What do exemplary nurse managers say about their own practice?

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ABSTRACT:

Nurse (and midwifery) unit managers (NUMs) struggle to contain their responsibilities to leave sufficient time for their clinical leadership role. This study aimed to identify the challenges, practices and behaviours typically experienced by 'exemplary' NUMs. Data were collected from 7 in-depth focus groups of 'exemplary' public sector NUMs (n=25), as identified by their Directors of Nursing. Data analysis was by Leximancer software, providing four key themes: 'people', 'difficult', 'staff' and 'clinical'. Findings include that the NUM role is demanding and carries high levels of role stress and role confusion. They maintain resilience and success through the use of good communication skills; engagement, involvement and delegation of management/leadership tasks to senior staff plus regular meetings and discussions with their team.

Keywords: health workforce issues, hospital management, healthcare management

The nurse (and midwifery) unit manager (NUM) role is widely regarded as the lynch-pin of healthcare organisations. A major review of this role highlighted that a lack of support and an overburdening of extraneous administrative tasks had resulted in NUMs having a further reduced clinical leadership focus (Queensland Health, 2008). Within that review, NUMs reported day-to-day crisis-managing, while experiencing role stress and conflict because of a desire to be more clinically-based, yet unable to, due to their heavy administrative burden. In that survey, 37% reported that they frequently consider leaving the NUM position and they were confused by ambiguous expectations of their core role functions. Such findings are consistent with national and international research, and reflect the global experiences of the front-line nurse manager role over a number of years (Garling, 2008; McCallin & Frankson, 2010; New South Wales Health, 2008, 2009). The current study extends this previous work by providing evidence needed to inform policy and practice changes, and identifies the leadership practices of NUMs recognised as exemplary by their supervisors.

THEORY/CONCEPTUAL FRAMEWORK

The importance of the NUM's role in the creation of a good working environment is well-recognised (Duffield, Roche, Blay, & Stasa, 2011; Shirey, 2006). Good nurse managers are instrumental in both staff retention and satisfaction, leading to better clinical outcomes for patients (Anderson, Manno, O'Connor, & Gallagher, 2010; Duffield et al., 2011). Reducing turnover is important as turnover is both economically costly and increases the burden on nurse managers due to extra training and induction requirements (Jones & Gates, 2007; O'Brien-Pallas, et al., 2006; Tomey,

2009). Further, to decrease turnover in nursing, a healthy work environment is required (Larrabee, et al., 2010; O'Brien-Pallas, et al., 2006), within which the role of NUMs is crucial.

NUMs occupy a diverse role that has been rapidly expanding over the last 30 years to encompass not just clinical objectives, but also a growing number of administrative tasks (Duffield et al., 2011; New South Wales Health, 2009; Paliadelis, 2008; Shirey, 2006). Few have formal management qualifications (Paliadelis, 2008), so it is unsurprising that Shirey (2006) found nurse managers feel under-prepared to take on their assigned multitude of tasks. NUMs particularly need to perform well in leadership tasks to be perceived as good managers, with suggestions made that formal training be undertaken to prepare NUMs for their role (Duffield et al., 2011). Unfortunately, as nurses and midwives progress to become NUMs, the associated role expansion leads to ambiguity surrounding their core role, compounded by the "proliferation" of new nursing roles and titles in Australia that lacks cohesion between and within jurisdictions (Duffield et al., 2011).

According to Duffield et al. (2011), the characteristics of good nurse managers include visibility, accessibility, consultation, recognition and support, while Anderson et al. (2010) further suggested communication, advocating for nurses, providing a supportive organizational culture, autonomous practice environment, scheduling, staffing, continuing education, and collaborative relationships. One study found that nurses who experienced good leadership and had allied health support on the ward experienced significantly higher job satisfaction (Duffield, Roche, O'Brien-Pallas, Catling-Paull, & King, 2009), demonstrating the value of NUMs' clinical leadership.

While these abilities can be developed through training and coaching, many NUMs find their role overwhelming due to limited training for key responsibilities (Paliadelis, 2008). Duffield (2005) reported that NUMs lacked managerial support in their roles, while Shirey (2009) found nurse managers often felt unable to perform well despite their own high standards. For similar reasons, Townsend, Wilkinson, Bamber and Allan (2012) argued that Australian hospitals need to further develop nurses both prior to and after promoting them to nurse manager roles. Once in the role, NUMs often report factors that restrict their ability to provide adequate clinical leadership. Two reviews highlighted that NUM core roles and functions needed to be defined and agreed, that inadequate support and extraneous administrative tasks resulted in NUMs having a reduced clinical

leadership focus and that further education and professional development was necessary to support and strengthen the NUM role (New South Wales Health, 2008; Queensland Health, 2008).

When factors of inadequate professional development and organisational limitations are experienced, they can create substantial levels of stress (Kane, 2009). Stress amongst nurses causes various adverse outcomes, including poor patient care, increased absenteeism, turnover and illness amongst staff (Shirey, 2006). In turn, high stress frequently leads to thoughts of resigning (White & Bray, 2003) and predicts reduced physical and mental health (Chang, et al., 2007). Common stressors in nursing include repetitive problems, the feeling of work never getting done (Kane, 2009), fiscal responsibilities, inadequate human resources, managing others, intrapersonal distress, the middle management role, competing priorities (Udod & Care, 2013), high-levels of work leading to extended days and work taken home, high volumes of work, and perceptions of lack of support from management (White et al., 2003).

There is a knowledge gap in understanding how nurse managers cope with their job responsibilities and stress, although there is a range of proven methods of stress management (Udod & Care, 2013). Unfortunately, Shirey (2009) found that nurse managers often lack awareness about proactive stress management strategies, particularly if they have been in the role a relatively short period. Shirey (2009) argued that there is a need to reconfigure the nurse manager role so that the stressors are less overwhelming and that taking on these roles is more appealing for nurses. The gap reported by Shirey (2009) regarding more- and less-experienced nurse managers provides a focus for investigating the issue of role-based stress among NUMs. Consequently, the current research was undertaken to identify practices adopted by those NUMs considered to be higher performing NUMs by their Directors of Nursing. From this study, we hope to describe their most difficult challenges as well as their most helpful strategies and organisational elements that led them to be resilient and successful in their role.

METHODS

The aim of the study was to identify the practices and behaviours used by NUMs in their leadership roles. To examine this, we investigated the practices used by those NUMs considered by their own management to be exemplary performers.

The research design sought to identify what might constitute the skills and behaviours that will support high quality patient outcomes and assist policymakers in making decisions about how NUMs can optimally undertake clinical leadership roles. A qualitative approach, using focus groups and semi-structured questions and interview was selected as the most efficacious to extract the thoughts and perceptions of the these NUMs working in the public healthcare sector in one state of Australia. Denscombe (1998) argued that the justification for the use of interviews was provided, firstly, when the data are based on emotions, experiences and opinions; secondly, when they were based on sensitive issues (which may call for sensitive handling in order to get the participant to be open and honest), and thirdly when the data are based on privileged information. As all these elements were present in the current study, we chose the interview technique for this research. Semi-structured interviews were chosen as appropriate because the researchers believed they knew "enough about the field of enquiry to develop questions about the topic in advance of interviewing, but not enough to be able to anticipate the answers" (Morse & Richards, 2002, p. 94). Focus groups were used because the primary aim of a focus group is to describe and understand meanings and interpretations of a select group of people to gain an understanding of a specific issue from the perspective of the group participants (Liamputtong 2009).

Participants were identified as 'exemplary' by District Directors of Nursing (DDONs), and recruited across selected locations to ensure that all four main work settings within the relevant healthcare provider (Metropolitan, Regional, Rural and Remote) were represented. The selection of a NUM by the DDON had to take into account the following:

1. *Someone you would judge to be a high performer and who you feel is held in high regard by others in the District in terms of their NUM role.*
2. *Someone who you believe is an excellent role model for other NUMs in the District.*
3. *Someone who is capable of representing the views of all NUMs in the District and has the credibility to be seen as an excellent spokesperson on issues affecting NUMs.*

Based on participant selection, seven focus groups were conducted during September-October, 2011. Twenty-five NUMs participated in the focus group sessions, which were conducted face-to-face in the majority of cases, although two long-distance focus groups were conducted using

videoconferencing facilities to capture the views of participants who were unavailable to travel. The focus group sessions lasted between one and two hours.

Focus groups were conducted on the basis of participant anonymity. Each focus group had two researchers present, with one acting as a facilitator and the other taking notes and observing participant reactions. Each participant gave permission to voice-record their session, which was later transcribed for analysis by the research team.

An Information Sheet was presented to each participant at the start of the session, explaining the rationale for the research, the protections for anonymity and confidentiality, and that participation or withdrawal would result in no benefits or detrimental consequences. All researchers were experienced in conducting focus groups and used a standardised protocol (see Table 2)

(Insert Table 1 here)

Ethics approvals from both the health care organisation and the authors' organisations were obtained prior to collecting data.

Data Analysis

Data analysis was conducted using individual and cross-referenced thematic analysis by the researchers using Leximancer software Version 3.5, and development of concept maps. One advantage of using Leximancer software is that it allowed for connections to be made between key concepts. Another advantage is that Leximancer has the ability to create and recognise themes, including those that might otherwise have been ignored or unnoticed if the data had been manually coded (Crofts & Bisman, 2010). Crofts and Bisman (2010, p. 319) argued, a 'distinct advantage for the researcher in using the concept maps, rank-ordered concept lists and text query options is the ability to read instances of specific concepts to understand their relationships with one another'. Within Leximancer, concepts are clustered into themes within a concept map, with themes named by their most prominent concept. This allows researchers to gain insight into concepts, themes and their relationships. Through the semantic structuring of the data, the map produces a visual representation, which importantly, also includes the strength of association between the concepts and their interaction (Figure 1).

After Leximancer identified concepts, the researcher validated and interpreted the meanings behind the concepts and the interconnections between these concepts and themes. The initial lexical analysis identified 46 concepts of which 23 were considered to be of a general rather than meaningful nature and were removed. These deleted concepts included names of some respondents, and language individuals used to express or emphasise themselves or situations such as 'thinking', 'feel', 'probably', 'sure', 'stuff' and 'things'. This left 23 concepts, as presented in Table 1.

Validity, reliability and rigour were enhanced by ensuring each focus group session was audio-taped, field notes were taken and there was more than one researcher at every focus group.

FINDINGS

Qualitative data collection provides opportunities to reveal more than 'spoken' data. In this case, the researchers noted that despite receiving reminders and confirmations, several participants were unable to attend because they could not be released from their duties. In this respect, there was a notable difference between metropolitan and other districts. All invitees from metropolitan districts were able to attend. By contrast, the remote district NUMs who were able to attend apologised in advance to the researchers that they would be constantly interrupted by their mobile phones, explaining that there was 'nobody else to take the calls'. These remote NUMs looked and sounded exhausted, and commented they had 'nobody to help' them with the job, and all left immediately after the allotted interview time. Nonetheless, role stress was reported by both metropolitan and remote groups. When asked about this, several NUMs referred to a lack of succession planning, which limited their capacity to delegate. Most participants were female (n= 22, 88%), consistent with the Australian nursing population, where 91% of nurses are female (Australian Bureau of Statistics, 2005). Participants had NUM experience ranging from less than one month to more than 20 years.

Based on the data analysis, the final 23 concepts (see Table 2) ranged from a count of 189, the highest count - for 'time', to 34, the lowest - for 'difficult'. While there are some concepts that are more prevalent than others, each has sufficient occurrences to be important. These concepts are then clustered into themes reflecting their over-arching relationships.

[Insert Table 2 here]

The Four Themes

In order of emphasis, the themes are 'people', 'difficult', 'staff' and 'clinical' (see Figure 1). In the following sections, each theme is combined with independent thematic analysis observations to provide a more complete representation of participants' reported components of effective NUM practice.

[Insert Figure 1 here]

The theme 'People'

The 'people' theme represents the human nature of the position and the complexity that human aspects bring. For example, this theme included the constant pressure of dealing with individuals, "... *sometimes you can have 20 people in your office in one day trying to sort out some of those issues, and that's good, but sometimes it doesn't help either*." and comments on how NUMs are trying to address people issues through inclusion, "*I am a really big one on empowering people, because I learnt very, very quickly that I was sinking [without help]*."

The people theme is central and connected to the other themes through the job demands and the confusion around clinical, administrative, managerial and patient roles and responsibilities. For example, '*I think when you are a manager, though, people respond differently to you'*. Changing positions between people and the role of being "the boss" rather than a colleague suddenly changes the interpersonal dynamic, and subsequently the behaviour.

Role confusion was often expressed by raising multiple role-relevant terms, including: nursing identity and nursing as a profession; the NUM's changed role, especially in losing focus on clinical care; being forced to accept responsibilities for administration, finance, occupational health and safety, Human Resource Management (HRM) and problem-solving; acting as an all-round interventionist; all compounded by insufficient or lack of explicit training in these areas.

Some participants advocated the value of regularly bringing staff within the unit together to discuss and plan while developing deeper, trusting relationships. While all participants saw this as important, not all reported having similar success, with time-pressures preventing some trying to bring the clinical team together (NUM and clinical nurses). *"That unfortunately went by-the-by over the last couple of years… because you can't get 10 people off for a whole day*." Still, many felt that

monthly developmental meetings were a valuable and important part of their role. It provides leadership, enhances planning, communication and staff engagement.

The theme 'Difficult'

The direct link from 'People' to the theme 'Difficult' is via the concept of 'the job'. Many participants reported that the job is difficult, both personally and professionally, because of daily human interactions. There were some personally-difficult areas, "*The operating rooms, yep – come across very difficult personalities and just managing those and managing myself to manage those".* In addition to the personally-difficult areas, participants noted more significant professionally-difficult areas, such as perceived lack of systems, support structures and training in managerial and administrative areas. Linking 'People', 'the Job', 'Difficult' and 'the Patient' together is exemplified in the following:

> *There is no consistency – (this) makes it very difficult because if you could have that consistency across the units, across divisions, we'd be all on the same page; but I'm afraid that doesn't happen.* And
>
> *That's difficult, and like I said, there's not been any process put in place to help us make some of those decisions or support us through this. There is no workplace instructions.*

Lack of assistance from more senior managers to help improve the system issues was evident in many comments like this; the expectation is that the NUMs will simply sort it out themselves.

Role stress and ambiguity are represented in many comments and are reportedly exacerbated as the sources are often outside NUMs' control and influence. This relates to time pressures as NUMs attempt to achieve outcomes, without effective processes and support systems in place. Occasionally initiatives were developed to address this, but these were isolated and rare. NUMs joked of the joy of acting as director of nursing or other higher positions, so that they could 'have a break' or 'get a rest'. In sum, current systems appeared to be sources of pressure rather than assistance.

The following quote is typical of issues faced by NUMs trying to manage clinical, administrative, managerial and organisational functions while being mentors, counsellors and support to their staff:

> *But coming from a rural area … One of my stresses is that I have so many different hats that make it difficult to fit into your day what you need to get out of it*.

Participants also commented that requests for developmental opportunities were common because, except for a small number from the city who had some effective but limited training, most NUMs had been self-taught. Training, when available, had been useful on managing the complexity, ambiguity, inconsistency and performance demands they faced. Also, hospitals that had made efforts to rationalise competing demands on NUMs were able to reduce levels of confusion experienced. Likewise, NUMs' own ability to recognise and prioritise which demands were most important was helpful, something they reportedly gained from having the opportunity to clarify demands with others.

The theme 'Staff'

The links between 'Difficult' and 'People' themes to 'Staff" lie in the transfer of people, professional and job issues into the typical and regular activities of people in their work function. NUMs reported attempting to have their nursing teams develop an understanding of organisational requirements and associated priorities, and not see these as inconsistent with patient care.

> *But it's also really good that the staff see that someone else is doing it, so there's not quite that division, "well look how the NUM has rostered us". It actually is like someone on the floor* [another nurse, not the NUM] *is making these decisions*.

As this quote indicates, inclusion and job-sharing bring clarity to these units or wards. However, the size and complexity of the staffing arrangements were of concern, as follows: *So there's that big inequality. Like, I have 65 staff and … I can't get everything done*.

The NUMs reported that they had to find alternative ways of achieving goals, in part by delegating tasks. Several NUMs identified that this was not just a factor for managing their own workload – it actively developed their staff and enhanced empathy and commitment. This was consistent with the other key discussion under this 'Staff' theme - the importance of managing priorities and impacts upon staff, the ward, patients and their care.

> *So ensuring that priorities – ensuring that runs smoothly, that the staff are coping with that – just that everything probably is running smoothly. That's my priority in day-to-day stuff.*

Effective NUMs were not focused simply on procedures and priorities, but primarily the people side of health care. Helping staff cope and maintaining staff morale were integrated with a concern for effective systems and performance, using action learning skills such as guiding and coaching a

subordinate in developing and producing a roster, actions like this not only develop and engage staff but opens up a shared ownership of the process and outcome. Participants also repeatedly mentioned their own efforts to improve their workload management and their abilities by talking to other successful NUMs and learning from their experiences and processes to make workloads and difficult tasks/people more manageable. In the context of a difficult and demanding role, NUMs provided examples of their own adaptive skills prioritising and compromising but never loosing focus on quality of patient care which appear to draw on their professional nature as providers of care, with concerns for both evidence-based practice and continual learning.

The theme 'Clinical'

The focus that several NUMs used for their own and their staff's development is patient care, which leads to this theme, 'Clinical'. There are several distinct aspects to the 'Clinical' theme, reflecting the confusion/ambiguity for NUMs between administrative and clinical roles, and the role of Clinical Nurses (CNs; a promotional position for a senior, experienced nurse who may deputise for the NUM and is typically required to be in charge of the ward in the NUM's absence). Adding to this are requirements for NUMs to focus on the maintenance and importance of clinical standards. A typical comments was: *For me there is ambiguity, with that mix between clinical and administration: how much clinical do you give?*

This issue of wanting or needing to be present in the clinical setting was emphasised at different levels across all groups, indicating that the link between NUMs and CN, and how this is managed, is important for developing a strong nursing team. Otherwise, it may manifest in the following divide:

> *[Clinical Nurses] are supposed to be experts on the clinical floor and some NUMs argue with that - me included - of not delegating things to them and letting them be responsible if something isn't right.*

When this relationship is developed and understood, NUMs and CNs form an effective management team, with NUMs developing, empowering and leading this team. So, it is crucial for NUMs to develop a relationship where aspects of clinical and administration can be handed over to the CN group.

It gives the CNs an awareness of what you actually do, how it works, and so I have a CN who does the roster. I have a CN who does all my clinical incidents.

This relationship can be so important to the effective management of these groups that those who have embraced the process (regardless of whether it was out of necessity) make statements such as, "*Without that clinical facilitator, I'd just pack it in and go home, really*." Therefore, while a key area of stress and confusion, the clinical role can be managed. The constant need for management and organisational training is important for those in both NUM and CN roles, because effectiveness increases when NUMs and CNs act together as a management team with the NUM as team leader.

The level of stress experienced by the NUMs should not be underestimated - it was the issue that participants were most concerned about and the descriptions were genuinely concerning. In fact, stress was such a sensitive issue that some participants would not allow their comments to be recorded. Some NUMs described anecdotes in which they had experienced particularly extreme stress-related consequences and occasional harassing and unsupportive behaviours by superiors. Even so, the exemplary NUMs who participated in these focus groups explained their behaviour throughout these scenarios yet still managed to sustain a high level of professional integrity. They explained how they displayed sufficient poise and resilience not to over-react to such experiences.

In summary, there were several factors consistently raised among exemplary NUMs that reportedly contributed to their performance, and these are presented in Table 3.

(Insert Table 3 here)

DISCUSSION

The aims of the study were to identify the challenges, practices and behaviours typically experienced by 'exemplary' NUMs. In exploring those aims, this research identified four key themes that dominate the understanding of effective performance among exemplary NUMs, namely: 'People', 'Difficult', 'Staff' and 'Clinical'. In the process of discussing these themes, key findings in terms of challenges emerged concerning the NUM position's high levels of role stress and confusion. The reported role stress is linked with job difficulty, including high level demands and complexity, supporting Kane (2009), Udod and Care (2013) and White et al., (2003). Regardless of their exemplary status, NUMs who participated in this research reported being time-poor, having to be

multi-skilled, having highly developed communication and leadership skills, and being administratively adept. However, few reported receiving formal training in these areas (confirming Kane, 2009), with any training being more likely available for urban-based NUMs and less likely for those in other areas. Nevertheless, when such training is provided, it is perceived as positive, and NUMs reported that it contributes to their ability to manage their roles more effectively.

In terms of identifying practices and behaviours typically experienced by 'exemplary' NUMs, a related initiative that appears to assist both the NUMs and their staff is making time for NUMs and clinical staff to meet monthly for at least ½ a day off-the-job to discuss and develop the job and the unit/ward's performance. This increases both clinical capacity of staff and free time for the NUMs, who are required to do less clinical supervision as a consequence. Yet ironically, time pressures on both NUMs and their staff make such regular meetings difficult, onerous, or impossible. Consequently, providing opportunities for these meetings represents a major opportunity for healthcare facilities to improve both work roles and clinical outcomes, as also argued by Shirey (2009), and it is recommended that trialling such meetings and evaluating their benefit could provide the evidence necessary to embed such practice into regular planning cycles for NUMs and their clinical teams.

Other challenges included - being nurses first, many NUMs lament being less directly involved in nursing care activities, yet they are still in sight of the professional activities that brought them to nursing - a profession of which each participant was clearly very proud. At the same time, many NUMs have had insufficient training to develop their role as managers, supporting reports by New South Wales Health (2008) and Queensland Health (2008), tempting NUMs to focus on clinical aspects and denying them satisfaction with managerial aspects of their roles. In terms of best practice of exemplary NUMs, where they and their clinical nursing staff had formed an effective management team, these problems were lessened and effectiveness and performance enhanced, not only for the NUMs but also their staff. Even so, NUMs clearly need administrative support for meeting preparation, minute-taking, filing, copying and so on, a finding also recommended and implemented in NSW (Centre for Clinical Governance Research, 2011). According to participants, this is essential and could be a shared resource, but was missing. From our observations, there is clearly a false

economy in asking such highly-skilled and experienced (and expensive resource) NUMs to be completing such tasks, when time for other crucial clinical leadership activities are often compromised.

Our study was not without limitations. The definition of an exemplary NUM was somewhat subjective and left to the discretion of the directors of nursing to identify such individuals, which contains its own set of biases. Further research needs to be conducted in other healthcare sectors and countries to support (or not) our findings. Also, different research and analysis methods could be applied to test the findings.

CONCLUSION

Our study sought to identify the experiences, skills and behaviours of exemplary NUMs to support high quality patient outcomes. The findings suggest the NUM role can be compromised by extensive administrative responsibilities, inadequate support and training, complex 'people' issues (including staffing), difficult circumstances, and high clinical demands. In this study, exemplary nurse leadership was characterised by effective communication, local supervisor support, adequate resourcing, high quality training and mentoring, effective staff leadership, continuous learning and self-management. Therefore, appropriate training for healthcare senior managers in providing support and acknowledging stress and role ambiguity factors associated with the NUM role is essential.

Such findings are likely to inform the leadership in other healthcare sectors, in other jurisdictions, as well as our own. We have provided a picture of what a sample of exemplary NUMs espouses to be important factors for their role, perhaps as an opening discussion point or research agenda for healthcare organisations and researchers to expand upon in future studies.

TABLES

Table 1: Questions used for NUM interviews

Qn #	Guide for wording of questions
1	You have a stressful and demanding job. What are the key issues that create these situations in your day-to-day activities?
2	What have you developed in order to best manage the demands of the job?
3	What have you developed in order to best manage the stressors of the job?
4	Are there other factors associated with your role of NUM that need to be understood so that others can gain insight to the position and how best it can be managed?
5	Are there aspects of the job that with the right structure and support could be delegated to others?
6	How would you personally develop someone for the position of NUM so that they had the attributes and abilities to best deal with the job?

Table 2: Summary of Final Concepts from the Lexical Analysis of the Focus Group Data

Concept	Count	Relevance	Concept	Count	Relevance
1. Time	189	100%	13. Unit	63	33%
2. Staff	173	92%	14. Ward	63	33%
3. Clinical	136	72%	15. Patients	56	30%
4. Work	132	70%	16. Nursing	55	29%
5. People	130	69%	17. Support	54	29%
6. Role	105	56%	18. Different	52	28%
7. NUM	81	43%	19. Working	46	24%
8. Nurses	80	42%	20. Management	39	21%
9. NUMs	77	41%	21. Care	36	19%
10. Nurse	71	38%	22. Patient	36	19%
11. Person	66	35%	23. Difficult	34	18%
12. Job	65	34%			

Table 3: What exemplary NUMs did to improve their team's performance

Example #	Action
1	Regular effective communication with teams about operational matters, but more importantly about how to improve team functioning.
2	Local support systems (for example: local senior management, NUM/midwife colleagues) that provide and enable coherent and consistent policies, systems and procedures, and rationalise competing demands.
3	Adequate resourcing, such as access to staffing and good rostering practices, and consequently greater capacity to achieve higher quality outcomes consistently.
4	High quality training and mentoring, especially on how to manage complex, ambiguous and demanding situations, including skills in recognising relative priority of conflicting demands.
5	Effective staff leadership, including clarifying and explaining organisational policies, demonstrating good work practices, leading by example, plus delegating and developing promising staff members to take on additional tasks and skills.
6	Continually learning from available sources, such as training courses, reading, conversations with fellow professionals, and listening to staff.
7	Managing themselves by ensuring their skills are up-to-date, and that they negotiated time demands on them to appropriate levels.

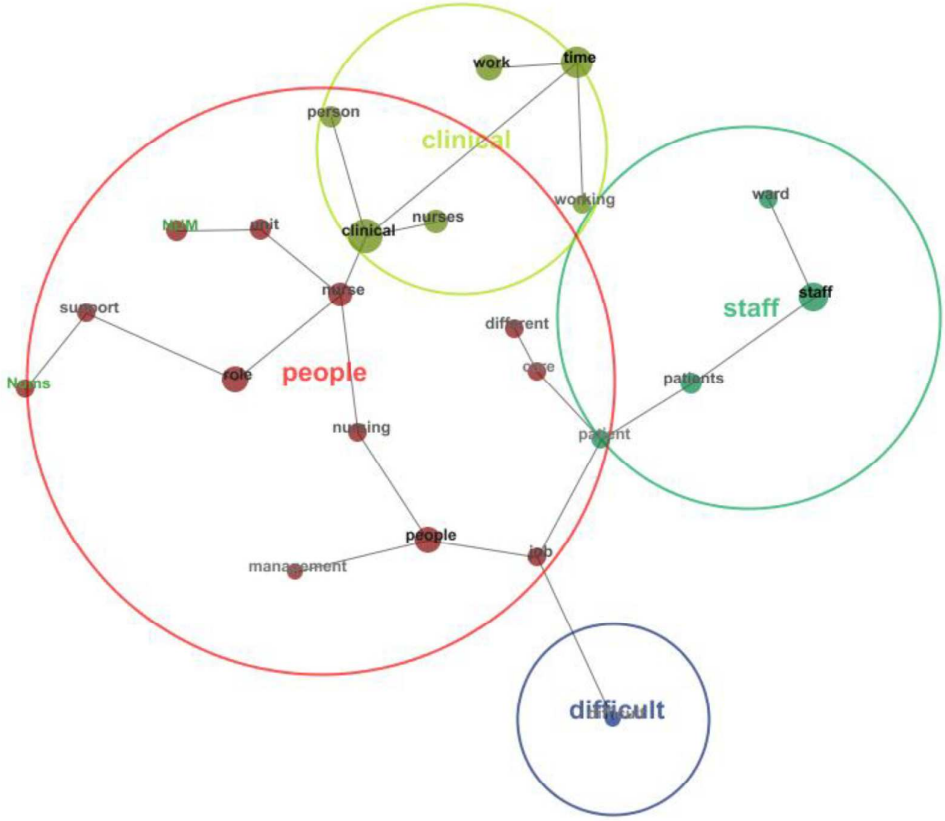

Figure 1: Concept map of focus group data

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