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It is now claimed that the role of the ward sister is confused and without power. Can nursing traditions of the past offer guidance on reclaiming the position?

Do ward sisters have influence over care?

In this article...

- › The history of the ward sister role
- › The impact of changes to management structure and nursing on the ward sister role
- › Reclaiming the traditional role of the ward sister

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Abstract Bradshaw A (2012) Do ward sisters have influence over care? *Nursing Times*; 108: 3, 17-19.

The role of the ward sister has changed significantly since modern nursing began in the 19th century.

This article looks at the history of the ward sister, explores the impact of political and professional changes on the role and discusses how ward sisters can help maintain the quality of care in today's NHS.

The UK nursing profession, current and former health secretaries and a recent government commission believe the ward sister should be the linchpin of the patient experience (Lansley, 2010; Prime Minister's Commission on the Future of Nursing and Midwifery, 2010; Royal College of Nursing, 2009; Johnson, 2007). All said ward sisters were ideally situated to oversee and coordinate services and ensure high-quality care in hospitals. However, they also admitted the ward sister role, once key to nursing, is now confused and without power, responsibility or control.

This article discusses the role of the UK ward sister and charge nurse, past and present. For the purposes of this article, the term "ward sister" includes the male "charge nurse" counterpart.

History of the ward sister role

The importance of the ward sister role has been emphasised since the start of modern nursing.

Florence Lees, who nursed wounded soldiers in the Franco-Prussian War, said the sister is the trainer who must not only exhibit virtuous qualities of her own but also try to cultivate these qualities in those under her charge. Lees said a religious dimension, involving love and charity, should underpin all nursing care (Lees, 1874).

Matrons Rachel Williams and Alice Fisher said the teaching of nurses by ward sisters should be done in the moral context of "Christian charity" (Williams and Fisher, 1877). Eva Lückes, matron of the London Hospital, argued that the personal qualities of the sister are the basis for nursing, and a good education is vital (Lückes, 1886).

Over the decades, similar views were expressed by nursing writers such as Smith (1929) and Fisher (1937).

In 1947, the Wood report – a government report on the recruitment and training of nurses – said a key function of the ward sister role was to set the tone of the hospital, a task largely dependent on the personal qualities of the ward sister (Ministry of Health et al, 1947).

This was backed by Evelyn Pearce, sister tutor at the Middlesex Hospital and author of *A General Textbook of Nursing*. She said that, although the doctor was the hospital

5 key points

1 The traditional ward sister's role was the "captain of the team" with complete authority over the ward

2 The 1966 Salmon report saw radical changes to the nursing management structure, which had a significant impact on the ward sister role

3 The 1972 Briggs report recommended removing the responsibility for nurse training from hospitals and sisters

4 The 1983 Griffiths report introduced a market approach to healthcare, replaced the nurse management structure and reduced the ward sister's authority over the care environment

5 The UK nursing profession and the Royal College of Nursing have called for the traditional ward sister role to be reclaimed



A key role of sisters in the 1940s was to set the hospital tone

Rex

director, the ward sister was the “captain of the team” (Pearce, 1949).

Changes to the ward sister role

From the 1960s, major changes to the NHS and reports on the nursing profession had significant effects on the ward sister role.

The Salmon report

The 1966 Salmon report proposed a new management structure for nursing, with lines of top management, middle management and firstline management (Ministry of Health and Scottish Home and Health Department, 1966).

The report was critical of existing structures, which it said resulted from a defunct and outdated moral code. It said the moral ethos of nursing originated in a passing phase of history and culture, and had little relevance to the present. The report criticised nurses who wanted to remain in clinical practice, rather than taking up managerial posts, for meeting their own needs rather than those of patients.

Nursing tutor and writer Winifred Hector blamed the report for creating a mood in nursing that was inward looking and status conscious, saying no student came into nursing to become a management expert (Hector, 1970). Castledine (2001) said the report reduced the control and authority of the ward sister, even though the complexity and size of the job remained the same.

Dutton study

In 1968, a study on the recruitment of nurse tutors found that ward sisters were reluctant to become sister tutors because they wanted to remain close to the patient’s bedside (Dutton, 1968).

It said ward sisters set the clinical standards of the ward, trained nurses and supervised clinical practice. It added that the ward sister was responsible for communicating and coordinating care needs, and had total control of the ward staff, environment and services. The ward sister was seen as the trustee of an ethos and tradition.

The Briggs report

In 1972, the Briggs report laid the groundwork for fundamental changes in nursing policy, practice and education, resulting in the Nurses, Midwives and Health Visitors Act (Department of Health, 1979).

The report criticised traditional nursing patterns, arguing that failings in nursing were directly related to some nurses assuming too much power. These



In 2009 it was recognised that sisters are motivated by care rather than managerial values

turned hospitals into institutions, replacing “ladies of the lamp” with “dictatorial automatons” (Briggs, 1972).

The Briggs report led to the responsibility for nurse training being taken away from hospitals, removing the authority for nurse training from ward sisters (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1986).

The Griffiths report

The 1983 Griffiths report introduced a consumerist approach to healthcare (Klein 1995; NHS Management Inquiry, 1983).

This meant nurses lost the right to be managed exclusively by a member of their own profession, as well as losing automatic representation on district management teams. The ward sister was effectively parted from having responsibility for standards of nursing practice and care.

Before Griffiths, ward services such as catering and cleaning were directly controlled by the ward sister who was therefore responsible for their standards. After Griffiths, these services were contracted out and ward sisters lost direct control over the environment of patient care.

Primary nursing

The late 1980s and early 1990s saw the adoption of new systems of nursing organisation, such as the “named nurse” and primary nursing (DH, 1991; 1989).

These devolved accountability for patient care, transferring autonomy to the individual nurse. Additionally, the NHS and Community Care Act (DH, 1990) created the internal market, with services such as laundry, catering and cleaning contracted out to the private sector. This increased the distance between the ward sister and the care environment.

The impact of change

A 1992 report from the Audit Commission said: “The profound changes in nursing and hospital management of the past decade have exposed nurse managers to a great deal of uncertainty about the expectations of others above and below them in the hierarchy” (Audit Commission, 1992).

Many nurse managers were functioning with new titles, or in new posts and structures. The Audit Commission admitted there was anxiety among managers and ward sisters about the concept of the “ward manager” and about further changes in nursing management.

Nursing analyst Isabel Menzies-Lyth was an early supporter of organisational change. However, in a 1999 article on the nursing crisis, she said: “The swing has been too great once more, and managers are not authoritative enough. They fail to operate with appropriate firmness. There is too much laissez-faire and ‘do your own thing’. In consequence, management is poor and ineffectual, which is bad for morale since people feel unsupported and insecure” (Menzies-Lyth, 1999).

In 2001, the DH admitted the role of the ward sister needed to be strengthened, recognising that ward sisters should be “the fulcrum of the healthcare team” and that their leadership was “crucial to efficient, effective and caring provision” (DH, 2001).

However, a 2003 study by Sergeant found ward sisters were preoccupied with finance and administrative responsibilities to the detriment of supervising standards of patient care (Sergeant, 2003).

Global consulting firm the Hay Group also expressed concern about nursing leadership. In a 2006 report, it argued that “great nurses do not always make great managers”. The report said the typical

characteristics associated with nursing, such as kindness, empathy and a caring attitude, were not enough to be successful in a management role (Hay Group, 2006).

The Hay Group's analysis was contradicted by the RCN in a report of an investigation into the role. This found that ward sisters "were motivated to manage their ward and ward team by a passion for nursing, rather than an aspiration or desire to be a manager per se" (RCN, 2009). This view was reflected in sisters' unanimous rejection of the title "ward manager". Study participants (ward sisters from different types of hospital trusts across England) were united in their desire to retain the title "ward sister" or "ward matron" because it identified them to patients, staff and the public as the ward nurse leader (RCN, 2009).

Reclaiming the ward sister role

The political and professional call to reclaim the ward sister role has two major problems.

First, current professional and organisational policies diminish the responsibility and authority of the ward sister for maintaining nursing standards; nurses are autonomous professionals, accountable for their own practice under the law.

The ward sister has lost the teaching role; pre- and post-registration student nurses are prepared in colleges and by mentors on ward placements, not the ward sister. The rise in specialist nursing posts also means nurses who are not ward sisters have teaching responsibilities on the ward.

Services facilities, such as catering and cleaning, are contracted to external companies because of organisational and economic structures in the NHS; ward sisters do not have managerial responsibility or authority over these services.

Second, although the RCN (2009) acknowledges that ward sisters are primarily motivated by patient care rather than

managerial values, the nature and significance of these values is ignored. The disparity in the title "ward sister" – backed by ward sisters themselves and the public – and the title "ward manager" as described by the Hay Group (2006) report, is not addressed. This is not just about terminology but the values enshrined in the term and entrusted to the role, and the different understandings of the function and purpose of the role.

Conclusion

Until the 1970s, the ward sister as leader, manager, communicator, teacher, trainer and expert was considered key to maintaining standards of patient care. The tradition was based on an explicit ideal that the ward sister was the trustee and transmitter of values.

Although many modern ward sisters still recognise the fundamental importance of this traditional ethos, organisational, managerial and educational changes have diminished the influence and authority of the ward sister role.

Perhaps the discarded nursing traditions of the past can offer modern nursing guidance on how to reclaim the ward sister role as the guarantor of high-quality patient care. **NT**

This article is an abridged and edited version of a paper published in the *Journal of Clinical Nursing* (Bradshaw, 2010)

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