; Van Bogeart et al., 2015).</td>
<td>NUMs’ practices in facilitating individual learning within the ordinary routines of care. Practices include providing direct incidental instruction, demonstrating procedures, seeking to facilitate confident practice.</td>
</tr>
<tr>
<td></td>
<td>Preceptors value NUMs’ oversight and support of precepting (Ward &amp; McComb, 2017). Oversight of precepting among generic roles of NUMs.</td>
<td>NUMs’ learning facilitation practices in oversight of preceptor relationships. Practices include seeking opportunities to influence precepting, adopting well-reasoned approaches to selecting preceptors and monitoring precepting relationships in their units, providing structure and oversight to precepting relationships, working with preceptors to enable new staff to effectively transition into their roles.</td>
</tr>
<tr>
<td></td>
<td>Studies limited to experience of mentee (McCloughen, O’Brien, &amp; Jackson, 2009).</td>
<td>NUMs’ practice in mentoring team leaders.</td>
</tr>
<tr>
<td>Facilitating learning within teams</td>
<td>NUMs’ role in supporting collaboration and providing feedback to staff in teams (Ammouri et al., 2015)</td>
<td>NUMs’ practices in influencing learning within teams: Routine team meetings Case and incident discussions Guided reflection and problem solving.</td>
</tr>
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<td></td>
<td>Staff members views on NUMs’ group reflection practices (Matsuo, 2012).</td>
<td>NUMs’ group reflection practices from the NUMs’ perspective.</td>
</tr>
<tr>
<td>Facilitating learning through artefacts</td>
<td>Artefacts are known to facilitate clinical learning (Billett, 2014; Sheehan et al., 2017).</td>
<td>NUMs’ practices in influencing learning through the design and promotion of staff engagement with artefacts: Learning artefacts designed by NUMs specifically for learning Learning artefacts that are ‘hidden’ within the routines of care.</td>
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8.5 Power

This section explores NUMs’ unique and dynamic use of power to support their learning facilitation practices. Underpinned by their identity, conceptions of staff learning, knowledge of staff performance, and motivations, NUMs use power to drive their facilitation of staff learning. In the Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1), power occupies a central and dominant position. Power links the foundations of NUMs’ learning facilitation practices, including identity, conceptions of staff learning, motivations and knowledge of staff performance, to the enactment of their learning facilitation practices. This study has
revealed that NUMs’ use of power to influence learning is unique, reflecting the diverse foundations and contexts that shape their individual learning facilitation practices. Sources of power that most influence NUMs’ learning facilitation practices include the legitimacy that is inherent in NUMs’ management roles as well as contextual factors including NUMs’ membership of powerful groups (such as senior management groups and multidisciplinary quality improvement groups), access to authoritative information including policies, and affiliation with the official work of the organisation. The nature and extent of NUMs’ power is also influenced by personal attributes, staff relationships, and their expertise and knowledge of relevant clinical areas. This section begins with an overview of theoretical perspectives on power in management work, as a basis for deeper interpretation of power as a driver for NUMs’ learning facilitation practices.

8.5.1 Theoretical perspectives and their relationship to NUMs’ learning facilitation practices

Power, as a recognised influence on human performance, has been the focus of scholarly research and theorising throughout history. Scholars and researchers from the disciplines of philosophy, history, sociology and psychology are among those who have sought to understand this abstract and important concept (Reed, 2013). Traditionally, power has been viewed as a repressive force related to domination of others within bureaucratic hierarchies, often described as ‘power over’ others (Lukes, 2005). More recently power has been viewed more positively as the capacity to achieve mutually beneficial objectives, reflecting ‘power to’ achieve objectives (Kanter, 1977). Kanter’s classic definition of power as “the ability to mobilise resources to get things done” (1977, p. 66) reflects the ‘power to’ distinction and introduces the idea of power as an organisational resource. Both of these perspectives, ‘power over’ and ‘power to’, highlight the intrinsic capacity of power to influence an attribute of an individual or a team and to achieve outcomes both of which are relevant to exploration of NUMs’ learning facilitation practices.

Power is inherently relational. Power cannot exist within an individual in isolation from others; it is always relative to a relationship between people, and power does not exist if others do not see it as being of value (McShane, Olekalns, Newman, & Travaglione, 2016). This creates a situation of dependence between those who have
greater access to power and those who have less. The perception and use of power, its value and influence is dependent on the nature of relationships, and in this research of the relationships between NUMs and nursing staff.

Power is also essential for the achievement of organisational goals (Robbins, Judge, Millett & Boyle, 2016). Power has particular relevance to hospitals as organisations where structural configurations create hierarchical relationships to enable the achievement of organisational aims. Structural power has been defined as the power that is inherent in organisational hierarchical relationships (Kanter, 1977). Structural power was clearly evident in NUM–staff relationships that characterised the work context in which this research was conducted.

However, structural power represents only one source of organisational power. An alternative view of power is presented by Foucault (1979), who views power as a naturally occurring force that has no ownership or visibility but is both a product and a source of knowledge that guides behaviour, beliefs and choices made by individuals and communities in everyday life. Foucault rejects the notion of power as a hierarchical or repressive force and instead considers power to be found in the structures of everyday life. Foucault argues that, by being aware of power in its embedded form, and how it shapes our lives, we can become more autonomous; we can question sources of power and make choices about whether we will abide by the norms that it projects on our lives. As people adopt values and behaviours determined by these invisible power structures, they become normalised: people do what is expected because they value these norms. Visible adoption of these norms, when observed and known by others, becomes a source of knowledge that then informs their behaviours and values. According to Foucault, power structures also provide a source of self-knowledge as people monitor their own behaviours in relation to known norms. Knowledge, developed alongside these power structures that influence behaviour and values, does not create uniformity but rather enables and liberates individuality as difference becomes more marked against the ‘standard’. For example, clinical units have particular routines and norms such as procedures for participating in case discussions. Staff understand what to expect and how to behave when they attend. They learn to adapt to variations that might occur during meetings such as how to deal with interruptions. These norms, as forms of power, are repeated and are adopted by other staff who attend case discussions in the
future. They also serve as a basis for staff to monitor their own performance during the meetings. The relationship between power, knowledge and self is perpetuated through the development of case presentation norms and the manner in which the case discussion is conducted. However, these norms can be challenged, and new norms developed to guide future participation.

This research has identified a range of embedded power structures that influence staff performance. Policies, procedures, and a range of activities and structures that seek to monitor compliance, also contribute to the norms that guide individual and team practice. Examples of surveillance strategies that resonate well with Foucault’s (1979) work include audits and surveys, and incident reporting systems. Surveillance also includes other people. In hospitals, the work of individual staff is constantly under the surveillance of patients, families, other nursing staff and members of the wider healthcare team.

While Foucault’s perspective portrays power as a contextual influence, a significant finding from this research was that NUMs use their individual power to influence learning. French and Raven (1959), in an older but still widely cited study, identified five sources of power in organisations: legitimate, reward, coercive, expert and referent. These sources of power, found to be integral to NUMs’ learning facilitation practices, can be more deeply understood in relation to their positional (legitimate, reward and coercive) or personal (expert and referent) origins.

Positional forms of power including legitimate, reward and coercive power are dimensions of power available to individuals by way of their position in an organisational hierarchy. Legitimate power includes authority to make decisions on matters that are significant to employees (French & Raven, 1959). Legitimate power exercised through information control can influence others based on the nature of the information provided, or withheld, or by the timing and manner of communication. Reward power, the authority to distribute rewards in terms of payment, recognition or opportunity, is also embedded in positions carrying legitimate power within a hierarchy (French & Raven, 1959). Finally, coercive power, in contrast to reward power, concerns the capacity to punish or discipline others who do not conform to requirements. It also relates to the ability of teams to punish members who do not conform (French & Raven, 1959). While each of these dimensions of power reside in
the power holder’s position, the nature of the power is uniquely formed by relationships and the value attributed by recipients to anticipated effects of the power holder’s influence. In my research, the participants were explicitly aware of the nature and scope of their influence on staff through the power afforded to them by their position within the hospital hierarchy.

Positional power, including legitimate, reward and coercive power, enabled the NUMs in this research to carry out their learning facilitation practices. The NUMs’ legitimate power is inherent in their management roles, defined by their formal position description and their identification as unit managers, a designated representative of the organisation’s formal administrative structure. A key source of the participants’ legitimate power was the policy and procedure environment. The language and actions of policy dominated their descriptions of their work, for example, “compliance” and “mandatory” were common terms alongside accounts of activities that focused on monitoring compliance and identified their affiliation with the official work of the organisation. Policies, procedures and related language, activities and artefacts reflected the legitimate power held by the participants. Their status as ‘holders’ of legitimate power was also supported by their membership of other groups that held power, including the wider network of senior health professionals who supported the work of the unit. The participants’ legitimate power opened opportunities for use of other forms of positional power. Reward power enabled the participants to provide opportunities for staff to attend learning events beyond those that were mandated by the organisation, and coercive power was sometimes used to ensure compliance. The participants were familiar with sources of positional power and explicitly emphasised activities that were underpinned by positional power.

Personal power, including expert and referent power, is found in personal attributes of employees who may or may not occupy a designated position of power (McShane et al., 2016). Expert power is sourced from individual knowledge, expertise and experience that is valued by others. It can also relate to an individual’s perceived ability to make and justify the right decisions, and is suggestive of trust. Referent power originates in individuals simply because others like them and see them as a resource for achieving their goals, qualities that are also conducive to trust, and are based on interpersonal attributes (French & Raven, 1959).
In my research, the participants’ use of personal power was integral to their work in facilitating learning. Their use of power was mediated through their identities, as nurses first (who cared) and managers second; the value they attributed to staff compliance with safety and policies; their understanding of their staff members’ capabilities; and their motivations to ensure safe care and to support the development of staff confidence and a sense of belonging. These relationships are represented in the model (Figure 8.1). The trunk, as supportive structure, represents power in its different forms, as a source of energy that unites the foundations of NUMs work with their learning facilitation practices. The NUMs’ use of referent power is enabled and enacted through their engagement with staff members in a non-threatening and collegial manner, and expert power is enacted through their use of knowledge of clinical practice to be able to guide staff performance.

My research has revealed a nuanced, complex, dynamic and individual nature to NUMs’ use of power in their facilitation of staff learning. In this research, power, in its personal and positional forms, as a capacity to influence staff, is enacted by the NUMs both through their practices, and through their interactions with others. The NUMs’ commitments to staff and staff participation in the work of the unit motivates their learning facilitation practices and shapes their use of power in an individual, situational and fluid way. In the following section I present a deeper discussion of NUMs’ use of power as it is enacted within the routines of their work and in combination with positional power to facilitate staff learning.

8.5.2 Power as a driver for NUMs’ learning facilitation practices

This research has revealed that NUMs’ use of power to facilitate learning is complex, situational and personal. Power, in its different forms, is used in different combinations and circumstances and is represented in the model (Figure 8.1) by the trunk of the tree. NUMs’ identities, conceptions of staff learning, knowledge and motivations shape how power is used to influence learning. For example, legitimate power (power inherent in their position) and referent power (power attributed to personal disposition) are both used to develop networks with other health professionals as a means of providing staff with access to learning opportunities. Expert power (power attributed to known clinical expertise), legitimate power and referent power are drawn on to instruct staff members on how to perform a clinical
procedure. In this research, each participant’s use of power to facilitate learning was unique and situational. The blending of sources of power in response to different situations to facilitate learning was an interesting and significant finding from my research that adds new knowledge to current understanding.

An important finding from this research was the dissonance between NUMs’ high level of responsibility for standards of clinical work and their limited access to sources of positional power that enabled achievement of those clinical standards. The participants in this research were well acquainted with the scope of their positional power, and emphasised its use as a resource for influencing staff learning. However, deeper interpretation of their accounts identified a propensity for tacit use of personal sources of power, including expert and referent power, to supplement positional power to influence learning. While the dissonance between power and responsibility in NUMs’ work has been identified (Paliadelis, 2008), my research revealed a deeper and more nuanced appreciation of NUMs’ use of power, and specifically how personal power is used in response to constraints on access to positional power to facilitate learning. For example, despite being responsible for the competence of staff in their unit, the participants did not possess the level of legitimate power to approve training resources for their unit, or extra staff to provide relief to others for training purposes. They lacked the positional power and authority to make decisions about resources that enabled fulfilment of staff professional development requirements. Instead they drew on personal forms of power to facilitate staff learning from the human and material resources available within the unit.

Furthermore, despite having limited access to positional power, the participants in this research exercised a high degree of discretion in their use of available power. In the following section, NUMs’ specific use of power is discussed as a key resource for their learning facilitation practices.

8.5.3 NUMs’ use of power to facilitate learning

The Living Systems Model of NUMs’ Learning Facilitation Practices (Figure 8.1) identifies three dimensions of NUMs’ learning facilitation practices: with individuals, within teams and through artefacts. NUMs’ used positional power, including legitimate, coercive and reward power, and personal power, including referent and expert power in different combinations within the three dimensions of
their learning facilitation practices: with individuals, within teams and through artefacts. Their use of power to influence learning within these three dimensions forms the basis of the following discussion.

**NUMs’ use of power to facilitate learning: With individuals**

The participants’ facilitation of individual learning generally occurred in response to incidental learning needs. During these encounters the participants drew on both personal and positional sources of power to provide direct instruction. They often used personal power to downplay the constraints imposed by positional power, and to facilitate relationships that were conducive to learning. In guiding a staff member through a clinical procedure, for example, the participants drew on expert power in sharing their knowledge of clinical work to influence the staff member’s skill development, and referent power which supported a relationship that enabled the staff member to feel comfortable. The participants adopted a sensitive and participative approach in an effort to modify the negative effects of their positional power on the learning encounter, to engage the staff member in the learning activity, and to increase their influence through personal forms of power. These one-to-one encounters for the purpose of learning also provided opportunities for relationship development which allowed personal power to develop as the activity brought the staff member and the participant together. Furthermore, the participants’ presence in the clinical unit, attending handovers, working with staff and undertaking ‘rounds’, also provided opportunities for relationship development and enhancement and enactment of personal (referent) power during encounters with individual staff members.

However, while expert and referent power were inherent in these learning facilitation encounters, the participants’ positional power, their access to rewards and punishment, was constant. Personal forms of power reduced some of the dissonance between the positional power held by the participants and by their staff, but the participants’ capacity to influence learning and performance through access to positional power was always present. The combinations of personal and positional power employed varied according to the situation, and the participants had a tacit understanding of how much personal and positional power was needed to influence
learning in different situations. This research identified that NUMs’ use of positional power dominates situations where staff performance is associated with patient safety, and personal forms were more often used when learning is related to less acute situations, such as how to operate a computer or perform a routine clinical task.

NUMs’ use of power to influence learning with individuals is based largely on their use of personal power. One-to-one learning facilitation encounters provide opportunities for referent power to be exercised, enabling relationships to develop. Personal power is also used by NUMs to modify the influence of positional power, which has the potential to constrain learning within an encounter.

**NUMs’ use of power to facilitate learning: Within teams**

NUMs’ use of power to enable learning within teams varies according to the purpose of the team activity. This research identified two common team situations where NUMs facilitate learning: routine meetings and case discussions.

As discussed in Section 8.4.2, the participants in this research did not explicitly recognise their learning facilitation role during team meetings. The participants generally considered these meetings as opportunities for information exchange. However, this research identified NUMs’ unique use of power to facilitate learning during team meetings. Staff meetings were occasions where the participants’ positional power, always present, was most apparent. The participants led the meeting guided by their agenda, were centrally positioned in relation to the team, and were differentiated from staff in other ways such as by their way of dress and accompanying folders and papers. The participants used their legitimate power to decide what information should be shared with staff; and to garner staff attention to policies and decisions that affected their work. Coercive power was used as the consequences of non-compliance were emphasised. The participants’ use of positional power was explicit in staff meetings. However, they also drew on personal power, by addressing staff by name and seeking their input, using conversational language, humour, and participating as a team member during discussions, for example referring to ‘us’ rather than ‘you’. This approach engendered discussion, and enabled sharing of perspectives. It was during these shared discussions that the participants were able to facilitate learning through modelling and by engaging staff
in problem solving, using inclusive language to empower staff and remove constraints imposed by their positional power. However, while the participants sought to engage staff in meaningful decision making and discussion during staff meeting, positional power dominated these meetings.

Case and incident discussions provided another important opportunity for learning facilitation. Similar to the staff meetings described above, the participants’ positional power was constant during these discussions. However, unlike routine meetings, they viewed these as shared learning events, and gave presenting staff members a central position in the meeting. The participants guided the discussion by questioning and encouraging reflection on the topic of the presentation. The participants used referent power by cultivating effective relationships during the meeting, reward power by encouraging and recognising good work, and expert power to contribute to the knowledge that was generated during the discussion. They used their positional power during these discussions to foster compliance and to orient the group to policy. The structure and nature of the case discussion approach provided an opportunity to nurture relationships and facilitate learning through personal and positional forms of power.

**NUMs’ use of power to influence learning: Through artefacts**

NUMs’ use of artefacts, represented in the model (Figure 8.1) alongside learning facilitation practices ‘with individuals’ and ‘within teams’, also reflects their use of power to facilitate learning. Artefacts found in this research included policy manuals, memos, read and sign sheets, and staff performance folders, as well as tools that were associated with policy compliance such as audits, reports and other tools that monitored compliance. The participants revered these artefacts, for which they were responsible, and which connected their work to the official work of the organisation. Artefacts complemented and supported the power inherent in participants’ position in the organisation.

The participants drew on the power of formal artefacts, such as policies, to facilitate learning by promoting their value as definitive sources of information, but also as sources of punishment if non-compliance should occur. However, the participants also used personal power to modify the formal power associated with policies, for example by engaging staff in critique of policies and of their application to the
clinical unit. This action reduced the dissonance between staff and the formal power of the policy and engaged staff in a way that facilitated familiarity and learning.

One of the most routinely used artefacts for participants’ learning facilitation practices was the skills pathway: a catalyst for participants’ learning facilitation work used during induction and ongoing performance review. Skills pathways belonged to a wider group of organisational artefacts that represented and reflected the legitimate power of the organisation, and served to embed organisational policy into the work of the unit. The participants valued the skills pathway tool, as it guided their work in managing staff performance, and its affinity to policy provided them with a significant source of legitimate power that was used to influence staff performance planning. The skills pathway tool also brought the participants and their staff together, and through discussion around performance enabled the participants to use personalised forms of power, referent and exert power, to influence learning.

The participants also drew on personal power to moderate the formal power of policies by developing tools such as ‘how to’ folders that drew on their knowledge of the unit, the language used, the staff routines and specialisation, to enable staff to understand and apply formalised policies to the workplace. They drew on their expert power in designing and developing the content of these artefacts, and on their referent power in adapting and translating official language and meaning to the needs of the local team. However, as discussed in the previous sections, the participants’ access to positional power was a key influence that underpinned the communication that was conveyed through artefacts.

In this section I have discussed power as a significant driver of NUMs’ learning facilitation practices. NUMs are familiar with several different sources of power through their status, their work context and their identity, and their use of power is guided by their conceptions of staff learning, motivations and knowledge of staff performance. NUMs use power in unique, dynamic and complex ways, as they respond to the diverse situations in their workplaces and to the specific learning needs of staff. Positional power is always present as NUMs facilitate learning. However, this research found that positional power, especially in relation to decision making and resource allocation, is limited and NUMs draw on personal sources of power – referent and expert power – to enable learning in response to these
constraints. Personal power, especially referent power, is developed as NUMs build relationships with staff. Personal power is used to enhance staff engagement and to offset the dissonance produced by hierarchical relationships, aiming instead to foster collegial relationships in which learning can occur. This is a significant finding as personalised forms of power are associated with leadership behaviours (Day & Legatt, 2015) which support learning in clinical workplaces (Curtis et al., 2011). Furthermore, NUMs use of power to influence learning in this way is poorly represented in the academic literature. This research found that NUMs’ use of personal and positional power to facilitate learning with individuals, within teams and through artefacts seeks to enhance staff learning, confidence and sense of belonging, to traverse the policy–practice void, and to reduce the dissonance between the legitimate power of the organisation, such as that represented by policies, and the work to be done. This new understanding of NUMs’ nuanced, dynamic and individual use of power to facilitate learning is an important outcome of this research.

8.6 Conclusion

In this chapter I have coalesced my research findings and have presented these coalesced findings holistically as a Living Systems Model of NUMs’ Learning Facilitation Practices. I have identified three key dimensions of NUMs’ learning facilitation practices: context, foundations, and power as well as the learning facilitation practices themselves. My research found that specific contextual factors arising from the wider healthcare environment, the hospital and the unit shape the enactments foundations of NUMs’ learning facilitation practices which are also influenced by their identity, conceptions of staff learning, understanding of staff performance, and motivations. NUMs’ use of power was found to be the mainstay of their learning facilitation practices, enacted with individuals, within teams and through artefacts. These findings extend existing knowledge and challenge assumptions about NUMs’ work that consider their learning facilitation practices to be redundant or confined to organising formal training and professional development opportunities. My research found that NUMs conceptualise, plan and engage in learning facilitation practices throughout their daily routines, even if they have limited explicit awareness of their practice in these areas. Significantly, this research
contributes an understanding of NUMs’ use of power, especially in its personalised form, as a key resource for facilitating learning in clinical workplaces.
Chapter 9: Conclusion

9.1 Introduction

This thesis was constructed on the premise that Nursing Unit Managers’ (NUMs’) central positions in clinical workplaces open up multiple opportunities for facilitation of staff learning within normal work routines including those of patient care. I reasoned that NUMs’ learning facilitation practices are integral to their clinical management roles, particularly their responsibilities around assurance of quality patient care. However, beyond the organisation of formal learning experiences, I found NUMs’ learning facilitation practices to be poorly understood in contemporary literature, obscured by an assumption that learning facilitation aspects of their work has become redundant with the transfer of nursing education to the tertiary sector in the 1990s. This research was built on the premise that NUMs’ learning facilitation roles have not disappeared but are largely hidden within the routines of their work and are integral to the achievement of safe and high-quality patient care. The aim of this research was to gain deeper understanding of NUMs’ practices in facilitating learning in clinical workplaces.

My overarching research question was:

How do Nursing Unit Managers facilitate learning in clinical workplaces?

To achieve this understanding, four sub-questions were developed to guide the research process:

1. What contextual factors influence Nursing Unit Managers’ learning facilitation practices?
2. How do Nursing Unit Managers perceive their role in facilitating learning in the clinical workplace?
3. How do Nursing Unit Managers’ perspectives on staff learning shape their learning facilitation practices?
4. What activities do Nursing Unit Managers undertake to facilitate staff learning?
A process of philosophical hermeneutic enquiry was used to develop a deeper understanding of NUMs’ learning facilitation practices as performed within the ordinary routines of their work. This research revealed the complex situated and embodied nature of NUMs’ learning facilitation practices. Contextual influences from within and beyond the clinical unit that significantly shaped NUMs’ learning facilitation practices have been described highlighting the situated nature of NUMs’ learning facilitation practices. Illumination of unique practice foundations including NUMs’ individual identity, conceptions of staff learning, knowledge of staff performance, and motivations revealed the uniquely embodied nature of each NUM’s learning facilitation practices. Further, these practices were found to be enacted in three key ways as they occur with individuals, within teams and through artefacts. Finally, NUMs’ access to and unique use of power was revealed to drive their learning facilitation practices. This new nuanced understanding of NUMs’ learning facilitation practices makes a significant contribution to existing knowledge around NUMs’ influence on learning and performance in clinical workplaces. This is important as performance of safe and quality care has become a matter for concern in healthcare in Australia and around the world and this safe and quality care is largely underpinned by staff learning.

The key findings of this research have been coalesced to form a Living Systems Model of NUMs’ Learning Facilitation Practices. This model represents three key dimensions of NUMs’ learning facilitation practices: Context, foundations, and power, as well as specific learning facilitation practices. The model will assist NUMs to reflect on and potentially enhance their own practices by making the implicit aspects of their work explicit. Academics seeking to enhance programs of learning in NUMs’ education can use the model to inform curriculum development. Furthermore, enhanced knowledge of the depth and scope of NUMs’ practice enables further definition and defence of the role of NUMs within the Australian healthcare system.

Figure 9.2 (below) illustrates the relationship between the dimensions of the model and the research questions.
The central thesis I have developed is:

NUMs’ learning facilitation practices are complex, fluid, situated, embodied and consequently uniquely practiced. NUMs’ access to and use of power is integral to and uniquely shapes their learning facilitation in clinical workplaces. Unique blends of personal and positional forms of power are used by NUMs to influence staff learning with individuals, within teams and through artefacts. Their use of power is shaped by the workplace context, NUMs’ identity, conceptions of staff learning, knowledge of staff performance, motivations. Finally, NUMs’ roles in learning facilitation are substantial and significant, and are embedded within the ordinary routines of their work.
In this final chapter, I present key contributions of this research to professional practice, university education and the nursing profession. A critique of the research approach is provided and the credibility of the findings established. This chapter concludes following a final discussion on the implications of this study for further research.

9.2 Summary of the contribution of this research

A Living Systems Model of NUMs’ Learning Facilitation Practices is presented as the final product of this research. This research illuminates the complex, multifaceted, contextual and unique nature of NUMs’ learning facilitation practices in acute care clinical settings. This research identifies three key dimensions of how NUMs’ implement their learning facilitation practices, that is: with individuals, within teams and through artefacts. These activities, which are represented in the model (Figure 8.1), occur within routine work activities, such as during incidental encounters between NUMs and their staff, during intense periods of staff learning such as during new staff or team leader induction, and during interactions that occur within routine unit staff meetings. Through the development and use of artefacts, NUMs seek to facilitate staff learning vicariously and to support and sustain ongoing learning within the nursing team. These findings explicate often informal and understated learning facilitation practices that are integral to NUMs’ work and contribute to a deeper understanding of how NUMs influence staff learning through their ordinary work routines.

The model (Figure 8.1) also illustrates key contextual and foundational factors that support, precipitate and sustain NUMs’ learning facilitation practices. Contextual factors identified by this research included those within the unit, the hospital, as well as the wider healthcare environment. Foundational factors relate to the frame with which each NUM approaches their learning facilitation practices, including their conceptions of staff learning, knowledge of staff performance, identity and motivations. Knowledge of contextual and foundational factors that influence and shape NUMs’ learning facilitation practices have not been explored in the literature previously. The more nuanced knowledge of these factors provided by this research opens up possibilities for better understanding of constraints and opportunities that
influence NUMs’ learning facilitation practices. This provides an important basis for NUMs professional development and reflection on practice.

Finally, unique and individual forms of power emerged as dominant drivers of NUMs’ learning facilitation practices. NUMs’ familiarity with sources of positional and personal forms of power drives their learning facilitation practices in unique and individual ways. NUMs’ use of positional and personal sources of power, often simultaneously, is shaped by their identity, conceptions of staff learning, knowledge of staff performance, and motivations. The complex, nuanced and particular way NUMs use power to facilitate learning illuminated in this research, makes a significant contribution to knowledge of NUMs’ learning facilitation practice.

Development of a framework for understanding NUMs’ learning facilitation practices

Another important outcome from my research is a theoretical framework that was developed to enable understanding of NUMs’ learning facilitation practices. The theoretical framework has been described in Chapter 3 (Section 3.4). This framework, which coalesces practice, management and workplace learning theories, provides a new and powerful lens for interpreting experiential texts around NUMs’ learning facilitation practices. The theoretical framework enables NUMs’ learning facilitation practices, including their use of language, artefacts and relationships, to be better visualised and understood. Key aspects of this framework including ‘practice architectures’ (Kemmis et al. 2014), domains of management work (Mintzberg 2009) and Eraut’s theories of informal learning (2004) and learning at work (2012) enabled NUMs’ learning facilitation practices to be more deeply understood in relation to the concepts of practice, management and workplace learning. The contributions of the theoretical framework to the findings of this research are detailed below in Table 9.1: Research findings through the lens of my theoretical framework.
Table 9.1 Research findings through the lens of my theoretical framework

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<td>Context: the unbounded environment comprised of unit, organisational, national and global influences on NUMs’ learning facilitation practices including policies, regulations, technology etc.</td>
<td>Mintzberg’s (2009) identification of the unit organisation and wider environment as the ‘mileu’ of management work. Kemmis et al. (2014) inclusion of the social political arrangements that influence practice. Eraut’s (2004, 2012) focus on the work environment.</td>
<td>Key contextual influences included: Policy and regulatory body, Nursing profession Unit specialisation Hours of operation Availability of networks</td>
<td>Context</td>
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<td>Conceptualising the unit context: Understanding unit work, generating and using information, communicating. (The quality and nature of the work, use and generation of information and knowledge of practice to support decision making and planning in relation to learning).</td>
<td>Mintzberg’s (2009) information plane, where knowledge is generated stored and communicated. Kemmis et al. (2014) language or ‘sayings’ that constitute, communicate and sustain practice.</td>
<td>Design conduct and use of audit information. Seek opportunities to understand staff performance (knowledge and skill) Support staff acquisition of knowledge for later sharing; Identify and translate policies; Develop unit knowledge resources (artefacts)</td>
<td>Foundations: Knowledge of staff performance</td>
<td>Legitimate positional power enabled access to knowledge sources Artefacts represented knowledge and information Foundations: Conceptions of staff learning Motivation Identity</td>
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<td>Developing a learning community: Leading, networking, shaping the learning context, communicating (Working to develop a professional learning community).</td>
<td>Mintzberg’s people plane: where NUMs plan and interact with others to create learning opportunities (including scheduling) Kemmis et al. ‘relatings’ influence the social conditions under which staff practice. Eraut (2004,2012): a supportive social context that provides opportunities for learning including challenge and support (including allocation of work).</td>
<td>Allocate staff (in relation to skill mix) to shift teams that create opportunities for learning in a supported environment; Convene team meetings and supported learning though problem solving and case discussion; Network with interprofessional team to facilitate staff learning opportunities; Facilitate staff knowledge sharing within teams; Develop and promote artefacts that support individual and team learning and overcome temporal limitations; Guide team based problem solving; Guide team reflection on problems; Used personal (expert and referent) power to engage staff in learning, and to modify the effects of positional power.</td>
<td>Learning Facilitation Practices: Teams</td>
<td>Legitimate power constant. Personal power, expert and referent underpinned collaborative team interactions. Artefacts promoted and designed to support team learning</td>
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<td>Participating in the work of the unit: Working alongside staff, communicating (NUMs working directly with staff to seek opportunities to facilitate performance).</td>
<td>Mintzberg’s action plane Kemmis et al. ‘doings’ acting to influence staff and shape the factors that constitute their practice., and ‘relating’ (from above) in working through the power structures that contextualise their roles. Eraut: Working directly, providing support and an appropriate level of challenge, and enabling development of confidence.</td>
<td>Provide direct instruction in response to incidental learning needs in a participative way and drawing on referent and expert power; Seek to enhance staff confidence through support of skill development; Seek opportunities to influence precepting relationships; Mentor team leaders, support during challenging tasks; Create and promote artefacts to support individual learning; Use formal artefacts such as skill pathway to mediate discussion and influence; Use positional but mostly personal and referent power to address incidental learning needs.</td>
<td>Learning Facilitation Practices: Individuals</td>
<td>Legitimate power constant. Personal power, expert and referent underpinned interactions with individual staff. Artefacts created and promoted to support individual learning</td>
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Table 9.1 presents key findings from this research and their relationship to the theoretical framework that was used to guide text interpretation. In Column 1, key dimensions of the theoretical framework: context; conceptualising the unit context; developing a learning community; and participating in the work of the unit are presented. These dimensions are defined further in relation to their theoretical foundations in Column 2. Column 3 presents key findings within each of these dimensions. Columns 4 and 5 present the dimensions of the Living Systems Model of NUMs’ Learning Facilitation Practices, as an outcome of the coalescence of findings presented in Column 3. These final two columns represent two levels of interpretation. Column 4, level 1 presents findings that emerged from initial interpretation of experientials texts: Context; Foundations (knowledge of staff performance); Learning facilitation practices: teams and individuals. Column 5 includes findings from deeper interpretation of findings presented in Column 4, as an outcome of interpretation based on question and answer in the philosophical hermeneutic tradition. Nursing Unit Managers’ use of power, and of artefacts emerged as significant themes that were embedded across the findings, and were included as key dimensions within the final Model. Similarly, NUMs conceptions of staff learning; motivation; and identity were revealed as key embedded themes, and as personal and individually defined themes were included among the foundations of NUMs learning facilitation work alongside knowledge of staff performance. Findings from Level 2 interpretation did not emerge from interpretation based on the theoretical framework as neatly as those listed in Level 1.

The theoretical framework provided a useful lens for viewing NUMs’ work. In particular Mintzberg’s theory of managing defined the domains of management work, upon which Kemmis et al. ‘Practice architectures’ (2014) and Eraut’s (2004, 2012) theories of learning at work could be incorporated. Findings presented in Column 3 that defined the context of NUMs learning facilitation practices (unit, organisation and external environment), their interpersonal relationships and work participation activities, reflect the generality of Mintzberg’s model, and the specificity of the findings that emerged from interpretation through the lenses of Kemmis et al. and Eraut.
Interpretation of text based on my theoretical framework also revealed the framework’s limitations. The main weakness was in enabling deeper understanding of the conceptual domain of NUMs’ learning facilitation work. Mintzberg emphasizes the “frame” of management work, the “mental models” (2009, p.117), based on the experiences, values and attributes a manager brings to the work. However, neither Kemmis’ practice architectures or Eraut’s workplace learning theories enabled deeper interpretation of this aspect of NUMs’ work. Findings (identity, perceptions of learning and motivations) emerged from philosophical hermeneutic interpretation of themes, but not from the theoretical framework. This demonstrates somewhat the complementary contributions of both the theoretical framework and the methodology. However, a more finely tuned theoretical framework that included avenues for interpreting these conceptual and individual perceptions of NUMs’ learning facilitation practices would likely enhance the quality of this framework as a tool for interpretation of management work.

9.3 Implications for practice

This research contributes a more nuanced understanding of NUMs’ learning facilitation practices in clinical workplaces than is currently reported in the literature. The research findings challenge the assumption that NUMs’ learning facilitation roles are largely redundant due to the repositioning of nurse education into universities. They also challenge a generalised explicit view held by my research participants, revealed by their identity and conceptions of staff learning, that all learning facilitation work is conducted away from the unit or by Clinical Nurse Educators. My research found that NUMs facilitate learning in complex, often informal ways, shaped by a network of factors that are inherent in the ordinary routines of unit work. These findings have implications for university education and work-based professional development programs for NUMs offered by hospitals, and contributes to defining the role of nurses in clinical management in the healthcare sector.

9.3.1 University education

Formal education in nursing management is typically offered by universities as a postgraduate qualification. If nursing and healthcare management education are to be
relevant and responsive to the learning requirements of students, the syllabus should ideally reflect contemporary knowledge of management practice (Ritchie & Yen, 2013). Research into practice is a highly regarded source of curriculum (Toohey, 1999), particularly when the research encompasses the perspectives of the practitioner (Reid & Green, 2009). Based on these arguments, my research, which reflects practitioner’s views on their practice, makes a valuable and meaningful contribution to the theoretical dimensions of NUMs’ work, which is typically included in management syllabuses. Furthermore, as discussed in Chapter 2, Registered Nurses are generally appointed to NUM roles based on their clinical experience, with very few having completed tertiary studies in management. Such lack of preparation can precipitate stress and compromise performance (McCallin & Frankson, 2010). Postgraduate courses in nursing and health services management recognise the transition of nurses (and other health professionals) as clinicians to management roles (Maddern et al., 2016), although most NUMs do not undertake these courses (Paliadelis, 2008). For academics who seek to support students’ transition from clinical to management practice, contemporary knowledge of NUMs’ roles has great potential to inform and enrich learning and teaching endeavours. My research focus on a distinct and previously understated aspect of NUM practice, has worthwhile implications for this knowledge base.

Importantly, the findings from this research have particular curricula implications for NUMs’ learning about how to enact their responsibilities for ensuring safety and quality of care. The relationship between nursing knowledge and skill and the quality and safety of patient care has been well established in the academic literature (Aiken et al., 2017; Duffy, 2013; Needleman, 2013). Curriculum design that exposes NUMs to knowledge of their learning facilitation practices has relevance to their roles in achieving quality and safety in their clinical units. The relational aspects of the model (Figure 8.1) open up opportunities for a deeper understanding of the relationships between the foundations and context of these practices and the use of power to enact them. Educators can present this knowledge to students as a lens with which to appraise their own learning facilitation practices and relationships to their work context, and to identify opportunities to influence staff learning. For example, educators can guide NUMs to consider sources of available power, and how they use that power to influence staff learning, and how their choices may enable or constrain
learning. NUMs can also be encouraged to consider how they use available artefacts on their units for example, to facilitate learning, and where there may be untapped opportunities. Furthermore, A Living Systems Model of NUMs’ Learning Facilitation Practices can guide NUMs and those who aspire to become NUMs to reflect on their practice context and to encourage them to think about the influences that are specific to their own work context that influence their learning facilitation practices, such as the availability of networks or opportunities to engage staff in learning during team meetings.

9.3.2 Professional development

My findings have important and relevant implications for NUMs’ professional development. My research illuminates previously understated roles in influencing learning at work, and in particular informal roles that occur within ordinary work routines. Informal learning strategies are important and have been considered to be the most common source of learning at work (Eraut, 2004), and so are worthy of attention. My research presents a framework that articulates relational aspects of practice that can be used to guide NUMs’ reflection on their own practice, and to consider possibilities for future practice. Studying learning facilitation practices undertaken with individuals, within teams and through artefacts can provide tangible ideas for facilitating learning and also serve as a basis for reflecting on personal practice. There is potential for each practice represented in the model (Figure 8.1) to be framed as a competency, such as ‘To be able to identify opportunities for gaining an understanding of staff performance’ or ‘to be able to maximise learning opportunities and support for staff through rostering’ and used as a guide for self-reflection. The model also positions power as an enabling force, and provides a basis for NUMs to reflect on their particular use of power, and the balance of personal and positional forms of power that influence their learning facilitation practices. The simplicity of the model and the arrangement of key dimensions within a tree enables practitioners to draw on a familiar structure to understand and apply complex theoretical relationships. This is important as the application of theory to practice can be daunting for practitioners. Presentation of theory in a form that invites closer inspection and engagement is therefore worthwhile.
9.3.3 Industrial aspects

Despite a long history of nurses occupying management positions in healthcare, plans for health system restructure in response to resourcing concerns have threatened the role of nurses in hospital management (Pegram, et al., 2014). Historically, plans to replace NUMs with business managers have been a topic of industrial negotiation (New South Wales Nurses’ Association [NSWNA], 2006). Threats to the role of nurses in hospital management structures involving erosion of roles and authority and distancing NUMs from the clinical environment are ongoing (Australian College of Nursing [ACN], 2015).

Nursing advocacy organisations, including the ACN (2015), the NSWNA (2006) and the Nursing and Midwifery Unit Managers Society of NSW (2016), defend the unique contributions that NUMs bring to healthcare, and their capacity to positively influence the health of populations into the future. My research makes an important contribution to this argument. My research identifies an aspect of NUMs’ work that not only contributes to the quality of care, but further defines the nature of NUMs’ work. NUMs’ use of personal and positional power to facilitate learning merges their clinical expertise with other personal and nursing-based traits such as empathy and a commitment to caring, with knowledge and familiarity with the formal sources of power inherent in their roles. It is unlikely that this blend of attributes would be replicated in non-nurses who manage clinical units.

9.4 Critique of the research approach

In Chapter 4 I justified my choice of research approach within the interpretive paradigm as an appropriate way to understand the human experiences of my study participants. Within this paradigm, philosophical hermeneutics enabled me to progressively and iteratively gain a deeper understanding of the different perspectives of the thirteen NUMs who participated in this study. By conceiving the process of understanding as a spiral of understanding (Paterson & Higgs, 2005), achieved by moving between different texts, asking questions, returning and asking more questions and considering each in relation to the growing whole, I felt satisfied that my final horizon was a credible reflection of the voices of my participants.
While my research provided a basis for understanding the perspectives of my participants in their learning facilitation work, it is important for readers of this thesis to be able to ascertain the transferability of these findings to other contexts. The quality of this research, including its credibility, rigour and transparency, has been appraised and reported in Chapter 4. I have provided a detailed account of the research methodology and strategies including participant characteristics to enable readers to fully understand the context of this research and assist them to judge the degree of applicability to their own circumstances. Attention was given to the nature of text interpretation that began on entry to the field and continued throughout the development of my thesis. I developed a reflexive stance that enabled me to ensure that my interpretations were a true reflection of my participants’ perspectives, and were not influenced by my own bias, assumptions and expectations. The continual interpretation and comparison of texts, which is integral to the hermeneutic spiral, supported the emergence of understanding that was true to the perspectives of participants.

Transferability of findings is also dependent on the nature of participants and the context in which the research is conducted. While this research was conducted in only two hospitals, participants’ past experiences as nurses and as managers in a range of other hospitals and contexts contributed to their practice perspectives, which were represented in the text that formed the basis of interpretation. Furthermore, the organisational contexts of each clinical unit in which participants worked were characterised by a range of influences that were common to other metropolitan hospitals in Australia at that time, including the influence of AHPRA and the government policy environment. These similarities will contribute to the readers’ assessment of the relevance of study findings to their own practice and context.

A significant challenge to the transferability of this research concerns the broader context in which NUMs’ learning facilitation practices are carried out. In this research, fieldwork was conducted in two large metropolitan hospitals. However, most hospitals in Australia are significantly smaller than these and many are located in regional and remote areas (Duckett & Willcox, 2015). NUMs working in rural areas are exposed to particular challenges including low numbers of RNs and CNEs, a requirement to manage and develop less qualified staff who need to take on extended scopes of practice (Lea & Cruickshank, 2015), and a lack of other health
professionals including doctors who have the skills required to work in rural contexts (Mason, 2013). Rural nursing has been considered a distinct area of nursing that is highly integrated with the local community, and is influenced by geographical location, and the nature and availability of a wider network of health professionals (Mills, Birks, & Hegney, 2010). These broader contextual factors are significantly different to those identified in this research and may shape NUMs’ learning facilitation practices in rural hospitals differently. This may therefore limit the extent to which these findings can be transferred to understanding of NUMs’ learning facilitation practices in rural hospitals.

9.5 Implications for further research

This research sought to more deeply understand how NUMs influence learning in clinical workplaces. The implications of my research are most relevant for large hospitals in metropolitan settings, as contextual factors that shape NUMs’ learning facilitation work are likely to be different in smaller or more isolated settings. A focus for future research could be to explore NUMs’ perceptions of their learning facilitation practices in other contexts including rural hospitals, aged care facilities and community health settings. Deeper understanding of NUMs’ learning facilitation practices is likely to emerge from comparison of findings between different contexts.

Further to studies of NUMs’ learning facilitation work in other contexts, a complementary study of NUMs’ learning facilitation practices from the perspective of Registered Nurses would also extend understanding of this topic. Registered Nurses’ accounts of how their confidence, knowledge and skill in clinical practice changed, and of NUMs’ influence on their experiences of adapting to clinical work during the induction phase or during their development as team leaders, would provide additional insights with which to compare the findings of this research.

As a key outcome of this research, my Living Systems Model of NUMs’ Learning Facilitation Practices offers several dimensions of NUMs’ learning facilitation practices that are worthy of further research. Focused studies of each element within the foundations and context of NUMs’ learning facilitation practices, of their use of power, and of each of their learning facilitation practices – with individuals, within teams and through artefacts – will refine, clarify and extend the understandings that have emerged from this thesis.
The findings of this research also establish a basis for conducting a larger study of NUMs’ learning facilitation practices, drawing on the model to construct a survey that can be distributed more widely. Exploration of NUMs’ learning facilitation practices from a positivist paradigm will enable meaningful comparison, and extend and enhance the meaning of the original research.

Future research can also draw from my model to illuminate NUMs’ practice in achieving the aims of the wider healthcare system. This is particularly relevant to the ongoing concerns about the safety and quality of healthcare. Deeper understanding of NUMs’ learning facilitation practices, of how they influence the safety and quality of patient care and of the potential to strengthen this aspect of their practice may attract further resources and contribute to professional understanding of the full scope of NUMs’ work.

Finally, as discussed in Section 9.2, my theoretical framework, as a product of this research (Section 3.4.4), presents a valuable lens for understanding learning facilitation practices within NUM work. Use of my framework in future research will generate critique of its contribution to development of understanding of NUM learning facilitation practice. Furthermore, owing to the generic nature of my theoretical framework, there is scope for its application to management research in fields other than nursing.

9.6 Conclusion

This research illuminates an aspect of NUMs’ practice that was previously concealed within the ordinary routines of their work. NUMs’ learning facilitation practices have been explicated in relation to their individually defined identity, conceptions of staff learning, knowledge of staff performance, and motivations, and situated within the context of their units’ work. NUMs’ unique use of power in enacting their learning facilitation practices is another important outcome of this research. Figure 8.1, A Living Systems Model of NUMs’ Learning Facilitation Practices, represents a coalescence of the research findings, and offers a framework for considering relational aspects of practice, for reflecting, sharing and deliberating on NUMs’ learning facilitation practices, and for identifying possibilities for further enquiry.
This research makes a valuable contribution to contemporary knowledge of NUMs’ learning facilitation practices. Philosophical hermeneutics provided a powerful approach to the conduct of this study. By its nature, understanding in philosophical hermeneutics has no end, and the power of the question within the spiral of understanding continues to deepen understandings. While new understandings produced from this research have important implications for practice, ongoing research guided by the power of the question will give true meaning to the findings of this research study.
References


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Appendices

Appendix 1: Fieldwork questions: Interviews 1&2 and observational visits

**Interview 1**

What is the title of your position?

How long have you been employed in this role?

How many years have you worked in management?

What roles have you worked in previously?

Can you tell me your qualifications?

Can you describe to me your roles or tasks as a NUM?

Can you tell me about a usual day for you?

What is your role in inducting new staff in your workplace? How/Why?

What is your role in preparing other staff to take on the induction role? How?

How do you know that induction or mentoring has been effective? If you feel it hasn’t been, what do you do?

Can you give me an example of the experience of a new staff member’s induction to the unit and how they developed the expertise needed to do the job? What prompted their adjustment to the ward and what was your role?

What do you do when staff do not perform well in your ward?

How do you determine their level of performance?

How do you respond to unsafe practice?

How do you go about introducing change in your workplace e.g. policies? Why?

Did you feel the staff adopted the change as you expected? Why or why not?

Can you give me an example?

What aspect of your work do you find most challenging?

What aspects of your work do you find the most rewarding?

How would you describe the work environment in your ward?
In what way does the unit environment affect the way that staff work?

What are the qualities of an effective NUM in your view?

**Interview 2**

Have there been any changes in your unit since we last met?

Can we talk in more detail about how you develop your understanding about how staff are performing?

You mentioned goal development within new staff induction, performance appraisal and management of underperformance. What are your views on goal development and its role in staff performance?

How do you think staff develop skill in coping with the pace of the ward? How do you influence that process?

What are your views on staff learning from other staff? What is your role in influencing that process?

When staff attend external development activities is this shared with the ward staff? What is your role in this?

Do your staff actively seek learning activities locally, what ward resources are available and what is your role in this? Do you see yourself as a resource? How do you prepare yourself for that?

Are staff encouraged to reflect and use journals? What are your views on this activity?

How would you feel about staff expressing interest in introducing a new procedure or process perhaps that they found from their studies or a journal. How would you respond to this?

How valuable are previous experiences of new staff to the unit?

How comfortable are staff in communicating upwards, for example team leaders communicating resourcing needs to senior managers or doctors? How do you assist them with that?

Is there a model of care used on this ward? What was your role in developing that model? Does the model influence what the staff do?

How well do you feel the current staff development approaches used within the hospital meet the needs of the staff and ward?

So in sum, how do you think staff adapt to the requirements of their roles? And how do you see your role in that process?
**Observational Visit**

What is the purpose of the meeting?

What is the nature of the NUM’s interactions with staff?

What are the seating arrangements and what can I say about the body language of the NUM and staff?

How are staff questions dealt with?

Are explanations provided?

How does the NUM involve staff in the meeting topics?

How does the NUM respond to learning needs that are raised in the meeting?

What is the nature of any artefacts are referred to during the meeting interactions?

How are they used and how important are they?

What learning artefacts are present in the meeting room environment?

Are my observations consistent with the impressions formed from the interview?

What do I need to follow up on in the next interview?
Appendix 2: Ethics approval from WSLHD

Our Ref: HREC2011/11/4.4(3411) AU RED HREC/11/WMEAD/268

7 February 2012

Mr Michael Wood
Nursing Clinical Resource Unit
Westmead Hospital

Dear Mr Wood

Project title: 'Educational dimensions of nursing unit management'

Thank you for your letter dated 17 January 2012 and Margaret Yin's email dated 7 February 2012 addressing the matters raised in the HREC's letter dated 6 December 2011 following single ethical review of the above project at its meeting held on 28 November 2011.

This HREC has been accredited by the NSW Department of Health as a lead HREC to provide the single ethical and scientific review of proposals to conduct research within the NSW public health system. This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research and the CPMP/ICH Note for Guidance on Good Clinical Practice.

I am pleased to advise that the HREC has now granted ethical approval of this single site research project to be conducted at Westmead Hospital - Chief Investigator Mr Michael Wood / Associate Researcher Ms Margaret Yin.

The following documentation has been reviewed and approved by the HREC:

- NEAF submission code AU/11/D44A03
- Study Protocol Version 1 dated 4 August 2011
- Revised Participant Information and Consent Form Version 2 dated 16 January 2012

Please note the following conditions of approval:

- The Chief Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- The Chief Investigator will immediately report any protocol deviation / violation, together with details of the procedure put in place to ensure the deviation / violation does not recur.
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: Educational dimensions of nursing unit management

Chief Investigator: Michael Wood
Department: Nursing Clinical Resource Unit

WSLHD Human Research Ethics Committee
APPROVED
Date: 1.5.2012

Invitation
You are invited to participate in a research study that explores the experience of Nursing Unit Managers in influencing learning in the workplace.

The study is being conducted by Margaret Yen, PhD Student, Charles Sturt University.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?
The purpose is to better understand the role of Nursing Unit Managers, and in particular how they influence learning in the workplace.

Who will be invited to enter the study?
You are invited to participate in this study because you are a Nursing Unit Manager at the Westmead Hospital.

Do you have a choice?
Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect the treatment you receive now or in the future. Whatever your decision, it will not affect your relationship with the Westmead Hospital or with Charles Sturt University. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

However, if you withdraw after participation in the focus group discussion it will not be possible to remove your data from the group data.

What will happen on the study?
If you agree to participate in this study, you will be asked to sign the Participant Consent Form. This study will be conducted over a period of 28 months. If you decide to participate you will be invited to participate in two interviews, a focus group, and a short period of observation. The first interview will take approximately one hour and will be guided by a set of questions. The second interview will be held two weeks later and will take between 40 minutes and one hour. The second interview will provide you with an opportunity to comment on your thoughts and reflections from the first interview. During the focus group which will be held approximately three weeks after the second interview, the researcher will present collated findings from the interviews, and you will be invited to comment further on these findings.
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: Educational dimensions of nursing unit management

You will also be invited to nominate a period of time where the researcher could observe your interactions with others in your workplace. This period of observation might include an event such as a staff meeting or planned induction session that would be suitable for the researcher to observe. The role of the researcher during this meeting would be that of an observer only. Data from the period of observation will be recorded by the researcher using field notes, or by tape recording if you and others who are present at the time consent to this.

The interviews and focus groups will be tape-recorded and transcribed. You may request in writing copies of your interview transcripts or recordings. You may also request in writing copies of your focus group participation. In this case, you will be provided with a record of your individual contribution only.

The researcher may also ask to view ward documents (not patient or employee records) that relate to the topics discussed at interview and focus groups.

Are there any risks?
It is not anticipated that significant risk is posed by participating in this research.

Are there any benefits?
This research will lead to deeper understanding of how nursing unit managers influence learning in the workplace. This will have implications for management practice through education and professional development programs.

Confidentiality / Privacy
Any identifiable information that is collected about you in connection with this study will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researcher named above and the research supervisors will have access to your details and results that will be held securely at Charles Sturt University.

Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law.

In any publication and/or presentation, or during transcription, information will be presented in such a way that you cannot be identified, except with your permission. The anonymity of participants will be protected at all times during the research by using pseudonyms in all coding and analysis, and any identifying information such as that pertaining to specific events, context, or roles will be removed or altered. Anonymity of place will be respected and in particular the Westmead Hospital will be referred to in generic terms only. As a member of a group of at least 8 participants, your contributions to this study will be analysed collectively and your individual identity will not be revealed.
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: Educational dimensions of nursing unit management

All members of the research team, including the transcriber will be briefed about the rules of confidentiality.

Will taking part in this study cost me anything, and will I be paid?
You will not be paid for your participation in this research.

What will happen at the conclusion of the study?
At the conclusion of the study the researcher will analyse the results.

What happens with the results?
The results will form the basis of the researcher’s PhD thesis. The researcher will also develop publications that will be submitted to peer reviewed journals, or used in conference presentations. This may include excerpts from collected data. This project is expected to be completed by mid 2016.

In any publication, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you, if you wish.

Complaints
This study has been approved by Western Sydney Local Health District Human Research Ethics Committee. If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact:

The Secretary, WSLHD Human Research Ethics Committee
Telephone No 9845 8183 or email researchoffice@swahs.health.nsw.gov.au

Contact details
When you have read this information, the researcher Margaret Yen will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact him/her on 02 9338 4497 or 0417 888874 If you have any problems while on the study, please contact

Michael Wood, Principal Researcher
Working hours Telephone No – 9845 6444

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: Educational dimensions of nursing unit management

CONSENT TO PARTICIPATE IN RESEARCH

Chief Investigator: Michael Wood

1. I understand that the researcher will conduct this study in a manner conforming to ethical and scientific principles set out by the National Health and Medical Research Council of Australia and the Good Clinical Research Practice Guidelines of the Therapeutic Goods Administration.

2. I acknowledge that I have read, or have had read to me the Participant Information Sheet relating to this study. I acknowledge that I understand the Participant Information Sheet. I acknowledge that the general purposes, methods, demands and possible risks and inconveniences which may occur to me during the study have been explained to me by (the researcher) and I, being over the age of 16 acknowledge that I understand the general purposes, methods, demands and possible risks and inconveniences which may occur during the study.

3. I acknowledge that I have been given time to consider the information and to seek other advice.

4. I acknowledge that refusal to take part in this study will not affect my relationship with Westmead Hospital or Charles Sturt University.

5. I acknowledge that I am volunteering to take part in this study and I may withdraw at any time.

6. I acknowledge that this research has been approved by the Western Sydney Local Health District Human Research Ethics Committee.

7. I acknowledge that I have received a copy of this form and the Participant Information Sheet, which I have signed.

8. I understand my identity will not be disclosed to anyone else or in publications or presentations.

Before signing, please read "IMPORTANT NOTE" following.

IMPORTANT NOTE:
This consent should only be signed as follows:
1. Where a participant is over the age of 18 years, then by the participant personally.

Name of participant ___________________________ Date of Birth ___________________________
Address of participant ___________________________

Signature of participant ___________________________ Date: ___________________________

Signature of researcher ___________________________ Date: ___________________________

Signature of witness ___________________________ Date: ___________________________

Version No 2 Dated 18/01/2012 Page 4 of 4
# Certification of Scientific Review

<table>
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<th>For review at SAC meeting</th>
<th>14 November 2011</th>
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<tr>
<td>Full Study Title</td>
<td>Educational dimensions of nursing unit management</td>
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<tr>
<td>Single Site / Multicentre</td>
<td>Single Site</td>
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<tr>
<td>Study Reference Number</td>
<td>SAC2011/11/4.4 (3411) AU RED HREC/11/WMEAD/268</td>
</tr>
<tr>
<td>Chief Investigator / Department / Address</td>
<td>Dr. Michael Wood, Nursing Clinical Resource Unit</td>
</tr>
<tr>
<td>Protocol Reference (incl version number/date)</td>
<td>Version 1 Dated 4 August 2011</td>
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<tr>
<td>Participant Information and Consent Form (incl version number/date)</td>
<td>Version 1 Dated 19 September 2011</td>
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<tr>
<td>Investigator Brochure (incl version number/date)</td>
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<tr>
<td>Other documents reviewed (OSMB Charter, etc)</td>
<td>Charles Sturt University HREC Approval Letter</td>
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In accordance with the completed Assessment Checklist and (for First Time in Human Clinical Drug Trials only) the Review by Clinical Pharmacologist, including all follow-up on issues raised, this study is:

✓ **Recommended as scientifically sound. The study has been forwarded to the HREC for consideration of the ethical issues.**

Signed by: [Signature] in the capacity of:

1. Secretary of Scientific Advisory Committee (SAC)

Name and Date: [Aravinda Thilagalingam] 7/11/2011

If a reply is required to this review, please direct it to:
The Secretary, Westmead Scientific Advisory Committee, Research Office, Room 1072 Education Block, Level 1 Westmead Hospital 2145
Appendix 3: Participant information sheet and consent form

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: Educational dimensions of nursing unit management

Chief Investigator: Bronwyn Merritt
Department: Nursing, Blacktown-Mt Druitt Hospital

Invitation
You are invited to participate in a research study that explores the experience of Nursing Unit Managers in influencing learning in the workplace.

The study is being conducted by Margaret Yen, PhD Student, Charles Sturt University.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?
The purpose is to better understand the role of Nursing Unit Managers, and in particular how they influence learning in the workplace.

Who will be invited to enter the study?
You are invited to participate in this study because you are a Nursing Unit Manager employed by the Western Sydney Local Health District

Do you have a choice?
Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect the treatment you receive now or in the future. Whatever your decision, it will not affect your relationship with the Western Sydney Local Health District or with Charles Sturt University. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

However, if you withdraw after participation in the focus group discussion it will not be possible to remove your data from the group data.

What will happen on the study?
If you agree to participate in this study, you will be asked to sign the Participant Consent Form. This study will be conducted over a period of 28 months. If you decide to participate you will be invited to participate in two interviews, a focus group, and a short period of observation. The first interview will take approximately 30-45 minutes and will be guided by a set of questions. The second interview will be held two weeks later and will also take between 30-45 minutes. The second interview will provide you with an opportunity to comment on your thoughts and reflections from the first interview. During the focus group which will be held approximately three weeks after the second interview, the researcher will present collated findings from the interviews, and you will be invited to comment further on these findings.
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: Educational dimensions of nursing unit management

You will also be invited to nominate a period of time where the researcher could observe your interactions with others in your workplace. This period of observation might include an event such as a staff meeting or planned induction session that would be suitable for the researcher to observe. The role of the researcher during this meeting would be that of an observer only. Data from the period of observation will be recorded by the researcher using field notes or by tape recording if you and others who are present at the time consent to this.

The interviews and focus groups will be tape-recorded and transcribed. You may request in writing copies of your interview transcripts or recordings. You may also request in writing copies of your focus group participation. In this case, you will be provided with a record of your individual contribution only.

The researcher may also ask to view ward documents (not patient or employee records) that relate to the topics discussed at interview and focus groups.

Are there any risks?
It is not anticipated that significant risk is posed by participating in this research.

Are there any benefits?
This research will lead to deeper understanding of how nursing unit managers influence learning in the workplace. This will have implications for management practice through education and professional development programs.

Confidentiality / Privacy
Any identifiable information that is collected about you in connection with this study will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researcher named above and the research supervisors will have access to your details and results that will be held securely at Charles Sturt University.

Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law.

In any publication and/or presentation, or during transcription, information will be presented in such a way that you cannot be identified, except with your permission. The anonymity of participants will be protected at all times during the research by using pseudonyms in all coding and analysis, and any identifying information such as that pertaining to specific events, context, or roles will be removed or altered, will be removed or altered. Anonymity of place will be respected and will be referred to in generic terms only. As a member of a group of at least 8 participants, your contributions to this study will be analysed collectively and your individual identity will not be revealed.
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

| Study Title: Educational dimensions of nursing unit management |

All members of the research team, including the transcriber will be briefed about the rules of confidentiality.

Will taking part in this study cost me anything, and will I be paid?  
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At the conclusion of the study the researcher will analyse the results.

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This study has been approved by Western Sydney Local Health District Human Research Ethics Committee. If you have any concerns about the conduct of the study, or your rights as a study participant, you may contact:

The Secretary, WSLHD Human Research Ethics Committee  
Telephone No 9845 8183 or email researchoffice@swahs.health.nsw.gov.au

Contact details  
When you have read this information, the researcher Margaret Yen will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her on 02 6338 4497 or 0417 696874. If you have any problems while on the study, please contact

Bronwyn Merritt

Working hours Telephone No  9881 8984

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form. This information sheet is for you to keep.
PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Study Title: Educational dimensions of nursing unit management

CONSENT TO PARTICIPATE IN RESEARCH

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Before signing, please read 'IMPORTANT NOTE' following.

IMPORTANT NOTE:
This consent should only be signed as follows:
1. Where a participant is over the age of 16 years, then by the participant personally.

<table>
<thead>
<tr>
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<th>Date of Birth</th>
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Address of participant

Signature of participant Date: ________________

Signature of researcher Date: ________________

Signature of witness Date: ________________

Blacktown-Mt Druitt Hospital Version 1 23/04/13 based on Master Version No 2 03/04/2013 Page 4 of 4
Appendix 4: Ethics approval from Charles Sturt University

26 August 2011

Ms M. Yen
School of Biomedical Sciences
Charles Sturt University
Panorama Avenue
Bathurst, NSW, 2795.

Dear Ms Yen,

The School of Community Health Ethics in Human Research Standing Committee has approved your proposal "Educational dimensions of nurse unit management" for a twelve month period from 26 August 2011.

The protocol number issued with respect to this project is 405/2011/07. Please be sure to quote this number when responding to any request made by the Committee.

Please note that the Committee requires that all consent forms and information sheets be printed on the appropriate CSU letterhead. Students should liaise with their Supervisor to arrange to have these documents printed.

You must notify the Committee immediately should your research differ in any way from that proposed. You are also required to complete a Progress Report form, which can be downloaded from www.csu.edu.au/research/forms/chrc_annrep.doc and return it on completion of your research project, or by 26 August 2012 if your research has not been completed by that date.

The Committee wishes you well in your research and please do not hesitate to contact the Chair, Caroline Robinson on telephone (02) 6051 9242 or email carolyn@csu.edu.au if you have any enquiries.

Yours sincerely,

Caroline Robinson (on behalf of)
Ms Mary-Helen Boag
Administration Officer
School of Community Health Ethics Committee
Direct Telephone: (02) 6051 9230
Email: mboag@csu.edu.au

www.csu.edu.au

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Fax: +61 2 6051 9238
Email: mboag@csu.edu.au