

# **An exploration of accountability in nursing and its impact on professional practice – a multiple case study**

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## Abstract

**Background:** Accountability is of critical importance to the nursing profession. It is assumed that greater accountability can safeguard patient outcomes, quality of care and standards of the profession. However, there is no empirical data of how accountability is enacted and very limited data on its impact on professional practice.

**Aims:** To explore how accountability is understood and enacted across the nursing hierarchy and to identify how it could be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession.

**Design and methods:** Multiple case study design. Semi structured interviews and focus groups were conducted with 49 Registered Nurses (RN) in three NHS Scotland Health Boards (HB). Each HB represented a case and each case had RN participants from point of care to Health Board. Framework analysis was used to analyse the data.

**Findings:** RNs had appropriate knowledge and understanding of accountability as it related to their individual role, level in the hierarchy and experience. There were similarities and differences of RNs perceptions of accountability which related to their position in the hierarchy. Overall, accountability across the nursing hierarchy was focussed on retrospective assurance and answerability, mainly through audit and 'tick box' documentation. RNs reported being disproportionately burdened with accountability for care, which was associated with a lack of collective accountability and fear of anticipated consequences and blame. Accountability to safeguard patient outcomes was linked to decision making, ability to challenge and effective record keeping. RNs ability to accept accountability was dependent on self-confidence, resilience and autonomy which were influenced by - identity and feeling valued, level of knowledge and skills, trust and support, and control of responsibilities and fairness.

**Conclusion:** In conclusion, this study identified that RNs had appropriate knowledge and understanding of accountability. They articulated two discourses of accountability task-responsibility and answerability. This study provides valuable insights into the factors that facilitate or hinder RNs accepting accountability. The findings also support the notion that it cannot be assumed that the purpose and influence of accountability as perceived and experienced by RNs is as the profession intends. Calls for greater accountability need to be cognisant of the complexity of the concept and the perceptions of the nursing workforce. Based on the study findings, a model for practice is proposed to enhance accountability to safeguard patient outcomes, quality of care and standards of the profession (Appendix 4). Such a targeted approach needs to be formally evaluated in future research and practice.

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## Abbreviations and Definitions

HB (Health Board), NHS Health Boards, public organisations responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services.

NHS National Health Service

IJB (Integration Joint Board), public organisations, known as integration joint boards and aims to break down the barriers to joint working between NHS boards and local authorities.

SG Scottish Government

END Executive Nurse Director

ND Nurse Director

CN Chief Nurse

LN Lead Nurse

AND Associate Nurse Director

NM Nurse Manager

SCN Senior Charge Nurse

RN Registered Nurse

M&M (Morbidity and mortality) The M&M process describes the review of incidents from the initial event to the mortality and morbidity meeting and implementation of identified actions or outcomes

CPD Continuous professional development

NMC Nursing and Midwifery Council

DATIX electronic software to record adverse events

Adverse events, where harm or potential harm has occurred

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# Chapter 1: Introduction

In this Chapter I will provide an overview of my thesis and the rationale for selecting this Doctoral study. Following this I will briefly outline the concept of accountability as it relates to the healthcare and public administration literature and the nursing profession, to set out the context for this study.

## 1.1 Overview of thesis

This section provides a brief overview of the thesis. The research reported in this thesis aims to explore how accountability is understood and enacted across the nursing hierarchy, and to identify how this could be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession. The thesis comprises of eight chapters including this chapter.

In Chapter two, a scoping review of accountability research in nursing is presented. Twenty five studies were identified (four from the UK) and presented as: those that aimed to define accountability n=3; those that aimed to explore accountability n=13; and those that reported on specific variables and accountability n=8. One study that aimed to measure accountability was also identified. Overall, this scoping review identified that accountability was deemed critical to the nursing profession yet, nurses were reported to have poor knowledge and understanding of accountability and a number of studies found that it was perceived as something to avoid and fear. There are two, potentially conflicting, discourses of accountability: accountability as a virtue and accountability as a mechanism of answerability. Nursing was also reported to be unwilling or unable to accept aspects of professional accountability. Other than Krautscheid (2014), who conducted a systematic literature review as part of a study to define accountability, no other systematic review of accountability was identified. Previous research has been limited to the perceptions of individual and one or two peer groups of nursing. There were no studies identified that explored how accountability is enacted across the professional hierarchy and the impact of this in practice. This chapter concludes with the presentation of the research question, aims and objectives.

The study methodology and methods are described in Chapter three. Following the identification of the research question and aims and objectives, different philosophical perspectives in qualitative research are considered and the rationale for selecting a multiple case study design for this research is provided. Following this the considerations in designing and defining the case are presented. The methods used in the study are discussed, including data management and use of Framework Analysis. This chapter concludes with a description

of how the concepts of trustworthiness – credibility, dependability and transferability have been achieved.

Chapters four, five and six present the findings from Case A, Case B and Case C. Three cases were identified during the design stage and nurses from across the hierarchy (from point of care to the Executive Nurse Director of the Health Board) participated. These data are presented using the analytic framework headings developed during the analysis phase. Presenting the findings from each case separately and including data extracts was important to capture the uniqueness of each Health Board and demonstrate transparency in the process of reaching overall findings about the concept under exploration. It was decided not to summarise the findings of each case separately but to do this across the three case studies to enable identification of similarities and differences and avoid duplication.

Chapter seven presents the findings from across the three case studies. This brings together the findings from Case A, Case B and Case C as presented in Chapters four, five, and six and analyses the similarities and differences to enable the identification of key themes across the three cases to address the research question, aims and objectives.

Chapter 8 provides the main discussion for this thesis. The discussion draws on the findings from the research to make recommendations for practice and policy that reflect the new knowledge from this study to optimise the acceptance and impact of accountability in practice and to suggest directions for future research. It builds on previous research and takes cognisance of current policy direction in the context of findings from this study. Finally, it presents the strengths and limitations of this study, recommendations for future practice, policy and research and a conclusion.

## **1.2 Why this study?**

This section provides a brief overview of the rationale for this study. This area of research was selected because of experiences throughout my nursing career as both a clinician delivering care and as the holder of a number of clinical management and leadership positions. Issues of accountability continue to ‘raise their head’ locally, nationally and globally as the context in which nurses’ practice evolves. Through exploring nurses’ experiences and views of accountability in the NHS the aims of this research study were to collect and analyse data on how accountability is understood and enacted across the nursing hierarchy and identify how this could be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession. The complexity, diversity and rapidly changing context of health and social care are well beyond the scope of one professional group to manage. However, in the context of healthcare, nursing represents the largest workforce, often with a twenty four hour, seven

days a week presence, and therefore presents with a compelling opportunity to affect care and safeguard patient outcomes.

Four key reasons led me to conduct this study to answer the overarching research question: how is nursing accountability enacted from point of care to Health Board and how can it be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession?

First, it is apparent from clinical practice, policy and the literature that accountability is critical to the nursing profession. In the United Kingdom the professional regulator for nursing, the Nursing and Midwifery Council (NMC) considers nursing professionalism as essential to safeguarding patient outcomes and quality of care. The NMC 'Enabling Professionalism' guidance (NMC 2017) states that professionalism is characterised by autonomous and evidence based practice and realised by nurses demonstrating and embracing accountability for problem solving, being able to challenge, reflect and being evidence based. Despite this, nurses are reported to have poor knowledge and understanding of accountability (Krautscheid 2014; Savage and Moore 2004). Research has shown that complexity and multiple accountability conceptual definitions exist, highlighting the apparent conflict between particular accountability requirements (Bovens 2006; Brinkerhoff 2004; Emanuel and Emanuel 1996; Sinclair 1995). There is minimal empirical research relating to accountability in nursing, therefore RNs knowledge and understanding of accountability requires further exploration to understand how this can be enhanced.

Second, there is an axiomatic assumption that greater accountability can safeguard patient outcomes, quality of care and standards of the profession (SGHD, 2014). However, organisational hierarchical accountability structures are reported to be disconnected, and disproportionately focused on efficiency and performance rather than quality of care (Hall et al. 2015). The deleterious impact of this has resulted in accountability being seen as synonymous with control and blame (Hall et al. 2015; Lewis and Batey 1982). Therefore, in the absence of any empirical data of how accountability is effectively enacted within the professional nursing hierarchy; and the findings from a number of health care inquiries reporting that accountability is either absent or weak (Francis 2013; Maclean 2014; HIS 2014), it is important to explore how accountability is enacted in practice.

Third, nursing is reported to be unwilling or unable to accept professional accountability (Choiniere 2011; Mitchell 2001; Young 1999) but specific details or aspects of this are unreported. Overall the literature reports the importance and relation of empowerment (formal and informal), professional supervision and mentorship, job satisfaction and access to knowledge and education with the ability of nurses to practice autonomously and accept

professional accountability. However, the facilitators and barriers to accepting accountability, at different levels of the organisation require further exploration.

Fourth, nursing must give careful consideration to embracing and calling for more accountability, without firm evidence of what this means to patient care and professional practice. If the ultimate pursuit for nursing is to safeguard patient outcomes, quality of care and standards of the nursing profession, an accountability framework for practice based on empirical research is needed. This needs to enhance the acceptance of professional practice and accountability with the aim of preventing poor care rather than simply accounting for it after the event.

An accountability framework for practice that enables and supports nurses to accept and confidently embrace accountability for safeguarding patient outcomes, quality of care and standards of the nursing profession is needed and should be underpinned by a substantive evidence base. The research reported in this thesis aims to contribute to that evidence base by focusing on RN knowledge and understanding of accountability; how and why accountability is enacted and the impact in practice, and individual and organisational barriers to RNs accepting professional responsibility and accountability.

### **1.3 Context of this study**

#### **1.3.1 Defining and describing accountability**

The word 'accountability' is Anglo–Norman, not Anglo-Saxon, in origin. It is closely related to accounting, in its literal sense of book keeping and can be traced to the reign of William I. Since the 1980s, the Anglo- Saxon world has observed a transformation from the traditional book keeping purpose of accountability to an almost iconic status of public accountability, where it has become the goal rather than the means. This shift was concurrent with the introduction of the New Public Management (NPM) era by the Thatcher government in the United Kingdom (UK) and the Clinton-Gore administration in the United States (US). This included the introduction of private sector management techniques such as bench marking, performance indicators to assure public sector efficiency and effectiveness (Bovens 2006). The era of NPM did not go unnoticed in the professional nursing arena with a plethora of UK and US grey literature relating to the professional consequences of accountability that considers efficiency and performance, above professional values, associated with NPM. Related to this were a number of publications describing the limitations of the concept of Clinical Governance within the NHS by the medical profession.

In its simplest form accountability is 'the obligation to explain and justify conduct' (Bovens 2006, p.9). Extending this, and continuing to keep the definition as narrow as possible, accountability is defined by Bovens, and widely accepted in the literature on public accountability, as 'a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor be sanctioned' (Bovens 2006, p.9). This description can be contextualised in law (where the forum is a court); in public administration (where the quasi-legal forums such as ombudsman, audit committees exist); and professionally (where peers and regulatory bodies are the forum of judgement). The discussion on accountability then extends to, who is the 'actor' accountable in such fora? In corporate accountability the organisation becomes the 'actor'; in hierarchical accountability the notion of 'one for all' is apparent where the person at the top 'carries the can'; and individual accountability where an individual is judged for their contribution rather than organisational position. This is most characteristic of professional accountability where individuals are judged on their performance against a set of professional standards.

It is apparent that definitions of accountability are dependent on the standpoint from which one attempts to define it. In empirical research, accountability has discipline-specific meanings, the public administration literature considers being held to account as actors by forums, political academics frame accountability as a political imperative, and professionals consider accountability to professional bodies as adherence to codes with standards for acceptable practice that are binding for all members. It is important to acknowledge the different and at times contradictory theoretical models of accountability that exist in the context of healthcare to fully appreciate the opportunities and risks of more accountability (Emanuel and Emanuel 1986).

### **1.3.2 Accountability in healthcare**

It is clear that professional nursing accountability does not exist in isolation. The proliferation of the concept, in a number of domains, is considered to have contributed to a loss of its former simplicity and the need for constant clarification and increasingly complex categorisation (Day and Klein 1987; Sinclair 1995). It could be suggested that accountability has become an 'icon' for good governance in healthcare.

Globally, healthcare systems contain multiple accountability relationships, all connected to each other by networks of control, oversight, cooperation and reporting (Brinkerhoff 2004). Around the world governments face resource and demand pressures to provide health care services efficiently and effectively. Improved accountability is often called for as an element to

improve healthcare system performance. Accountability has therefore become a 'keyword', on an international platform, in healthcare policy that is synonymous with public sector transparency, efficiency and trustworthiness.

To state that accountability in healthcare is complex is commonplace in the public administration literature (Bovens 2006; Brinkerhoff 2004; Emanuel and Emanuel 1996; Sinclair 1995). Political, professional, financial, managerial and personal accountability processes can simultaneously exist in any healthcare setting (Sinclair 1995). In each form two discourses are apparent, a personal and a structural discourse, and within each discourse three questions emerge -accountable to whom, for what and how? This infers a minimum of thirty potential accountability relationships, which quickly increase when you consider nursing is only one of a number of regulated professionals working in a healthcare setting. Acknowledging the complexity and seeking to understand the ever expanding concept of accountability is considered important if it is to be implemented with good effect and to no detriment (Bovens 2006; Brinkerhoff 2004). Many of these forms of accountability cannot easily be integrated in practice and without careful consideration may conflict and undermine each other (Emanuel and Emanuel 1996; Sinclair 1995). Three predominant models of accountability in healthcare are described by Emanuel and Emanuel (1996): professional, economic and political. The professional model is considered to rely on trust, collaboration and common purpose between the clinician and the patient where the clinician is intrinsically motivated to improve the patient's wellbeing. This is reported as incompatible with the focus of the economic model which is maximising financial success (Emanuel and Emanuel 1996). Political accountability is rooted in the traditions of vesting responsibility in the public servant. In UK healthcare this is often a direct line from the public servant, Chief Executive Officer (CEO) of the Health Board, to the Government Executive for the NHS, who is in turn accountable to the accountable minister to the cabinet, to the parliament and hence to the electors. The loci of political accountability is performance (access and finance) and political favourability which often conflict with local resource, ability to meet performance expectations and professional obligations.

Where this becomes less clear for nursing is the introduction of the concept of 'personal accountability'. Personal accountability is described as fidelity to self, based in values such as respect for human dignity and acting in a manner that accepts responsibility for affecting the lives of others (Harmon and Mayor 1986). In nursing this has been described as being 'answerable to self' (Krautscheid 2014, p.45). Sinclair (1995) reported that personal accountability was described by Australian chief executives as 'a self-imposed personal ultimate limit which invokes fidelity to a higher cause, and values such as honesty to do the

right thing because it's right and live with the consequences'. The emotional impact and behavioural response to personal accountability is considered, in this study, to supersede any other form of accountability (Sinclair 1995). The consequences of not accepting personal accountability 'can haunt you like a ghost'. This concept of personal accountability, would appear similar if not the same as the concepts of moral and ethical responsibility which are closely aligned to the concept of professionalism.

### **1.3.3 Accountability in nursing**

Contemporary RN status requires membership of a professional regulatory body and acceptance of the status of a RN, with the rights and responsibilities as defined by the professional standards set out by the regulatory body. International and national codes of professional ethics and standards for nursing practice statements incorporate the concept of accountability. The emphasis of accountability is placed with the individual registrant. The International Council of Nurses, Code of Ethics (ICN 2012, p.3) states that, "the nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning". According to the code of ethics of the American Nurses Association (ANA 2017, p.1) accountability in nursing requires nurses to follow an ethical conduct code based in the principles of "respect for the inherent dignity, worth, unique attributes and human rights of all individuals". The Nursing and Midwifery Board of Ireland (NMBI 2014, p.16) considers nurses to be "responsible and accountable for their practice, attitudes and actions including inactions and omissions". The Scope of Nursing and Midwifery Practice Framework (NMBI 2015, p.16) provides definitional guidance and describes the concepts of accountability, responsibility and autonomy as the cornerstones of nursing practice. As nurses and midwives hold positions of responsibility they are expected to be accountable for their professional judgements. "Being answerable for one's judgements, actions, and omissions as they relate to professional practice, incorporating maintaining competency, and upholding the values of the profession" (NMBI 2015). This statement was adapted from Krautscheid's (2014) definition of accountability which is included in Chapter 2 as the only identified definition of accountability based on empirical evidence.

Accountability is not a new phenomenon for nursing in the United Kingdom (UK); however, understanding of this complex and broad concept beyond professional regulatory organisations statements is limited. Understanding the history of accountability in nursing is important to help explain the importance placed on the concept by the profession and is set out by Tilley and Watson (2004, p. 9-20). Following the Nurses' Registration Act in 1919, nurses in the UK achieved the status of an 'accountable' profession. This was a long fought 'battle' and a landmark moment for the profession. This meant that nurses were legally

accountable for their acts and omissions, and could be removed from the register for unprofessional behaviour (which at the time included having an extra marital affair). The concept of accountability was first recognised by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1989 and was subsequently included into codes of practice and guidance in UKCC (1992a), UKCC (1996a) and UKCC (2002). The UKCC (1996a) guidelines suggested that nurses had three accountability obligations: a professional accountability, a contractual accountability to the employer and accountability in law for their actions. The NMC, who produced a code of conduct in 2002, defined 'accountable' as being 'responsible' for something or someone (NMC 2002). At the core of a nurse's accountability is a sense of personal accountability, described in the updated NMC code (2008) "As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions. You must always act lawfully, whether those laws relate to your professional practice or personal life."

The current framework through which a UK RN is accountable is the NMC Code (2018a). This is similar to the 2015 version, which replaced the NMC Code (2008), with the addition of the new responsibilities for the regulation of nursing associates. Supplementary information in relation to delegation and accountability is provided alongside the NMC Code (2018a), where accountability is defined as: "Accountability is the principle that individuals and organisations are responsible for their actions and may be required to explain them to others" (NMC 2018c, p.3). A supplementary leaflet, 'Enabling professionalism in nursing and midwifery practice' (NMC 2017) was produced by the NMC under the commission of the four Chief Nursing Officers (CNOs) for the UK to support the implementation of the Code. This aligns accountability with the 'Practice Effectively' component of the NMC Code (2018a p.9) and highlights the importance of problem solving, ability to challenge, reflection and evidence based. Education standards, revalidation and fitness to practice are the three NMC processes in which RNs are accountable to their regulatory body.

### ***The NMC response to the Francis Reports***

Since the publication of the first independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Volume I (Francis 2010) and subsequent two volumes (Francis 2013) chaired by Robert Francis QC, the NMC state that they play a significant part in raising standards and bringing about the changes in culture which are so critical to improving patient safety and making healthcare patient focused. The Executive Summary Francis report (Francis 2013) contains a table of the two hundred and ninety recommendations. Some of these were addressed singly or jointly to the NMC with a number of other recommendations directly or indirectly affecting the work of the NMC. A summary of

the changes required and made by the NMC are regularly updated and published on the website (NMC 2013). Of particular relevance to this study are the changes that have been made to the new strategic direction of the NMC 'Dynamic regulation for a changing world' strategy (2015–2020) (NMC 2015). This has two primary drivers, ensuring patient safety and enabling professionalism:

1. Ensuring patient safety: using our regulatory powers to encourage fairness, openness and learning; taking regulatory action where it's needed; and avoiding punishing nursing and midwifery professionals for mistakes
2. Enabling professionalism: supporting nursing and midwifery professionals to address concerns about their practice, so that members of the public can continue to have confidence in the professions and confidence in us to promote and uphold high standards.

To date the implemented changes have included a new Code (NMC 2018a); the launch of revalidation in 2016, which is the process all RNs have to follow to maintain their registration; and in September 2018, the NMC updated its fitness to practise policies to move away from a blame culture towards a just culture in health and social care (NMC 2018b).

### **1.3.4 Does accountability work?**

Empirical research has revealed that accountability has both constructive and deleterious consequences (Hall et al. 2015). In addition, it is suggested that either too much or too little accountability can be deleterious (Ferris et al. 1995). This supports the critical need for nursing to understand accountability.

Lerner and Tetlock (1999) conducted a review of the psychology literature and provided a model that described when accountability diminishes or enhances cognitive biases. Key moderators within this model were the timings of the accountability- does the actor know they will be held accountable before or after they have made a decision or committed to an action or behaviour. Lerner and Tetlock (1999) reported that pre-decisional accountability to an unknown audience resulted in increased cognitive complexity and improved judgement, as individuals carefully choose their course of action, in an attempt to minimise feeling 'foolish or incompetent'. In contrast, pre-decisional accountability to a known audience often results in cognitive laziness, and defaulting to the most acceptable and heuristic options (that are defensible). However, if individuals discover they are accountable after they have made a decision or engaged in an action they are most likely to engage in retrospective rationality

(also known as defensive bolstering), as they use justifications and excuses to rationalise past behaviour (Lerner and Tetlock 1999).

Both Hall et al. (2015) and Frink et al. (2008) introduced the notion of the accountability environment: accountability source, accountability focus, accountability salience and accountability intensity. These environmental features were described as discretely impacting on an individual's subjective experience of accountability. Concerning accountability source, individuals will go to extreme lengths to explain or defend their performance to superiors in comparison with peers. 'Focus' of accountability considers the benefits of accountability for the outcome or process. Outcome accountability was associated with lower quality decision making (Janis and Mann 1977) and process accountability often resulted in higher quality outcomes. There is a concern about only considering outcome accountability related to creating a culture where 'the outcome justify the means' and unethical behaviours prevail (Hall et al. 2017). Accountability salience describes the extent to which individuals are held accountable for important outcomes (Hall et al. 2015).

There is little known about the barriers to accountability (Hall et al 2015). In contrast, the literature on moderators of accountability is more established and can be categorised as: characteristics of the focal actor; characteristics of the audience (forum); task characteristics; context conditions; affective variables; cultural variables. In the same review Hall et al. (2015) synthesises the literature considering the dependent variables for accountability. Four types of dependent variable are reported, affective states (such as satisfaction, stress); behaviours; cognitions; and decisions.

## **1.4 Chapter summary**

An overview of the wider literature, perspectives and concepts that consider and relate to accountability has been provided in this chapter. Contemporary health and social care requires nurses to effectively practice in the context of multipurpose, multi professional systems. These systems are increasingly exceeding the constraints of traditional organisational and professional boundaries to reflect and meet the needs of the population. Thus, understanding accountability considerations and interfaces as either 'actors' or members of 'forums' is critical if nursing is to keep pace. In the next chapter, a systematic scoping review of the nursing literature as it relates to accountability is presented.

# **Chapter 2: A systematic scoping review of accountability research in nursing**

## **2.1 Introduction**

This review focused specifically on nursing literature to gain clarity on studies about accountability in nursing; to help develop an in-depth understanding of how accountability has emerged within this field, and with what purpose.

Scoping review methodology was selected in contrast to other review typologies that address more specific and narrowly focused research questions. A scoping review can map the key themes that emanate from the research as well as working to clarify definitions and conceptual boundaries (Joanna Briggs Institute 2015; Munn et al. 2018). An initial literature review was conducted between November 2015 and September 2016. An additional search was conducted in December 2018 to update this review and to ensure the inclusion of up to date publications. The scoping review framework designed by the Joanna Briggs Institute (JBI, 2015) contains the following six stages: developing the title, objective, and question; background; inclusion criteria; search strategy; extraction and presentation of findings. The six stages of the framework provides the reporting structure for this review and summary of evidence. It is considered a rigorous and transparent methodology for reviews to ensure that the findings are trustworthy (Munn et al. 2018).

## **2.2 Methodology**

### **2.2.1 Rationale for review methodology**

The diversity of terminology used to describe review types is identified as a factor that can lead to confusion, with 'literature review' often being used as a generic term. Fourteen review types are identified in the literature (Grant & Booth 2009). Scoping reviews are useful for examining emerging evidence when it is still unclear what other, more specific questions can be posed and valuably addressed (JBI 2015). Scoping reviews aim to provide a method to map existing evidence as opposed to seeking only the best available evidence to answer a particular question related to policy and practice. An important distinction between scoping reviews and other systematic reviews is that, unless otherwise specified, a quality assessment of the included studies is generally not performed. A scoping review is appropriate as the aim of this review was to identify the research literature available in order to map contextually relevant, existing research on accountability that could be used both in practice and to identify further research potential.

### 2.2.2. Rationale for scoping review framework

The scoping review framework proposed by Arksey and O'Malley (2005) and enhanced by the subsequent work of Levac et al. (2010) were drawn on in the development of the JBI approach to conducting scoping reviews. Levac et al. (2010) provided more explicit detail regarding each stage of the review process, to increase both the clarity and rigour of the review (see Table 1).

Table 1- Scoping review frameworks

Stage	Arksey and O'Malley framework (2005) (p.22/-23)	Enhancements proposed by Levac, Colquhoun and O'Brien. (2010)(p.4-8)
1	Identifying the research question	Clarifying and linking the purpose and research question
2	Identifying relevant studies	Balancing feasibility with breadth and comprehensiveness of the scoping process
3	Study selection	Using an iterative team approach to selecting studies and extracting data
4	Charting the data	Incorporating a numerical summary and qualitative thematic analysis
5	Collating, summarizing and reporting the results	Identifying the implications of the study findings for policy, practice or research
6	Consultation (optional)	Adopting consultation as a required component of scoping study methodology

The decision to use the JBI methodology was based on the logical, systematic and contemporary nature of the methodology. Ideally, the JBI methodology requires two reviewers in order to minimise bias, but this was not appropriate for this doctoral thesis.

### 2.3 Stage 1: Developing the title, objective, and question

The mnemonic PCC: Population, Concept and Context was used to focus the title of the review to allow easy identification of the type of paper it represents (JBI, 2015). The population is RNs and, accountability is the concept being explored in the context of health and social care. Therefore the question to guide this scoping review was: 'How has Registered Nurse accountability been researched and reported?' This question evolved and was clarified over a period of months, during which time discussions and thoughts were shared with colleagues and supervisors, and familiarity with the wider accountability literature was achieved.

## **2.4 Stage 2: Background**

Professional accountability has been shaped by social norms and involves the development of a social consensus about what is considered as good and acceptable performance (Day & Klein 1987). This still holds today although the context of societal expectations, the nursing profession and healthcare provision have changed significantly. Increased public, political and professional calls for greater accountability have repeatedly been made in response to failures in care, as a means to assure the safe and effective performance of healthcare systems (Francis 2013; Maclean 2014; HIS 2014). Despite these calls for increased accountability there is little know about the impact of accountability on individual or healthcare organisational behaviours.

The professional discourse of accountability underpins safe practice, supporting congruence between nursing actions and standards of care (Shultz 2009). Although accountability is synonymous with professionalism, it is also reported in the wider accountability literature as having both constructive and deleterious consequences (Hall et al. 2015). It is apparent from clinical practice, policy and the literature that accountability is important to the nursing profession. Despite this there is no clear consensus about what accountability means for nursing, how it is perceived and how it is demonstrated, in particular how lines of accountability, can assure professional standards of practice and prevent poor care.

Prior to conducting this review a preliminary search of the following databases, MEDLINE, CINAHL, The Cochrane Library and Google was undertaken. No existing systematic reviews on this topic were identified. This review was therefore conducted in order to present an evidence-based conceptualisation of nursing accountability that could be used in both future research and in practice.

## **2.5 Stage 3: Inclusion Criteria**

Defining the inclusion criteria for this review was an iterative process and followed the recommendations of Arskey and O'Malley (2005). This approach enabled decisions to be made once some sense of the scope and volume of the literature was gained.

The framework of Population, Concept and Context (PCC) (JBI 2015) was used to articulate the topic criteria on which papers would be included or excluded from the review.

Inclusion criteria:

- Population: Registered Nurse at all levels and specialties
- Concept: Nursing accountability and/or social responsibility as both are used interchangeably as - the main context of the article; as the main predictor variable; or as the main outcome.

- Context: Health and social care sectors (public and private), acute care, primary care, mental health, community care, UK and Worldwide

Exclusion criteria:

- Population: Student Nurses; Midwives; Health Care Support Workers; other professions
- Concept: Patient accountability; Public accountability
- Context: Non healthcare environments

Decisions on the sources to be included in the review evolved. Initially, the search incorporated primary research, review, theoretical, expert opinion, concept, framework and scholarly papers. However, it was found that many papers were based on subjective definitions or value judgements of individual authors, therefore the decision was made, following discussion with my supervisors, to include only, primary research and systematic review papers.

## **2.6 Stage 4: Search strategy**

Prior to conducting the review a preliminary search of the following electronic databases, MEDLINE, CINAHL and The Cochrane Library for existing reviews of accountability in nursing was undertaken in 2015 to identify the terminology used in reporting this concept. The volume of literature relating to nursing and accountability was identified as high. The scope of topics related to accountability was also recognised to be wide. Initially one database, CINAHL was searched. Although this does not reflect the JBI methodology, which states two databases should be searched, it was considered reasonable as a first step. In addition, to mitigate the risk of bias in the identification of key terms related to accountability, a group of five nurse consultants and four chief nurses were asked to identify the concepts that they felt were related to accountability. Both groups were asked to separately 'brain storm' on a flip chart the concepts that they thought of when considering accountability. During interactions with numerous Senior Charge Nurses (SCNs) and RNs delivering direct care, I took the opportunity to ask them what they thought about accountability. This helped inform the choice of terms and combination of terms, as presented in Table 2.

Following the initial search of CINAHL further searches were conducted in MEDLINE, PsycINFO, Cochrane Library and EMERALD using the same search strategy. Boolean operators were used to maximise the penetration of terms identified and 'wild cards' to capture plurals and variation in spelling. Non English language papers were included in the original search. Where these were identified it was determined if they were seminal pieces of work that required to be translated for inclusion. This was done by hand searching papers in English to ensure any content was not missed, if important. No papers required to be translated

following this process. No date exclusions were applied to the search as accountability has been an underpinning concept for nursing since the passing of the Nurses' Registration Act in 1919, when nurses in the UK achieved the status of an accountable profession. The King's Fund, Royal College of Nursing and Nursing and Midwifery Council organisations were also contacted and asked for research relating to nursing and accountability. This produced one additional study (Savage and Moore 2004) that met the inclusion criteria.

Table 2 – Extract of search strategy used in CINAHL (as at December 2018)

<b>Search #</b>	<b>specific term</b>	<b>no. of results</b>
1	nursing	641,576
2	accountability or social responsibility	16,216
3	1 AND 2	3,794
4	decision making	92,349
5	3 AND 4	306
6	behaviour	17,815
7	3 AND 6	13
8	professionalism	5642
9	empowerment	10,989
10	3 AND 8	95
11	3 AND 9	111
12	quality	109, 776
13	3 AND 12	429
14	hierarchy	3,400

15	3 AND 14	7
16	shared/clinical governance	2912
17	3 AND 16	86
18	scapegoating/blame	3274

The process of refining the literature search strategy was conducted in phases over a period of ten months. Initially, a final date of the 1<sup>st</sup> Sept 2016 was set for concluding the search but this was extended until December 2018. All papers that identified nursing accountability and/or social responsibility were reviewed for relevance. The search generated thousands of bibliographic references which needed to be appraised for inclusion in the final review. A combination of EBSCO, REFWORKS and paper files were used to manage these references.

The completed search identified 5205 papers in total. The selection process is summarised using a Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) diagram, as presented in Figure 1.

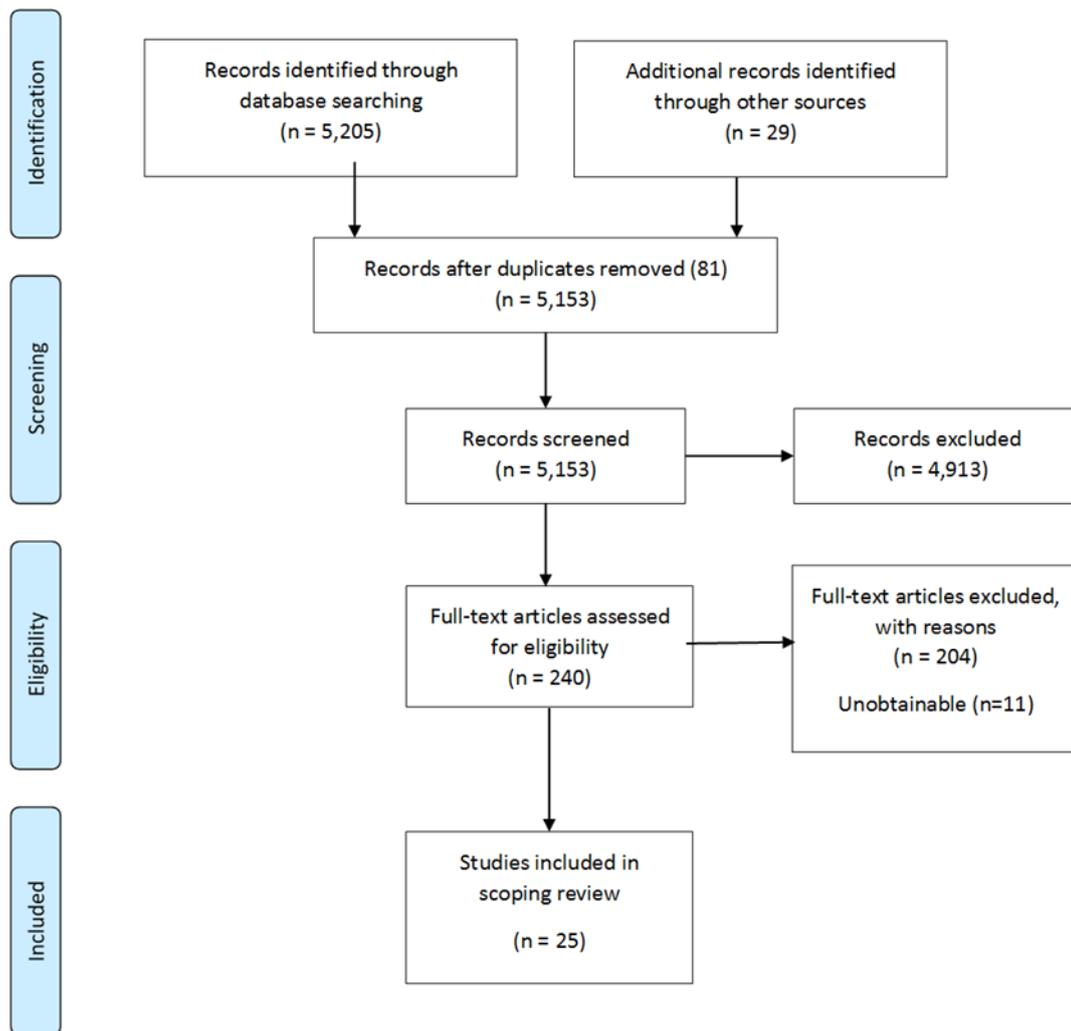


Figure 1- Screening and Identification of Papers for Inclusion Flow Diagram (PRISMA 2009)

Following removal of duplicates, 5153 titles and abstracts were reviewed for relevance. Applying the inclusion and exclusion criteria at the stage of reviewing titles and abstracts was challenging as many papers did not have abstracts or the abstracts were vague. This led to a significant number of papers being read in full to ensure articles were not excluded inappropriately. Following this review stage 4193 articles were excluded. A large number of articles were excluded as initial reference to accountability/ or social responsibility in the abstract only related to the introduction of the article and accountability was not the main concept, variable or outcome in the article; accountability being discussed related to the organisation or the public/ patients, not nursing; articles such as editorials were excluded.

A total of 240 articles were identified as suitable to assess full text for eligibility. Despite a number of approaches to source these studies, 11 were unobtainable. Theoretical, expert opinion, concept, framework and scholarly papers were excluded as the purpose of the scoping review was to map previous research undertaken in this field. Following a full text

review and application of the inclusion/ exclusion criteria, 25 studies were selected for inclusion in the scoping review. Reference lists of empirical research and systematic review papers were reviewed by hand to ensure all relevant papers were considered. No new studies that met the inclusion criteria were identified.

## **2.7 Stage 5: Extraction of results**

To enable a logical and descriptive summary of the results, data were extracted using the following key headings:

- A. Author(s), Year of publication and Title of publication
- B. Country of origin
- C. Study sample/population
- D. Aim
- E. Main construct of accountability
- F. Methodology
- G. Key findings

Although there is an imperative for clarity of the concept being investigated for any study not all studies clearly reported this. Despite this, the way in which accountability was constructed and investigated could be identified from the overall paper. For the purpose of this review, the main construct(s) of accountability was included as a data extraction heading.

## **2.8 Stage 6: Presentation of results**

In total, 25 studies were included in this scoping review. The main limitation of the studies reported was the trustworthiness of the data. This related to a lack of outcomes; and lack of methodological and analytical detail contained within the published reports. The 25 studies retrieved were published between 1982- 2018. Twenty four research studies and one systematic review were identified. Two papers were based on the same research study. Nine studies originated from the United States, four from the United Kingdom, four from Canada, four from Israel, one from Finland, two from Australia and one from New Zealand.

The majority of research studies adopted a qualitative approach (n=15), which included a range of methods: individual interviews, focus groups, vignettes, participant observations, case study, ethnography, grounded theory and discourse analysis. Mixed methods were identified in one paper (Surakka 2008). Eight quantitative studies were identified, three of which used the Specht and Ramler Accountability Index (1991) to measure accountability. The only other tool identified to measure accountability was reported by Drach-Zahavy et al.

(2018) who used a three –stage validation study to develop and evaluate a three dimensional questionnaire.

Following tabulation of the extracted data (using the headings identified in stage 5) it was possible to group the papers. With the exception of one study, which was the development of an evaluation tool (Drach-Zahavy et al. 2018), the studies were grouped according to definitions of accountability (Batey and Lewis 1982; Lewis and Batey 1882; Krautscheid 2014) n=3; those that explored, examined or reported accountability as a finding (Mitchell 2001; Robertson et al. 2010; Surakka 2008; White et al. 2015; Cohen et al. 1994; Koerber- Timmons 2014; Choiniere 2011; Sorensen and Iedema 2010; Manuel and Crowe 2014; Young 1999; Luhanga et al. 2010; Savage and Moore 2004; Semper et al. 2016; and Leonenko and Drach-Zahavy 2016) n= 13; and studies that reported the impact of specific variables on accountability (Hughes et al. 2015; Nolan et al 2010; Laschinger and Wong 1999; Sorensen et al. 2009; Boni 2001; Rashkovits and Drach-Zahavy 2017; Srulovici and Drach-Zahavy 2017) n=8.

### **2.8.1 Defining accountability**

Three papers, two of which pertained to the same study, defined the concept of accountability (Batey and Lewis (1982), Lewis and Batey (1982) and Krautscheid (2014) as summarised in Table 3. Lewis and Batey (1982) proposed a structural definition of accountability. Within this study, nurse directors defined accountability as a personal commitment or personal disposition as well as a structural mechanism, however, the authors did not include this dimension in their definition. This limited the potential that professional accountability presents to a structural definition. In Krautscheid’s (2014) definition, this personal discourse is contextualised to nursing as a professional responsibility. Within their construct of structural accountability, Batey and Lewis (1982) acknowledge the influence of organisational control and power that is inferred by the nurse directors and the potential impact this may have on nurses suggesting that accountability could both perform the role of containing nursing practice and be used as a system of control and punishment. The authors provide very little or no information about their methodological approach to data collection, analysis or literature searching, impacting on the credibility of the work.

Thirty years on, a literature review was published which synthesises commonly occurring language and related concepts, to define professional nursing accountability (Krautscheid 2014). This included 19 primary and secondary articles that defined professional accountability in nursing. This definition, “taking responsibility for one’s nursing judgements, actions, and omissions, as they relate to lifelong learning, maintaining competency and upholding both quality patient care outcomes and standards of the profession while being

answerable to those who are influenced by one's nursing practice" (Krautscheid 2014, pp 46) which encompasses both the concept of professional responsibility and accountability, inferring that by being responsible you have to be accountable. Both studies consider the concepts of accountability and responsibility to exist on a continuum and that to be accountable you must have the responsibility, authority and autonomy. This research moves beyond the concept of hierarchical accountability and of being called to account, towards a recognition of the contemporary requirements for professionals to offer an account to enable transparency and candour with patients, families and peers.

Table 3- Summary of studies with the aim of defining accountability

Study	Country	Sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key findings
(Batey and Lewis 1982)  Clarifying Autonomy and Accountability in Nursing Service: Part 1	US	n= 12  Nurse Directors in selected small hospitals (200 beds) in the Pacific Northwest.	As part 1 of a 2 part series this report aims to gain conceptual clarity of autonomy and accountability.	Main focus is antecedents and consequences of attitudinal and structural accountability	Results from an initial systematic literature review of accountability and interview responses of 12 nurse directors provided empirical illustrations to extend conceptual development.	The principle antecedents to accountability are responsibility, authority and autonomy.  The main consequence of autonomy is accountability.  Analysis of the interview data suggests that the degree of autonomy manifested by nursing departments is related inversely to the extent to which the decisions affect others.  Interview data suggested organisational and individual factors influenced nurse's ability to practice autonomously. The socialisation of nurses was found to increase willingness to use autonomy. Further research is required to assess the relation between information flow and autonomy
(Lewis and Batey 1982)  Clarifying Autonomy and Accountability in Nursing Service: Part 2	US	n= 12  Nurse Directors in selected small hospitals (200 beds) in the	To achieve greater conceptual clarity about autonomy and accountability.	Main focus is structural accountability	Results from an initial systematic literature review of accountability and interview responses of 12 nurse directors provided empirical illustrations to extend conceptual development	Developed the definition of accountability as: The fulfilment of a formal obligation to disclose to referent others. Disclosure occurs so that decisions and evaluations can be made and reckoning carried out.  Verbal and written forms of accountability were described- except for budgets accountability was informal.

		Pacific Northwest.				<p>Accountability could be used prospectively, retrospectively or intermediate.</p> <p>The interview data suggested that accountability structures were represented by patterns of disclosure.</p> <p>In cases of violations to a quality assurance plan nurse had to produce a report to deal with it. Recounting reduces autonomy and authority. The most common synonym for accountability was responsibility. The blurring of accountability and control structures is acknowledged and the negative impact of accountability as systems of punishment.</p> <p>Hierarchical accountability – the buck stops here.</p>
(Krautscheid 2014)  Defining Professional Nursing Accountability: A literature Review	US		To provide a reliable and comprehensive definition of professional nursing accountability derived from a synthesis of the literature	Responsibility and answerability	Systematic review of the literature	<p>Professional nursing accountability will be defined as taking responsibility for one's nursing judgements, actions, and omissions and how they relate to lifelong learning, maintaining competence and upholding both quality care outcomes and standards of the profession while being answerable to those who are influenced by ones nursing practice</p> <p>11 of the 19- responsibility for actions; 8 of 19 responsible to self and others who are influenced by ones actions; omissions; lifelong learning, quality of patient care upholding professional standards were themes that emerged.</p>

## **2.8.2 Exploring accountability**

Thirteen studies which explored, examined or understood accountability or reported accountability as a finding were included in this review (Choiniere 2011; Cohen et al. 1994; Leonenko and Drach-Zahavy 2016; Luhanga et al. 2010; Manuel and Crowe 2014; Mitchell 2001; Robertson et al. 2010; Savage and Moore 2004; Semper et al. 2016; Sorensen and Iedema 2010; Surakka 2008; White et al. 2015; and Young 1999) (Table 4). The synthesis of these papers enabled the findings to be categorised and presented into two broad groupings: accountability and responsibility; and nursing disinclined or unable to accept professional responsibility.

### ***Accountability and responsibility***

Savage and Moore (2004) explored how accountability was understood within one clinical team in general practice. The authors reported the understanding of accountability to be confused with participants describing the concept as both a retrospective way of apportioning blame and as something that can motivate good practice. It was also used to describe relationships. The authors proposed that the concept of accountability was 'elusive and ambiguous' in practice and recommended the need for a joint regulatory body statement from the General Medical Council and the Nursing and Midwifery Council to aid clear understanding across medical and nursing professions. The conflation of accountability and responsibility was stated as a limitation of the study. Savage and Moore (2004) identified the difficulty in numerous conversations about accountability as participants talk about their accountability but shift towards the use of the word responsibility. The tendency to use the terms interchangeably was unnoticed by the practice team and it was so subtle that at times it also went unnoticed by the researchers. Both concepts were commonly associated and at times presented as virtually synonymous in the literature.

Two other studies provide explicit examples of the conflation of accountability and responsibility (White et al. 2015 and Surakka 2008). White et al. (2015) recorded accountabilities of RNs to include patient assessment, administering medication, and personal care. The results indicated that the greatest proportion of time was spent on documentation and information review (20.9% and 21.4 %) rather than direct care delivery. Accountability is similarly conceptualised by Surakka (2008) as being at the heart of the nurse manager role. Results from this study indicated four domains: responsibility activities; accountability activities; understanding nursing practice; and outcome orientation, which were then used for the proposed leadership model for nursing management. Although this model links both the concepts of responsibility and accountability, it fails to acknowledge that one concept cannot exist without the other.

In a study to understand “bedside nurses’ ” and nurse managers’ perceptions of accountability and enablers of accountability behaviours (Leonenko and Drach-Zahavy 2016), nurses described accountability, more particularly responsibility, as critically important for the nursing profession and strongly associated it with the quality of patient care. Accountability was considered as a personal attribute and although discussed as a positive concept this was only in the context of responsibility and not transparency and answerability. Choiniere (2011) identified that restructuring and integrating units had resulted in an increased managerial accountability. This resulted in a loss of mentoring and advocacy support which was reported to be deeply missed by nurses delivering direct care.

### ***Nursing disinclined or unable to accept professional responsibility***

This review found that nurses were sometimes disinclined or unable to take on the responsibility that has been claimed by the profession. A number of causes for this emerged including: different perceptions of responsibility; blame avoidance; clinical responsibility as something to be avoided; uncertainty linked to professional accountability; and hiding behind the complexity of accountability relationships with medical and managerial colleagues (Mitchell 2001; Savage & Moore 2004; Choiniere 2011; Cohen et al. 1994; Young 1999). For example, Cohen et al. (1994) found patients viewed nursing as a task orientated workforce that were rarely observed to practice as autonomous, responsible professionals. Similar findings emerged from qualitative study by Mitchell (2001) who found a lack of RNs’ knowledge in relation to legal accountability and a preference to defer responsibility and blame onto others, mainly managers and medics, rather than accept their responsibility in relation to the law. Manuel and Crowe (2014) also identified that nurses attempt to shift responsibility and use defensive practice to avoid blame. This study of mental health RNs found that clinical responsibility was viewed as something to be avoided rather than a professional privilege, and record keeping was used as the mechanism to shift responsibility to medical or managerial staff. Cohen et al. (1994) identified nurses reporting both seeing staff provide unsafe care and seeing the results of inadequate care and not challenging these staff members, although some said they “ought” to discuss these incidents with the people involved.

Subtle inferences that nurses find it difficult to define what they are responsible for and therefore, accountable for were made by several authors. Surakka (2008) reported that nurses were relied upon to fix every problem from clinical issues to plumbing and engineering- and they did find the solutions. This suggests that greater clarity is required on what nurses are responsible for and what that focus should be. Similarly, Young (1999) identified the complexity of accountability and conflict experienced by managers (from a nursing background) trying to deal with system flow from a perspective of budget silos. The authors highlight the conflict of professional accountability for individual patient care and accountability

to the employer for utilitarianism and the system. The participants in the study by Young (1999) acknowledged that their responsibility for the system compromised high quality care at an individual level and potentially compromised the position of nurses responsible for care delivery.

The orientation of nurses to accountability as an outcome was identified in two studies. For example, Koerber-Timmons (2014) explored nurse educators' perceptions of issues and strategies related to teaching effective patient care documentation. 'Internalising' accountability emerged as the core category. A new theory with four competency levels of accountability in practice emerged to include sub-themes; (a) progressing levels, (b) reflecting on conflicting roles of nurse educators, (c) accepting transitioning, and (d) engaging and empowering through leadership. This theory of internalising of accountability offers a potential opportunity to consider the different levels of professional responsibility at which nurses' practice. Further, Robertson et al. (2010) explored how RNs deployed discursive strategies to deal with unspoken professional concerns around the events leading to a patient suicide. In this study the words accountability, blame and responsibility were never articulated, only alluded to. The authors concluded that the nurses' orientation to accountability simply serves to reinforce the professional and political discourse of control.

Table 4 - Summary of studies that aimed to explore accountability

Study	Country	Sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key Findings
(Surakka 2008)  The nurse managers work in the hospital environment during the 1990s and 2000s: responsibility, accountability and expertise in nursing leadership.	Finland	n= 155  Nurse managers working across a range of Finnish hospitals	To describe and compare characteristics of nurse managers work in different hospital environments at different times	Accountability as a professional behaviour and as responsibility	Longitudinal study Triangulation of qualitative and quantitative content analysis of diary and focus group data	A leadership model was proposed that differentiates accountability and responsibility activities in leadership.  Definitional guidance was not provided.  The nurse manager work was themed as responsibility activities such as organising, cooperating and communicating, it was felt that such activities could be delegated or postponed; supporting staff, assuring skills and developing performance were identified as accountability -related activities. These were described as activities that could not be delegated and require the nurse manager to be available at all times. In addition to responsibility and accountability activities direct and indirect care were included.  Accountability and responsibility were reported as different tasks not on a continuum.
(White et al 2015)  The examination of nursing work through a role accountability framework	Canada	n=35 RN n= 17 HCA  A convenience sample of RNs and HCAs on 2 medical wards in large teaching Calgary hospital.	To describe the amount of time RNs spend on key clinical role accountabilities and other work activities through work analysis data.	Responsibilities ie patient education described as accountabilities	Qualitative  1:1 observations Activities captured using the palm pilot Function analysis	This study identified that RNs spent considerable time on bio medical assessment and relatively little time on other aspects of care and considered the role of Licensed Practical Nurses (LPN)  The data were categorized according to clinical role accountabilities. The data indicated that RNs spent greatest time on documentation and information review; individual nursing interventions and medications were next and then least time was spent on psycho- social- cultural –spiritual assessment and support. The coordination role of the RN was more within the discipline of nursing than with other professionals. Claimed to be unique in its consideration of RN roles using an accountability framework- the framework used was not identifiable.
(Cohen et al 1994)	US	n= 24 ( of each)	For informants to discuss what was important to them related to	Knowledgeable, competent practice is a hall mark of	Phenomenological study. Interviews conducted	The nurses in this study did not meet the expectations of their regulatory code in relation to knowledge and presence and thus make accountable practice difficult if not impossible.

<p>Knowledge and Presence: Accountability as Described by Nurses and Surgical Patients</p>		<p>patients and nurses</p>	<p>a recent surgical intervention and hospitalisation</p>	<p>professional accountability.</p>	<p>24-48 hours after discharge</p>	<p>Perceptions of patients and nurses of 2 major elements of accountability were knowledge and presence, although the focus on categories within these differed.</p> <p>Key factors to enable accountable practice were identified as individual patient knowledge, professional knowledge, teaching/providing information/ leadership.</p> <p>Some nurse explored what they would do to get this knowledge others made no attempt to gain core information such as patient history and diagnosis.</p> <p>Barriers such as staffing, equipment and time were identified as preventing nurses speaking with patients or reading charts.</p> <p>Education was discussed equally often by nurses and patients. Nurses focused on the structures, process and barriers. Patients focussed on the outcomes.</p> <p>Nurses discussed both seeing other staff provide poor care and seeing the impact of inadequate care. Very few confronted staff. Many felt they lacked credibility with patients.</p>
<p>(Mitchell 2001)  A qualitative study exploring how qualified mental health nurses deal with incidents that conflict their accountability</p>	<p>UK</p>	<p>n= 23 nurses who were undertaking a professional studies module</p>	<p>To explore how qualified mental health nurses deal with critical incidents that conflict with their accountability</p>	<p>Accountability as answerability to multiple fora ( NMC, law, public, employer) and as personal accountability</p>	<p>Qualitative: new paradigm research  By using written critical incidents nurses were able to describe incidents that were important to them and were able to</p>	<p>From the data analysis the majority of conflict is between doctors and nurses. The impact of this affects the nurse -patient relationship.</p> <p>Patient aggression and lack of support from the nurse manager and medical colleagues led to the adverse events. This was further impacted by the nurse's lack of knowledge about their legal accountability. The main learning points from the critical incident were a requirement for roles and responsibilities to be clear and the relationship with accountability.</p> <p>The author identified that education was required and the nurses identified team support, clinical supervision and debriefing as helpful. Nurses are unsure of their responsibilities, in particular in relation to legal responsibilities.</p>

					write them down in their own time.	Clinical supervision and debriefing; team support and education will all enhance accountability
(Robertson et al 2010)  Accounting for Accountability: A Discourse Analysis of Psychiatric Nurses Experience of a Patient Suicide	UK Scotland	n=2 Registered Mental Health Nurses	Explore how RNs construct and orientate to accountability when talking of the experiences of a patient suicide.	Giving an account / transparency	Discourse analysis of interview data	The word accountability was never used by the nurses however discourse analysis has identified that the nurse's stories are orientated to accountability and therefore inferring that accountability is an important issue for them. Accountability is accepted and is considered a burden to nursing Internalising accountability in relation to suicide may feel like blame.
(Choiniere 2011)  Accounting for Care: Exploring Tensions and Contradictions	Canada	n= 63 RNs	Examine nurses accountability (1997-2001) related experiences with the managed care reforms and to more clearly expose and understand the tensions and contradictions	Discusses both accountability as a mechanism of control and as a professional value	Qualitative Interviews and focus groups	The majority of RNs report that managed care changes to their practice environments are interfering with their ability to provide quality patient care rather than enhancing accountability; They report a dramatic rise in stress levels; the merging of units has reduced access to managers and a change from nurses managing nurses has resulted in reduced supervision, advocacy and mentorship. Nurses describe how the focus of nurse managers is no longer on the nurse patient relationship.  The introduction of rationalising technologies such as tick charting and standard reporting forms moves nurses from the patient toward the administrated functioning of the unit. Instead of the espoused greater autonomy and accountability nurses are suffering a deepening disconnect with their ability to demonstrate accountability for patient care.
(Sorensen and ledema 2010)  Accounting for health-care outcomes: implications for intensive care unit practice and performance	Australia	n=15 clinical mangers and n=29 nurses	To understand the environment of healthcare, and how clinicians and managers respond in terms of performance accountability	Responsibility for performance	Qualitative Interviews, focus groups	Good communication and MDT process was described as contributing to patient care- no systems or processes were evident to support this.  Although healthcare teams were regularly cited they were not routinely constituted. Care is found to be individual, subjective and medical rather than team based and deliberative.  Managerial focus on abstract goals such as budgets detracted from managing the core business of clinical work.

						Fractures identified between clinical units and managerial domains as well as within the clinical unit.
(Korber-Timmons 2014)  Value based teaching: a grounded theory of internalising accountability in teaching documentation.	US	n=16 nurse educators from a baccalaureate nursing program	This study included two main purposes: (a) to explicate the issues and strategies of nurse educators teaching of nursing documentation while transitioning from paper-based to an electronic health record format, and (b) to generate an explanatory theory of teaching nursing documentation and its negative or positive influences of student learning of the competency.	Professional value	Grounded theory	The concept of accountability was frequently expressed as a finding from this research.  Internalizing accountability emerged as the core variable/core category through classic grounded theory data collection and analysis in a simultaneous fashion. The main concern was for the nurse educator to accept increased accountability to produce competent students.  A new theory emerged with four sub-categories and components also emerged and include (a) progressing levels, (b) reflecting on conflicting roles of nurse educators, (c) accepting transitioning, and (d) engaging and empowering through leadership.
(Manuel and Crowe 2014)  Clinical responsibility, accountability, and risk aversion in mental health nursing: A	Australia	N= 10 RN nurses working in mental health	Examine how mental health nurses understood clinical responsibility and its impact on their practice	Accountability as a continuum of responsibility	Qualitative Semi structured interviews	Three themes emerged from the data to describe participant's perceptions and experiences of clinical responsibility: being accountable; fostering patient responsibility and shifting responsibility.  Being accountable – referred to participants taking responsibility for their practice, which involved weighing up the patients' needs against blame in the organisations culture of risk management.

descriptive, qualitative study						<p>Most participants regarded accountability as a response to an adverse event and associated it with blame. In the nurses descriptions accountability was explained as being aware that their practice could come under scrutiny and was related to a life threatening event occurring rather than something related to day-to-day practice.</p> <p>Shifting responsibility-this described a culture of defensive practice fostered by the organisations approach to risk management. The strategies undertaken included writing handover not verbal. Some used documentation to cover themselves others to pass decision making to a medic as they did not wish to take the responsibility.</p>
(Young 1999)  The Bed Crisis of Winter 1995-1996 in the British NHS: An Illustration of Accountability Issues	UK	n=5 Middle managers who were RNs	To explore the practical complexity of accountability in healthcare by focussing on a particular bed crisis.	Accountability as answerability and responsibility	Case study	<p>The 5 managers seemed to work across 4 domains of accountability- professional, public, pecuniary and personal.</p> <p>These areas often conflict. Government targets were viewed as a hindrance at times of crisis. Professional accountability constructed as as legal and professional code.</p> <p>The impact of devolved budgets on creating divisive accountability was raised.</p>
(Leonenko and Drach – Zahavy 2016)  “You are either out on the court, or sitting on the bench”: understanding accountability from the perspectives of nurses and nurse managers.	Israel	n=23 RNs	To understand implicit and explicit perceptions of accountability from the perspective of bedside nurses and their managers and to identify factors that facilitate accountability behaviours		Qualitative semi structured interviews	<p>Accountability as a continuum of responsibility is vital to professionalism. Transparency was considered important but bedside nurses mentioned the discomfort that this caused for fear of retribution.</p> <p>Accountability is one option for behaviour, which is often punished by managers. A nurse who decides to behave accountably shows loyalty and commitment to the profession and patients, but exposes herself to social sanctions even to the point of being a victim of bullying.</p> <p>Answerability was perceived as unjust and frightening.</p> <p>Extreme language used when describing enacting accountability behaviours</p>

						<p>The gap between responsibility and authority as a barrier to accountability behaviours, nurse managers did not support this view.</p> <p>Accountability is perceived as a personal attribute and can be shaped by unit accountability. Bedside nurses reported accountability to patients, nurse managers reported being accountable to the organisation.</p> <p>Only one of the components of accountability – responsibility was perceived as essential and positive by all interviewees.</p> <p>Nurse managers can cultivate accountability by making nurses feel important and valued.</p>
<p>Savage and Moore 2004)</p> <p>Interpreting accountability: an ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance.</p>	UK	5 GPs; 4 practice nurses; 2 community nurses; a practice manager, administrator and 6 receptionists	To explore how accountability was understood within one clinical team of clinicians working in general practice following the introduction of clinical governance.	Accountability as responsibility and answerability in the context of professionalism	Ethnographic study using interviews, vignettes and participant observations.	<p>How accountability was understood:</p> <p>Accountability and responsibility conflated.</p> <p>The study found accountability elusive and ambiguous; described as retrospective and for apportioning blame; it was also described as something that can motivate good practice and implies a readiness to take the consequences of action. Accountability was used to describe some relationships.</p> <p>The nature of relationship between accountability and decision making: Some practitioners were seen as more accountable than others. Accountability was considered to sit with those that had most expertise even if not present at decision making. If a lack of previous patient contact or lack of knowledge existed (nurse taking on a medical task) less accountability existed. Blame inferred Documentation was viewed both, as a way to protect and expose practitioners to litigation.</p>
(Luhanga et al 2010)	Canada	n=22 preceptors	Examine ethical and accountability issues that	Accountability as answerability and responsibility.	Qualitative Interviews	Preceptors acknowledged their accountability for safe care as well as facilitating student learning. They reported that if a student was unable to demonstrate safe practice it is they (the preceptors) responsibility to intervene.

<p>The Preceptorship Experience : An examination of ethical and accountability issues</p>			<p>considered the challenges for preceptors when working with students whose clinical practice was unsafe</p>		<p>Trust and honesty were raised as behavioural problems. Student confidentiality was raised in respect of sharing performance information from previous placements. Evaluation and failure to fail was discussed.</p> <p>Although the preceptors were focused on patient safety they did not fail students with marginal results. A number of contributing factors to this were- lack of preceptor experience, reluctance to cause students to incur personal costs, personal feelings of guilt or shame, complacency about taking on the additional work, lack of robust tools to objectively evaluate and a perceived shortage of nurses and requirement for more graduates.</p>
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### **2.8.3 The impact of specific variables and accountability**

Eight studies reported on the impact of specific variables related to accountability (Hughes et al. 2015; Nolan et al. 2010; Laschinger and Wong 1999; Semper et al. 2016; Sorensen et al. 2009; Boni 2001; Rashkovits and Drach-Zahavy 2017; Srulovici and Drach-Zahavy 2017) as summarised in Table 5. These were: learning and performance; reporting structures; job satisfaction; productivity and self-related work effectiveness; peer review; nursing models and missed nursing care. Three studies utilised the Specht and Rambler Accountability Index – Individual Referent (Specht & Rambler 1991) to measure accountability (Boni 2001; Sorensen et al. 2009; Laschinger and Wong 1999).

Boni (2001) identified a significant relationship between hours worked per week and individual nurse accountability; nurses who worked full time had significantly higher accountability scores than those who worked 20 hours or less; nurses in the early years of their current position demonstrated higher levels of accountability and nurses who had been in their positions for fifteen years or more demonstrated lower levels of accountability. However, the reasons for these relationships were not identified. Laschinger and Wong (1999) found that nurses perceived their work setting to be moderately empowering. Opportunity was the most empowering factor and perceived access to information the least empowering. Nurses' formal power (structure or status) was not high. Informal power was most strongly related to accountability highlighting the importance of networking widely. When staff felt appropriately supported with sufficient access to resources and information to get their work done they were more likely to feel responsible as professionals for patient outcomes and feel more effective at work. Rashkovits and Drach-Zahavy (2017) identified a similar finding in the context of team accountability. The results showed that nursing teams' accountability was positively associated to time availability, autonomy and feedback delivered with caution.

Further, Sorensen et al. (2009) described the relationship between job satisfaction and accountability among RNs. The majority of respondents agreed or strongly agreed that they perceived themselves as being accountable. Accountability was identified as both an external and internal mechanism. In this study the self-reported nature of accountability using a survey tool was a limitation. The lowest correlation with accountability was extrinsic reward i.e. pay, and the most highly correlated variables to promote accountable practice were autonomy, professional development, interdisciplinary relationships, personnel policies and programmes and professional models of practice.

Hughes et al. (2015) reported the frustration experienced by Nurse Directors (NDs) having to deal with non-clinical staff in managerial roles. The management structures which were seen

to hold operational responsibility were driven by fiscal accountability, which made the role of the NDs to assure patient safety and professional standards challenging to enact with only professional and not operational authority. The issue of fiscal accountability was previously highlighted by Batey and Lewis (1982), who described both written and verbal accountability disclosure mechanisms. They found that verbal disclosure was the most common form of reporting, except when financial issues were highlighted. With the exception of budgetary disclosure, disclosure processes were not systematic (Lewis & Batey, 1982). This focus on measurable performance accountability linked to efficiency, determined through standardised, numerically based system metrics such as length of stay and delayed discharges was also evident in Canadian health system reform (Choiniere 2011).

Two studies considered peer review in relation to accountability. Semper et al (2016) evaluated the impact of Clinical Nurse Specialists in delivering a peer review education programme. This programme was positively received despite initial reservations about fear of retribution and embarrassment. Nolan et al. (2010) demonstrated improved patient outcomes and improved responsibility taken on by nurses, after participating in Morbidity and Mortality Peer Review Conferences (MMPRC) to reduce Ventilator- Associated Pneumonia rates (VAP). Nursing accountability was measured by “I” and “you” statements made by small groups of RNs using discourse analysis. Eleven MMPRCs were held over 3 months. There was a significant shift from almost equal “I”- and “you”- statements in ‘beginning MMPRCs’ to 283.3% as a percentage increase of “I”- statements and 47.6% as a percentage decrease of “you” statements in ‘mature MMPRCs’. Ventilator Acquired Pneumonia (VAP) bundle compliance improved from 90.1% to 95.2%. This study was limited by a lack of follow up to observe if the improvement was sustained. Srulovici and Drach-Zahavy (2017) found nurses’ personal accountability to be negatively associated with missed nursing care, over and above nurse’s overload and socio- demographic characteristics.

Table 5- Summary of studies of the impact of specific variables and accountability

Study	Country	Sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key findings
(Sorensen et al 2009)  The Relationship Between RN Job Satisfaction and Accountability	US	n=857 RNs	To describe the relationship between job satisfaction and accountability among RNs employed by a rural healthcare network.	Accountability as answerability and professional practice.	Descriptive correlational secondary data analysis. Surveys.	<p>Nurse accountability is moderately correlated with overall job satisfaction.</p> <p>The Specht and Rambler Accountability Index has a possible range of 11-44. The accountability scores ranged from 28 to 44, with a mean of 36.56 (<i>SD</i> =4) The majority of respondents agreed or strongly agreed that they perceived themselves as being accountable. Overall job satisfaction using MMSS ranged from 56 to 155, with a possible range of 31-155, with a mean of 104.60 (<i>SD</i>=17.91).</p> <p>Using Pearson's correlation a statistically significant positive relationship was found between nurse accountability and overall job satisfaction at a significance level of &lt;.01. Although significant the correlation was weak.</p> <p>The correlations of subscales that were strongest were control and responsibility; praise and recognition; professional opportunities and scheduling.</p> <p>Items focus mainly on responsibility and therefore do not pertain to transparency and answerability.</p>
(Boni 2001)  Accountability in nurses who practice in three different nursing care delivery models.	US	n=21 medical and/or surgical patient care units at five acute care hospital sites in New England.	To describe and compare relationships between perceived nurse accountability and three different nursing care delivery models-team	Accountability as a responsibility and answerability for ones actions	The dependent variable, nurse accountability, was measured, on individual and group levels, using the Specht and Ramler Accountability Index. The independent	<p>Overall group and individual accountability scores were presented.</p> <p>Mean group accountability scores were significantly lower than mean individual accountability scores. Significant relationships were detected between group accountability scores and years in current position, and between individual accountability scores and hours worked per week. A weak relationship between group accountability scores and nursing care delivery model was detected with registered nurses who practice in a team nursing care delivery model demonstrating lower</p>

			nursing, primary nursing and patient-focused care.		variable, nursing care delivery model, was measured with a researcher-designed nursing care delivery checklist. Nurse demographic data were also collected.	group accountability scores than registered nurses who practiced in primary and patient-focused care environments.  Both group accountability and individual accountability scores for each nursing care delivery model remained relatively unchanged when controlling for each of the significant demographic variables. Implications for nursing administration, education, practice and research were presented.
(Semper et al 2016)  Clinical Nurse Specialist Guide Staff Nurses to Promote Practice Accountability Through Peer Review.	California, US	n=900 RNs	To describe the CNS role in developing and implementing a staff nurse education programme to promote practice accountability using peer review principles	Accountability as hallmarks of professionalism and self-regulation	Evaluation of programme	Peer review is an expectation of professional practice and CNSs have a positive role to play. Positively received in practice.  Challenges encountered – staff feared retribution and discomfort addressing certain issues or behaviours with some peers.  Strong personalities and fear of engaging in peer review with difficult people.  Cultural and language barriers highlighted. Coaching and support to accept change in culture as peer review is embedded.
(Rashkovits and Drach- Zahavy 2017)  The moderating role of team resources in translating nursing teams' accountability into learning and performance: a	Israel	n=45 RNs	To test the moderated – mediation model suggesting that nursing teams' accountability affects effectiveness by enhancing team learning when relevant	Concept of team accountability and culture of accountability	Quantitative: cross sectional study using moderated mediation analysis.	Considered organisational resources of time availability, team autonomy and team performance feedback.  When performance pressure increases team learning may decrease, since the motivation to perform well interferes with experimentation and learning and is translated instead into greater efforts for doing more of the same rather than improving suboptimal care  Nursing teams' accountability is positively linked to nursing teams' learning and subsequent team effectiveness, when time availability and team autonomy are high rather than low.

cross –sectional study.			sources are available to them.			In contrast, nursing teams' accountability is positively linked to nursing teams' learning and subsequent team effectiveness, when team performance feedback is low rather than high.
(Srulovici and Drach-Zahavy 2017)  Nurses' personal and ward accountability and missed nurse care: A cross sectional study	Israel	n=172 focal nurses and n=123 incoming nurses across n= 32 wards in 8 hospitals	To test the joint effects of personal and ward accountability on missed nursing care.	Values of accountability as characteristics of the individual or ward.	Quantitative  Cross -sectional design. Mixed linear models were used as the analysis strategy.	Personal accountability was negatively linked to missed care, whereas ward accountability was not.  The importance of considering the source of accountability.  Lowest levels of missed nursing care were obtained under both high personal and high ward accountability  Misfit between personal and ward accountability resulted in increased missed care.  When ward accountability is high and personal low the nurse exhibit behaviours that are a façade and more visible to peers and managers while masking behaviours that are less important.
Nolan SW et al 2010)  Effect of M&M Peer Review on Nurse Accountability and VAP rates	US	n = not reported  RNs volunteering to attend	Evaluate the effect of M&M peer review conferences for VAP on nurse accountability and evidence base VAP prevention	Accountability as a responsibility	Qualitative Introduction of M&M peer process	Accountability increased and VAP reduced.  Nursing accountability measured by "I" and "you" statements using discourse analysis. Of the 256 statements counted, 65 (25.4%) were you and 191 (74.6%) were I. The accountability statements were analysed by placing MMPRC's into 3 groups: beginning (MMPRCs 1-3); middle (MMPRCs 4-7) and mature (MMPRCs (8-11). There was a significant shift from (x= 24.041, P <.001) from almost equal I- and you-statements to an increase of I- statements from 24 to 92 (283.3%) and a reduction of you statements from 21 to 11 (47.6%)
(Hughes et al 2015)  Structural positioning of nurse	NZ	n= 20 Health Boards Directors of	To analyse the reporting structures of nurse leaders of publicly	Accountability as reporting lines	Qualitative Semi structured questionnaires	Four themes emerged from the data: Variable positional reporting of DoN and CEO; variable levels of inclusion and influence at Exec level decisions; ambiguous financial responsibilities and accountabilities; blurring between operational and professional reporting lines.

leaders and empowerment		Nursing and CEOs	funded hospitals and seek both views of nurse leaders and CEOs		<p>Varying levels of visibility and inclusion impact on the structural positioning of nursing and influences authority and empowerment.</p> <p>Structural empowerment of nurse leaders was defined by the factors of opportunity, power and proportion were hindered by dual accountability lines of reporting and lack of financial control</p>
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The three-stage validation study conducted by Drach-Zahavy et al. (2018) included in this review and discussed in the previous section is summarised in table 6.

Table 6- Summary of the three-stage validation study conducted by Drach-Zahavy et al. (2018)

Study	Country	Sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key findings
(Drach- Zahavy et al 2018)  Towards a measure of accountability in nursing: A three-stage validation study	Israel	Phase 1 n= 74 items developed based on literature review; phase 2 n=229 nurses; phase 3 329 nurses	To develop and psychometrically evaluate a three dimensional questionnaire suitable for evaluating personal and organisational accountability in nurses	Accountability as internal and external	Three phase tool validation study.	Nurses personal and organisational accountability is positively related to nurses' performance and negatively related to nurses' neglect, thereby showing good construct validity  This questionnaire considers nurses accountability as a three-dimensional construct composed of responsibility, transparency and answerability.  Refers specifically to personal (internal) organisational (external) accountability.

## 2.9 Discussion

The overarching aim of this scoping review was to identify the research literature available on the topic of nursing accountability and to identify further research potential. Having carried out this scoping review eleven broad statements can be made:

1. There is a lack of empirical research relating to the concept of accountability in nursing;
2. Accountability has been studied in a variety of ways depending on the researcher's methodological preferences and definition of accountability;
3. A number of studies fail to make a distinction between accountability and responsibility and continue to use the terms interchangeably;
4. Most research has emerged from out with the UK and it has studied individual nurses or peer groups;
5. Accountability is reported as being poorly understood by nurses;
6. Two main discourses of accountability in nursing were found: personal virtue and answerability;
7. Studies report accountability to be disconnected, disproportionately focused on efficiency and performance, and it is a negative retrospective way to apportion blame and enact control;
8. Empowerment, support, job satisfaction, authority and autonomy are positively related to nurses accepting professional responsibility;
9. Uncertainty and blurring of managerial, medical and nursing roles and responsibilities and the perceived punitive nature of accountability are said to influence nurses not accepting responsibility;
10. Mechanisms of accountability underpinning professional practice, clinical governance, and care assurance are largely unreported in the literature;
11. How accountability is enacted in professional hierarchical structures is unreported.

The relative lack of research on accountability in nursing is surprising considering the continued political and professional calls to strengthen it as a means to assure standards of care and professionalism. It could be argued that in the absence of a strong evidence base the nursing literature has become characterised by a plethora of unchallenged expert opinion and hypothesising on accountability, amounting to more than four thousand five hundred publications with no empirical basis. The empirical studies included in this review introduced accountability as a complex and poorly understood phenomena, potentially perpetuating the notion that the concept is challenging.

Definitions of accountability are dependent on the standpoint from which one attempts to define it. From the nursing literature there are two, potentially competing, stand points: accountability as a professional virtue; and accountability as a means of answerability. The former being described in a number of studies as the cornerstone of professional practice, and the latter as a mechanism of retrospective blame in disconnected organisational structures of hierarchy and control (Robertson et al. 2010; Savage and Moore 2004).

There was a requirement for definitional clarity in order to be consistent in the use of language and understanding of accountability for nursing. Although other definitions of accountability are offered, Krautscheid (2014) acknowledges two stand points (virtue and mechanism) within her contemporary definition and recommends 'answerability' to replace 'accountability' and 'professional virtue' replaces 'professional responsibility'.

Even with definitional clarity, how professional accountability is enacted, for what purpose and by whom needs further exploration. If accountability in clinical practice is to maintain competence and safeguard patient care (NMBI 2015), the negative connotations identified in this review need to be addressed. The literature included in this scoping review spans four decades ending with Drach-Zahavy et al. in 2018. It is apparent that much of the discussion of accountability in nursing stems from Batey and Lewis's (Part 1, 1982) and Lewis and Batey's (Part 2, 1982) work. This research study aimed to expand the concept of accountability from the ideas of professional virtue to include the requirement for responsibility, authority and autonomy as prerequisites for nursing accountability. In essence this aligned accountability to position, performance and outputs as required in the developing era of New Public Management (NPM) and away from a professional virtue.

A number of studies have suggested that nurses were disinclined or unable to accept professional responsibility, and of particular concern was the reluctance of RNs to challenge poor practice. Nurses identified both an uncertainty of their relationships with managers and medics as well as a preference to working collaboratively in multi-disciplinary teams (MDT). Although nursing has a complementary knowledge and skill base to medical and managerial colleagues, the literature highlights a lack of clarity as to where nursing accountability lies and the overlap in medical, managerial and nursing roles.

The notion that nurses may be disinclined or unable to accept the full professional responsibility and defer issues to medical or managerial colleagues is concerning. This literature review highlighted the importance and positive correlation of empowerment (formal and informal), professional supervision and mentorship, job satisfaction and access to knowledge and education with the ability of nurses to practice autonomously as professionals. This requirement for appropriate professional supervision and access to knowledge to enable

learning and development is confirmed in a number of the studies (Mitchell, 2001; Cohen et al, 1994; Surakka 2008; Sorensen & Iedema, 2010; Choiniere 2011). Understanding how nurses can be supported to accept professional responsibility and therefore accountability as part of a Multi-Disciplinary team (MDT) is worthy of further exploration.

## **2.10 Chapter summary**

In summary, this scoping review has identified that accountability is deemed critical to the nursing profession yet, nurses are reported to have poor knowledge and understanding of accountability and a number of studies found that it was perceived as something to avoid and fear. There are two, potentially conflicting, discourses of accountability- accountability as a virtue and accountability as a mechanism of answerability. Nursing is reported to be unwilling or unable to accept aspects of professional responsibility and in the absence of any empirical data of how accountability is enacted it is unclear how accountability is a contributory factor to lack of acceptance of responsibility in practice. There was no literature identified that considered accountability from point of care to the Health Board.

A qualitative enquiry is necessary to explore: RN knowledge of accountability; how it is enacted and the impact in practice; and what influences RN acceptance of responsibility to understand how this can be enhanced. The following section sets out my research question, aims and objectives.

### **2.10.1 Research question, aims and objectives**

The following research question was developed to reflect the aims and objectives identified following the scoping review.

My research question: How is nursing accountability enacted from point of care to Health Board and how can it be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession?

The research aims and objectives of this doctoral study are set out below:

Research aims: Through exploring nurses' experiences and views of accountability in the NHS, the aims of this research study were to collect and analyse data on how accountability is understood and enacted across the nursing hierarchy and identify how this could be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession. In order to address these aims, the following objectives were identified:

## Objectives

1. To explore RNs' knowledge and understanding of accountability;
2. To explore how and why accountability is enacted across the professional hierarchy and the impact this has on practice;
3. To identify factors that facilitate or hinder nurses accepting accountability for safeguarding patient outcomes, quality of care and standards of the profession;
4. To portray a practice framework that prevents poor care rather than accounting for it after the event.

In the next chapter *Methodology and methods* the underpinning philosophy, design rationale and methods are presented.



## **Chapter 3: Methodology and methods**

### **3.1 Introduction**

In this chapter the philosophical assumptions and theoretical perspectives that have informed this study are presented. The decision to approach this study using a qualitative, multiple embedded, case study design will be justified. Issues of rigour in case study design will then be addressed. Following this the methods used for data collection and analysis are explained.

### **3.2 Philosophical perspectives**

Creswell (2013) highlights the importance of understanding and including philosophical perspectives in qualitative research. This makes transparent any values and beliefs that the researcher brings to the study and helps to frame the design and methods used.

#### **3.2.1 Epistemology**

Epistemology relates to the way in which the phenomenon being studied is known and learned. A philosophical background for deciding what kinds of knowledge are adequate and legitimate (Gray 2018). There are a range of epistemologies and Crotty (2015) discusses three that have emerged. Firstly objectivism, where meaningful reality exists separately from the operation of any consciousness. In this objectivist view of knowledge, understandings and values are considered to be objectified in the people being studied and that there is an objective truth to be discovered. Secondly, and in contrast to objectivism is constructionism, where truth, is constructed not discovered. This construction of truth, or meaning, is dependent on individual's interactions with the world. Hence, multiple, possibly contradictory (although equally valid) truths can exist in relation to the same phenomenon. Thirdly is the epistemology of subjectivism (Crotty 1998). In subjectivism knowledge is not generated from the interaction but imposed on the object by the subject. People (subjects) do construct meaning however not from the object but from their unconsciousness, from dreams and religious beliefs, et cetera (Gray 2018). In my study the meaning (truths) attributed to accountability in nursing have already been identified to be multiple and are dependent from the stand point one attempts to define it. Therefore, my epistemological position is constructionism.

#### **3.2.2 Ontology and theoretical perspective**

Ontology is the study of being and what constitutes reality (Creswell 2013). There are two ontological positions to consider (Ritchie et al. 2014). Realism, where an external reality exists irrespective of beliefs (associated with the theoretical perspective, positivism (Crotty 2015); and idealism which considers that reality is only knowable through the human mind and

socially constructed meanings (associated with the theoretical perspective, interpretivism (Crotty 2015). With regards to this study, the main phenomena under investigation is accountability. Therefore, the following question was posed in regards to my ontological position: is accountability a construction of the beliefs of nurses, or is its existence independent of these beliefs? Extrinsic accountability represents a version of reality ( independent of nurses beliefs) through which the action of holding someone to account can achieve an outcome (Boven 2006), but the context and its relationship with the concept of intrinsic accountability is dependent on how the nurse constructs meaning from this process, which in turn affects the outcome (Lerner and Tetlock 1999). Therefore, this study does not fit neatly with the extreme philosophical positions of positivism or interpretivism. According to social constructivism, knowledge is a human product, which is socially and culturally constructed (Ernest 1998). Knowledge is therefore neither bound to the external world nor wholly to cognition, but it exists as perceptions of interactions with other people in the environment (Schunk and Usher 2012). Therefore, my ontological approach is one of social constructivism.

### **3.3 Methodological approach**

#### **3.3.1 Qualitative research**

Exploring RNs views to understand the purpose of accountability and the real impact in practice is an essential component of this study. Qualitative research is conducted when a problem or issue needs to be explored through a process of inquiry that develops holistic and context dependent knowledge that is constructed from a participant's perspectives and lived experience (Gray 2018). This study therefore adopts a qualitative approach to gain a detailed understanding of accountability in nursing. This will help develop theories that capture the holistic complexity of professional practice at different levels of the nursing hierarchy from subjective evidence to be developed from individual views. Talking directly with nurses and adapting questions to the context in which they practice and experience accountability will enhance the richness of the data. In particular, capturing the differing perspectives and interpretations of accountability within the same organisation was dependent on being responsive to issues raised by nurses at different levels of the hierarchy and exploring the differing constructs of reality based on listening and further enquiry. A qualitative approach that captures the context of practice was therefore the best fit for this research study. A quantitative approach was not considered as the aim was not to measure or quantify accountability.

### 3.3.2 Rationale for case study design

Three popular qualitative research designs were appraised to identify which were the most appropriate for a study of this nature: ethnography, grounded theory and case study. The distinct features of case study design— contextual relevance, ability to study integrated systems and the prior development of theoretical propositions, are my rationale for the use of the case study approach within a philosophical framework of qualitative inquiry.

**Ethnographic studies:** Ethnography focuses on the description and interpretation of the shared patterns of values, behaviours, language and beliefs of an entire culture sharing group (Creswell 2013). The culture sharing group must be intact and interacting enough to develop patterns that can be observed. Taking this approach to study accountability in the nursing hierarchy would have several limitations. To 'do an ethnography' requires detailed description, analysis and interpretation of a culture sharing group. The aim of this study to explore accountability in the hierarchical structure of nursing means that, for example the nurses at point of care and the nurse director, would not interact frequently enough to develop patterns that could be studied. Ethnography was therefore excluded.

**Grounded theory:** First developed by Glaser and Strauss (1967), an approach where theories are not applied to the subject being studied but generated from the empirical data. The challenges identified with this approach were the ability to set aside, as far as possible, theoretical ideas to enable the emergence of substantive analytic theory. Having undertaken a scoping review of the literature prior to deciding on my methodological approach and to help my understanding and clarity framing nursing accountability with a working theory, this would not appear to fit with the inductive approach in grounded theory. A further consideration was the expectation of the researcher to make several visits to the field to collect data. Analysing the data between visits. The practical implications of being able to do this at all levels of the nursing hierarchy was consider impractical for this doctoral study. Grounded theory was therefore excluded.

**Case study:** Yin (2018) defines case study research as “an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident” (p15). In a case study, the case can be the situation, individual, group or organisation (Stake 1995). The attraction of a case study approach to address the research aims and objectives of this study is the opportunity to study accountability in context (levels of hierarchy) as part of a system, even if the parts of the system do not work particularly well, they are still part of a system (Stake 1995 P.2). Case study design can build up a detailed in-depth understanding and is of particular relevance

when a single perspective cannot provide a full account or explanation of the research issue, such as different perspectives within a hierarchy. Case study enables a holistic, comprehensive and contextualised understanding (Ritchie et al. 2014, P 67) and is considered appropriate when the researcher has no control of behavioural elements and when the focus is on contemporary rather than historical events (Yin 2018). Case study approach was therefore identified as the most suitable design to meet the objectives of this study.

### **3.3.3 Designing a case study**

A research design is the logical sequence that connects the empirical data, to the research question and ultimately to its conclusion (Yin 2018). This section discusses my case study design rationale.

It is apparent that there is not a consensus on the design and implementation of case study amongst research methodologists. This section discusses my rationale for using a combination of Robert K. Yin and Robert E. Stake case study design elements to best meet the needs of this research study and my underpinning philosophical assumptions. Stake is explicit about his epistemological beliefs that “knowledge is constructed rather than discovered” (Stake, 1995, p.100). Therefore, his constructivist perspective is that case study research can enable multiple views of one concept, within a system. Yin, is less explicit about his epistemological position however is considered to demonstrate positivistic tendencies in his perspective of case study research (Yazan 2015). As a social constructivist I find myself aligned to the philosophical stance of Stake. However, as a novice researcher, the guidance and strategies suggested by Yin are attractive. Therefore my overall design has not solely utilised one approach.

A flexible design that allowed for a combined inductive and deductive approach in the development of methods and during analysis was adopted for this study. This approach allowed the research process to take account of the scholarship that had gone before and to design an approach that would get to the nub of the underpinning issues (Stake 1995). This approach acknowledges the flexible nature of a case study approach and that the theory adopted at the beginning of the study may not survive to the end (Hartley 2004). Inductive and deductive approaches to case study research are debated in the literature (Simons 2013; Yin 2018; Stake 1995; Gray 2018; Denzin and Lincoln 2018). The two most opposing views are that of Simons (2013) and Yin (2018). Where Simons’ (2013) position is that cases should be used to inductively generate theories contrasts with Yin (2018) who recommends that case study research should be theory driven, with researchers generating a theoretical position prior to the study. Similarly Stake (1995) discusses that identified issues help to force the

attention of the research purpose to acknowledge the complexity and importance of context to help inform practice. Having reviewed and analysed the literature on the topic of accountability in Chapter 2, I will now assert a working theory.

My theoretical proposition: the professional discourse of accountability is focused on responsibility with the opportunity for professional deliberation and use of professional judgement. The emphasis in practice is on answerability which compromises the acceptance of professional responsibility and scope of practice. Therefore, current mechanisms of accountability challenge the moral implications of professional nursing accountability by focusing on answerability.

From this proposition questions were developed and tested with colleagues and my supervisors. A question guide was developed that contained three broad questions, with further supplementary questions (Appendix 1). These were designed to enable individual experiences to further explain what is already known about accountability in nursing and generate new knowledge.

### 3.3.4 Defining the case

Defining the boundaries of a case is necessary to help determine the scope of data collection and in particular to help distinguish between the subject being studied and the context. This process is also considered to improve the connection between the case, research question and theoretical propositions (Yin 2018). Yin (2018) advises novice researchers to utilise structure in the research design to avoid common pitfalls and proposes four different designs and provides a 2x2 matrix to illustrate four different designs (Table 7).

Table 7- Types of case study design

	Single case design	Multiple case design
Holistic ( single unit analysis)	TYPE 1	TYPE 3
Embedded (multiple units of analysis)	TYPE 2	TYPE 4

In contrast, Stake (1995) asserts that flexibility in design enables significant change if required as the research evolves. Both Stake (1995) and Yin (2018) concur that defining the case is a fundamental step in case study design. Yin (1994; 2018) suggests that a case can be a decision, process or phenomenon; highlighting that the boundaries of a case are not always clear. This view contrasts with Stake (1995) who argues that a case must be a 'functioning specific' (such as a person or organisation) not a generality (such as a policy). As the concept under investigation is 'accountability' in the context of nursing in Scottish Health Boards a Yinian perspective was adopted, and defined as, an embedded multiple case study design. As this study aimed to explore perceptions of accountability across the nursing hierarchy, the sub units (nurses at different levels of the hierarchy) are important to meet the research aims and objectives. Despite the importance of these sub units, Yin (2018) warns against the sub units becoming the focus of the study diverting away from the bigger picture (accountability across the hierarchy).

The overall focus of this study was to explore nurses' perceptions of how accountability is enacted, with a particular focus on the context of different levels in the nursing hierarchy from point of care to Board. Therefore a case was identified as the nursing hierarchical structure in a territorial Health Board (HB), and for pragmatic reasons this was contained within NHS Scotland. There are fourteen territorial health boards in Scotland.

Yin ( 2018) suggests that if each case is carefully selected to either (a) predict similar results (a literal replication), two to three cases are appropriate; or (b) predict contrasting results but

for anticipated reasons (a theoretical replication), four to six are appropriate. In considering how many cases would be sufficient for this doctoral study, my experience and time were two pragmatic limitations. I therefore decided to include three HBs (cases) as I predicted the overall case results to be similar. The criteria for the selected cases were two HBs with similar contextual features and one contrasting HB. All HBs provide a range of primary, secondary health services and have similar professional structures. This case selection provided the opportunity for literal replication across the HBs and allowed for contrast and comparison across the cases. The embedded nature of this case study necessitated the identification of subunits within each case. The subunits of a case are identified as nurses from each level of the hierarchy. Sub unit participants were purposively selected to represent the hierarchy within each case from Executive Nurse Director (END) to RN delivering direct care. Using the following inclusion and exclusion criteria:

***Inclusion Criteria:***

Nurses were eligible for inclusion in the study if they met the following criteria: Male and female RNs working full or part time in a hospital or community setting in the identified case (health board); and in the following roles: nurse director, associate/deputy nurse director, chief/senior nurse, nurse manager, senior charge nurse and registered nurse that report to a senior charge nurse.

***Exclusion Criteria:***

Nurses were excluded from this study if they were: non -registered, student nurses, advanced nurse practitioners (ANPs) and clinical nurse specialists (CNSs) as the diversity of roles and accountability structures were considered beyond the scope of this study.

Others within the system such as managers, doctors and patients that are identified in the literature as having an accountability relationship were excluded as the aim of this study is to explore RNs experiences and views on accountability.

### **3.3.5 Pilot study**

A pilot study was undertaken as part of the preparation for data collection; i.e., to refine data collection plans with respect to both the content of the data and the procedures to be followed (Yin 2018). The pilot study also helped to enhance my confidence in the interview questions and the logistics of the field work. The pilot study site was chosen for its convenience and accessibility. Five interviews were conducted with a nurse at each level of the hierarchy: Nurse Director, Chief Nurse, Nurse Manager, Senior Charge Nurse and Staff Nurse. Contemporaneous notes and reflections after each interview allowed me to refine the interview approach and research instruments to clarify questions used.

## **3.4 Methods**

In the previous sections the rationale for the choice of research methodology were outlined providing detail about the research design and the case selection. The following sections are used to discuss the methods used in this study.

### **3.4.1 Identification of cases**

Five of the fourteen HBs were excluded as they do not deliver a range of health services, for example Health Improvement Scotland and NHS 24. Nine ENDS from NHS Scotland territorial health boards that met the criteria were initially contacted by email and/ or telephone. All island health boards (n=3) were excluded due to travel cost implications. Six responses were received (no response from two ENDS) with three favourable indications to proceed. Research & Development (R&D) approval was confirmed prior to contacting any staff. This was carried out centrally through NHS Research Scotland Permissions Coordinating Centre.

### **3.4.2 Ethical considerations**

An application was made to the University of Stirling NHS, Invasive or Clinical Research (NICR) Committee on the 26<sup>th</sup> September 2017. With a few minor amendments, and confirmation that consideration by the NHS North of Scotland Research Ethics Committee (REC) was not required, approval was granted for the study (NICR 17/18- Paper No.83) on the 19<sup>th</sup> December 2017. This approval was conditional pending R&D approval. A central application was submitted and approved late February 2018 following an amendment discussed in 'Executive Nurse Director Recruitment' section below 2018. The probability of any major risks to participants in this study was considered to be low.

Ethical considerations related to the nature and purpose of the study: data integrity, confidentiality, anonymity and the subject matter of interviews and focus groups were considered.

#### ***Data Integrity***

It was acknowledged that due to the nature of the study there may potentially be some risk to the integrity of the data as RNs who agreed to be interviewed may be a biased group and or RNs within a hierarchical institutional relationship which might inhibit their true feelings. There was also a small chance that I would be known in my nurse director role rather than that of a researcher. To minimise the risk of this I identified myself in all correspondence as a researcher using my university email account. This was also reiterated in the participant

information sheet (PIS) and consent form (Appendix 2a, 2b and 3). Additionally, when first meeting participants I introduced myself as a researcher. To minimise the risk to the integrity of the data, aspects of confidentiality and anonymity were reiterated.

I was identified as a nurse director by six participants during data collection. They confirmed they were clear that I was there in my capacity as a researcher and that knowing me as a nurse director would not compromise their integrity in participating.

### ***Confidentiality and anonymity***

To maintain confidentiality and anonymity within each case, Executive Nurse Directors identified a contact from within their Board to facilitate the identification of potential participants from the hierarchical structures. Approaching these individuals by email was not considered to be obtrusive, and facilitated the opportunity for them to decline to participate in the study. The recruitment of the potential RNs was planned to be a confidential communication between myself and the RN. Participants that had to leave the ward (SCNs and RNs) had pre-arranged cover and advised colleagues that they were attending a meeting. Interview and focus group transcriptions were anonymised in a manner designed that only I knew participants identity. Focus group participants knew each other, but the data was anonymous. In addition, focus group participants were asked to keep their discussion confidential and not to reveal the identity of others. Data were managed and stored in accordance with the University of Stirling's Data Protection Policy and I complied with the requirements of the General Data Protection Regulation 2018 with regard to the collection, storage, processing and disclosure of personal information. No identifiable data will be used in presentations, reports and publications.

### ***Subject matter of interviews***

Due to the nature of the study there was the potential that examples of poor practice may be disclosed during the interviews and focus group discussions. The PIS highlighted that any practice that was disclosed that put patients or others at risk would be reported.

There was a possibility that participants may be uncomfortable with some questions. Should this have happened, the participants would have been sensitively supported. This was to include reiterating confidentiality and their opportunity to contribute to research that aims to improve professional accountability. If this approach did not alleviate the discomfort or at any time the participant became distressed, they were to be asked if they wished to pause or stop the interview. Rescheduling was to be offered as an option. None of these measures were required as no participants became distressed.

### **3.4.3 Recruitment**

Three cases and fifty-two RNs were recruited to the study. Purposeful sampling was used to identify study participants. Purposeful sampling in case study research optimises the opportunity to fully describe multiple perspectives (RNs at different levels of the hierarchy) of the same concept (accountability) (Creswell 2013). This approach enabled the purposeful choice of RNs due to the qualities they possessed. Simply put, RNs were recruited based on their willingness to participate, meeting the inclusion criteria and practicing at the hierarchical levels identified by the END. This approach enabled a representative sample across the nursing hierarchy in each HB to meet the research aims and objectives. This deliberate choice of participants had two phases. Phase one identified and recruited ENDS from Scottish HBs. Each END then provided their hierarchical structure from point of care to HB. Phase two then invited RNs from each layer of the nursing hierarchy identified by the END to participate.

The sample size was based on two requirements: achieving representation of each level of the hierarchy and achieving data saturation at each level of the hierarchy. Defining data saturation was discussed with my supervisors in the context of this doctoral study. It was agreed that although each participant would bring individual lived experiences to the research, data saturation would be achieved when the views of RNs coalesced. This approach enabled ample opportunity to identify themes in each case and the rich data to conduct across case analysis (Creswell 2013).

#### ***Executive Nurse Director (END) Recruitment***

Following confirmation of R&D approval from three sites, approaches were made to the ENDS to discuss the study in detail and agree access to nursing staff. The three confirmed ENDS were sent a study pack containing the PIS and a consent form. They were contacted at least two working days after the distribution of the study pack to arrange a date and time for interview. At this point they were asked to identify and provide the contact details for the nurses in the next layer of their professional structure.

Of the three ENDS that had agreed to participate, one of them was subsequently unable to proceed. Consideration was given to using two cases, rather than the planned three with my supervisors. The HB that could no longer be included was the HB with contrasting features, and therefore attempts to identify an alternative case were made. Following individual conversations with ENDS, an alternative HB was identified. University ethics were contacted and updated. NHS Research Scotland Permissions Coordinating Centre amended the

application to proceed R&D approval with the new Board. The END from Case C was then sent a study pack containing the PIS and a consent form (Appendix 2a, 2b and 3).

As outlined in the research protocol, nurses from each layer of the hierarchy (each sub unit) would provide the contact details of the nurses in the layer below. The ENDs from all three cases identified and provided the contact details for RNs in the next layer. Only Case C RNs adhered to this process of recruitment for the remainder of the participants. My approach was adapted in Case A and Case B to utilise one member of senior staff identified by the END to identify potential participants across the hierarchy- this worked well. Participant anonymity and confidentiality was reiterated to both identified individuals. On receiving the email with names and contact details of potential participants, an email was sent inviting them to participate with a study pack containing the PIS and a consent form included in the email. They were contacted at least two working days after the distribution of the study pack to arrange a date and time for interview. I remained available by phone or email to answer any questions. Completion of signed consent forms was required prior to data collection.

Recruiting nurses from each level of the hierarchy across the three cases was completed with interview dates and locations confirmed by May 2018.

#### **3.4.4 Informed consent**

It was important that the nurses did not feel coerced into participating particularly due to the hierarchical nature of the study. The readability of the PIS and study pack was tested with peers in the pilot study. The following steps were also taken with regards to informed consent:

- Nurses were informed that participation in the study was entirely voluntary;
- They were advised that their decision to withdraw or not participate in the study would not be shared with their END
- The use of a digital audio device to record interviews was highlighted in the PIS and the confidential storage of data was reiterated.

#### **3.4.5 Data collection**

Data collection took place sequentially in each case as follows: Case A in June, 2018; Case B in July, 2018; Case C in August, 2018. This allowed me to focus on comparisons within each case and avoided any unintentional 'contamination' in relation to each cases specific context. Yin (2018) identifies six possible sources of evidence that can be used in case study research:

documentation, archival records, interviews, direct observations, and physical artefacts. For practical reasons this study design used interview data as the main source of data.

A total of 49 nurses participated in this study, two scheduled interviews did not go ahead, due to the cancellation by the participant and an inability to reschedule. One interview was withdrawn from the data as it became apparent that the RN did not fit the inclusion criteria. Fifteen interviews and nine focus groups were conducted. Table 8 provides the details of nurses interviewed.

Table 8 – Registered Nurses interviewed

Health Board case	Nurse participants
Case (A) individual interviews	1 Executive Nurse Director 4 Chief Nurses
Case (A) focus group interviews	3 Lead Nurses 4 Senior Charge Nurses 10 Direct care giving RNs
Case (B) individual interviews	1 Executive Nurse Director 2 Nurse Director/Chief Nurse 3 Associate Nurse Directors
Case (B) focus group interviews	2 Nurse Managers 3 Senior Charge Nurses 4 Direct care giving RNs
Case (C) individual interviews	1 Executive Nurse Director 1 Deputy Nurse Director 2 Lead Nurses
Case (C) focus group interviews	4 Nurse Managers 2 Senior Charge Nurse 2 Direct care giving RNs

### ***Interview and focus group data collection***

Regardless of the approach taken in qualitative research, during data collection ethical considerations will arise (Creswell 2013). In particular, I considered how I engaged appropriately as a researcher with the participants during interviews and focus groups. It was important that as a novice researcher I took time to prepare for each interview and focus group. To do this I scheduled protected time prior to each interaction to ‘get in to the mind –set’ of a researcher by reading my scoping review and methodology chapters and reflecting on the interviews that I had completed so far. During the interviews and focus groups I was honest

and open about the research purpose, sharing with the participants issues that emerged from other participants. After the interviews and focus groups I reflected on what had been discussed. This included my contribution and the impact that may have had. As outlined below reflection occurred in field notes, with supervisors and through processes of reflexivity.

All ENDs were interviewed first. Following these interviews participants were interviewed in order of role seniority. This allowed perceptions of senior RNs to be raised and further probed with RNs closer to point of care. Focus groups were restricted by hierarchical level to allow participants to speak freely without senior RNs being present.

All participants were offered a phone call to discuss the interview or focus group prior to the scheduled time. Semi structured individual and focus group interviews were conducted using a question guide (Appendix 1) which was not restrictive and was used to help guide the interview rather than control it. My questions and approach evolved based on my field notes, reflections and on a case by case basis. Whenever interviews were conducted face-to-face in the HB, they were carried out in a private and quiet area. Where face-to-face interviews were not possible Skype and then telephone interviews were offered. Twelve interviews were conducted face to face, one by Skype and three by telephone. The individual interviews lasted between 50 minutes and 85 minutes. Each focus groups lasted between 60 and 90 minutes, and each participant was interviewed only once. Interviews were recorded using a digital audio recorder with the consent of participants and transcribed verbatim by a professional transcriber. Using transcription to familiarise the researcher with the data is considered to be helpful to novice researchers (Gale et al. 2013). The decision to outsource this step in the process was carefully considered and discussed with my supervisors. A confidentiality agreement was signed. After each interview was transcribed I checked the accuracy by reading the transcription and listening to the audio recording several times. I made corrections during my reviews of the transcripts.

Each participant was assigned a unique identifying number associated with the individual's audio recording and transcript. Anonymised contemporaneous and reflective field notes were kept by the researcher. These notes were reviewed between interviews to prompt small changes to aspects of the process that didn't work so well and to follow up issues that were identified that required augmenting. They also supported a process of reflection. Throughout the study I was careful to focus on my role as a researcher and consciously managed my responses and approach appropriately. This was most apparent during the data collection phase. My field notes contained the following two entries:

*"Today's focus group was difficult. I was primarily concerned with my ability to listen as the researcher. The nurses were frustrated and I was uncomfortable. The data will*

*be very strong in this study but I feel sad that nurses have to work like this. I have reflected on the train home and although emotions were high I wonder how much of that was about the opportunity to be heard. I did listen and supported the discussion. I will discuss this at my next supervision."*

*"I am really conscious that nurses appear to be trying to please and have rehearsed aspects of the NMC code and in particular the phrase "I am accountable for my actions and omissions in relation to the code". Have they? Why is this? On deeper exploration the meaning behind this is variable. Is this part of nurses wishing to comply and please in relation to the research process?"*

### **3.4.6 Reflexivity**

Reflexivity is the process of critical reflection of the researcher on self as 'the human instrument' (Guba and Lincoln 1981). It is used to describe the relationship between researcher and the object of research. The process of reflexivity involves the realisation that the researcher is not a neutral observer and is implicated in the construction of knowledge (Gray 2018).

There are two forms of reflexivity identified by Gray (2018): First, epistemological reflexivity where the researcher reflects on their assumptions about the world and about the nature of knowledge. In relation to this study, I considered how my epistemological assumptions had influenced my choice of research question and methodological approach. I acknowledged that alternative approaches could have been used to deliver alternative aims and objectives. Second, personal reflexivity, where the researcher reflects the way in which their values, attitudes and beliefs have served to shape the research and, how the research process has shaped the researcher. Dupuis (1999) considers this to be a continuous, intentional and systematic self-introspection throughout the research process. For this doctoral study a reflective journal was kept by the researcher as recommended by Lincoln and Guba (1994).

One characteristic of good qualitative research is that the researcher makes her position explicit (Hammersley and Atkinson 1995). Creswell (2013) makes the suggestion that the researcher talks about her experiences with the phenomenon being explored and how these experiences shape the researchers' interpretation of the phenomenon. To that end this reflexivity section will conclude with a brief narrative about me:

*"For the last nine years I have been a doctoral student at the University of Stirling. I have worked as a Registered Nurse in a variety of clinical and leadership roles across NHS Scotland since qualifying as a Registered Nurse in 1994. My personal and professional experiences have shaped my view of the world to focus much more on how people make their decisions rather than what decisions they make. My experience of accountability has been unremarkable, not positive or negative. What I*

*have experienced is that accountability does not assure care and hence my interest. My preference for logic and process has softened over the years to acknowledge cultural impact. My understanding that different perspectives can be equally valid has also matured. Accountability nine years ago was conceptualised (although I'm not sure I would have used that word) by me as answerability and issues could be addressed with improved structures of governance. How naive. I have consciously recognised that as an RN I bring my own perceptions to this research study and have attempted to mitigate the risks of this throughout every stage of this research process to the best of my ability."*

### **3.4.7 Data management and analysis**

In this section, I describe the data management and analysis phase of the study. This will include an overview of the approach, Framework Analysis (FA), and to conclude, the final step of abstraction and interpretation and development of the analytic framework (Table 15). I used QSR International's NVivo 11 qualitative data analysis software to store and manage data. NVivo 11 is a computer assisted data management system. The use of NVivo 11 provided a clear audit trail to enhance transparency by enabling analytic decisions and interpretations to be traced back to raw data. In case study design it also enabled easy management of data within and across cases.

#### ***Introduction to framework analysis***

There are a number of approaches to qualitative data analysis, and no prescriptive recipes for the most effective analysis of case study evidence. Framework analysis (FA) sits within a broad family of analysis methods often termed as thematic or qualitative content analysis (Gale et al. 2013). In this section I will justify my choice of FA and explain how I approached each stage of the process.

FA was an attractive choice for this study as it is considered a flexible tool that can be adapted for use with many qualitative approaches and particularly for generating themes; it is not aligned to a particular epistemological, philosophical, or theoretical approach and both inductive and deductive research can utilise this approach; importantly for a novice researcher the approach appeared logical and systematic. The approach used in this study follows the stages of FA identified by Ritchie et al. (2014)

1. Familiarisation
2. Constructing an initial thematic framework
3. Indexing and sorting
4. Reviewing data extracts
5. Data summary and display

## **1. Familiarisation**

The aim of this step was to immerse myself in the data and to develop labels that were grounded in the data (Ritchie and Spencer, 1994 p.179). Audio recordings were listened to repeatedly both in isolation and in conjunction with written transcripts and with field notes. This process ensured familiarisation with each individual interview (n=25) and also the overall feel of each case (n=3). Labelling at this stage was extensive and problematic. This became unwieldy and at times I felt as if I was copying the entire transcription. My ability, at this stage, to use NVivo and FA confidently was limited. To continue to make progress I arranged to have some additional tuition on the programme and in the meantime resorted to a manual process. This involved writing labels on the transcripts and then transcribing the labels onto post it notes and grouping labels of related concepts and ideas into areas. These groupings were readily visible to me on flip charts on a wall. The groupings were based on the research questions and the repeated themes in the transcripts. Six groupings were identified at this point:

1. Knowledge of accountability
2. Nurses' experiences of demonstrating accountability
3. Perceptions of the impact of accountability
4. Perceptions of the purpose of accountability
5. Factors that facilitate or hinder nurses accepting accountability
6. Miscellaneous

A miscellaneous group was identified for any labels that did not fit into one of the other groupings.

## **2. Construction of initial thematic framework**

The aim of this stage of the FA process was to organise data in a manageable and meaningful way into a set of themes and subthemes that creates the initial thematic framework (Ritchie et al. 2014). This process was both inductive, using emergent issues arising from the earlier familiarisation step and deductive based on priori issues identified in the literature and explored through interview data collection. This process was iterative and not linear. From the seven groupings and associated labels there were several attempts made to create initial subthemes that were not repetitive and /or irrelevant to the study. Some labels could have sat in several subthemes. The labels were finally grouped into n=27 initial subthemes. Following this stage I renamed the groupings as the six initial themes based on the study objectives and emergent subthemes. The labels in the miscellaneous grouping were distributed across the subgroups or removed as considered irrelevant to the study. I then tested the thematic

framework on three of the most diverse transcripts. The initial thematic framework provided the flexibility to address study objectives and identify emerging issues in the data. The Initial Thematic Framework V1 is displayed in Table 9.

Table 9- Initial Thematic Framework V: 1

	Initial Theme	Initial Subthemes
1.	RN knowledge and understanding of accountability. <i>Description:</i> The meaning that RNs give to accountability.	<ul style="list-style-type: none"> <li>• Accountability as responsibility</li> <li>• Accountability as personal value</li> <li>• Accountability as a relationship and answerability</li> <li>• Other</li> </ul>
2.	RNs perceptions of the intent of hierarchical accountability structure. <i>Description:</i> RNs perceptions of the intent of the hierarchical accountability structure from point of care to Board	<ul style="list-style-type: none"> <li>• Professional intent of hierarchical relationships</li> <li>• Organisational intent of hierarchical relationships</li> <li>• Other</li> </ul>
3.	What are RNs accountable for? <i>Description:</i> RNs perceptions of what they are accountable for.	<ul style="list-style-type: none"> <li>• What are RNs professionally accountable for</li> <li>• What are RNs as employees accountable for</li> <li>• What are RNs personally accountable for</li> <li>• Other</li> </ul>
4.	RNs experiences of demonstrating accountability. <i>Description:</i> RNs experiences of how and why they demonstrate accountability.	<ul style="list-style-type: none"> <li>• How do RNs demonstrate accountability</li> <li>• Why do RNs demonstrate accountability</li> <li>• Other</li> </ul>
5.	RNs perceptions of the impact of accountability in practice <i>Description:</i> RNs perceptions of how accountability (relationships and answerability) impact in practice	<ul style="list-style-type: none"> <li>• What is the impact of accountability on professional practice</li> <li>• What is the impact of accountability on safeguarding patient care</li> <li>• What is the impact of accountability on individuals</li> <li>• Other</li> </ul>
6.	Factors that facilitate or hinder RNs ability to accept responsibility. <i>Description:</i> Factors that were a facilitator or barrier to an RN accepting responsibility	<ul style="list-style-type: none"> <li>• Interactions with colleagues</li> <li>• Environmental and cultural factors</li> <li>• Perceptions of fairness</li> <li>• Perception of risk</li> <li>• Confidence to challenge</li> <li>• Clarity on responsibilities</li> <li>• Resilience</li> <li>• Other</li> </ul>

### 3. Indexing and sorting

The initial thematic framework was then applied to all transcripts. The thematic framework themes and subthemes were entered into NVivo 2017. Extracts from each transcript were grouped under the subtheme headings. If data that was considered relevant did not fit into a sub theme it was entered into a subtheme named 'other'. When this process was completed all extracts named 'other' were then assigned to the most appropriate subtheme or a new subtheme was added under the relevant theme.

### 4. Reviewing data extracts

At this stage, all data extracts were reviewed to ensure no important themes had been excluded. Following discussions with my supervisors I amalgamated themes one and three, as RN descriptions of their understanding of accountability; this also incorporated what they considered themselves accountable for. Therefore, the overlap of data was significant in the subthemes. Similarly, themes four and five were merged as RN experience of accountability was descriptive of the impact in practice. Following this stage in the process, the initial thematic framework now comprised of four themes and 15 subthemes. This was updated in NVivo and is presented in Table 10.

Table 10- Initial Thematic Framework V2

	Initial Theme	Initial Subthemes
1.	RN knowledge and understanding of accountability. <i>Description:</i> The meaning that RNs give to accountability.	<ul style="list-style-type: none"> <li>• Accountability as responsibility</li> <li>• Accountability as personal value</li> <li>• Accountability as a relationship and answerability</li> </ul>
2.	RNs perceptions of the intent of hierarchical accountability structure. <i>Description:</i> RNs perceptions of the intent of the hierarchical accountability structure from point of care to Board	<ul style="list-style-type: none"> <li>• Professional intent of hierarchical relationships</li> <li>• Organisational intent of hierarchical relationships</li> </ul>
3.	RNs experiences of how and why accountability is enacted and the impact in practice	<ul style="list-style-type: none"> <li>• How do RNs demonstrate accountability</li> <li>• Why do RNs demonstrate accountability</li> <li>• What is the impact of accountability in practice</li> </ul>

4.	<p>Factors that facilitate or hinder RNs ability to accept responsibility.</p> <p>Description: Factors that were a facilitator or barrier to an RN accepting responsibility</p>	<ul style="list-style-type: none"> <li>• Interactions with colleagues</li> <li>• Environmental and cultural factors</li> <li>• Perceptions of fairness</li> <li>• Perception of risk</li> <li>• Confidence to challenge</li> <li>• Clarity on responsibilities</li> <li>• Resilience</li> </ul>
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**5. Data summary and display**

Matrices for each theme were generated in NVivo and then exported to Excel to enable easier manipulation and oversight of the tables. In total, there were twenty tables. For each case four tables were created, reflecting the themes and subthemes, as presented in Table 10. Each table displayed the theme, subtheme, level of the hierarchy, the data extract and a summary of the extract. This enabled comparison within the hierarchy and across cases of RN perceptions and experiences of accountability. According to Ritchie et al. (2014), this stage is considered optional by some researchers however its use is advocated to ensure a ‘firm foundation’ on which to conduct the abstraction and interpretation phase. An example of one matrix is displayed in Table 11.

Table 11- Matrix Case C Theme 1: Subtheme 1

RN responsibilities					
Board ←			→ Point of care		
<u>Responsible for professional standards and standards of care being delivered across the system</u>	<u>Responsible for professional standards, patient safety, improvement, older people across nursing</u>	<u>Supporting staff and being approachable.</u>	<u>Individual practice in accordance with the NMC code</u>	<u>High quality care, safe staffing levels and upholding standards</u>	<u>Patient care</u>
<p><i>"I would say I'm responsible for care, so clinical delivery of care by nurses, midwives, and allied health professions, standards, and the standard of care throughout the system." END</i></p>	<p><i>"If you want the quick version of what my job is, it's responsibility for professional standards, education and training, patient safety and improvement, older people (which includes lots of things), and just that professional lead for nursing." DND</i></p>	<p><i>"So, a lot of the work that I'd done and I suppose a lot of my Lead Nurse stuff is about the members of staff who work within my team and making sure that they're equipped to be able to deal with the things that they need to be able to deal with and they know that they can come to me if they need to come to me." LN</i></p>	<p><i>"I'm responsible for what I do in accordance with my NMC code." NM</i></p>	<p><i>"I think, overall, I am responsible for ensuring high quality care. I am responsible for ensuring safe staffing levels. I'm responsible that the standards are being upheld." SCN</i></p>	<p><i>"So, patients care from the start of the day until the end of the day, any deterioration with a patient, any requirements they might have, for example, wound dressings, medication rounds, all your day to day nursing tasks dependant on your ward area. Basic care, washing, dressing, skin checks... Vital sign recording." RN</i></p>

<p><u>Challenging decisions to ensure patient care remains a priority in a financially challenged service</u></p> <p><i>"I can ask the difficult questions because I don't hold fiscal responsibilities but we're all tasked to land the board in an acceptable financial envelope. So my job is to bring the patient back in to the discussion and I do so without fear or favour." END</i></p>	<p><u>Standards and external scrutiny</u></p> <p><i>"The HIS standards, I've got responsibility for that but I also have food nutrition, and I also have adult support and protection. When you look at the joint inspection stuff around care inspectorate and HIS, I also have the health lead for that." DND</i></p>	<p><u>Driving continuous improvement</u></p> <p><i>"Community Nurse Managers really want to drive forward and get to being able to say, "Actually, we're making an improvement, we've met bronze in this"</i></p>		<p><u>Delegation and ensuring (folk) have the capability to undertake their roles and delegated tasks.</u></p> <p><i>"It's the delegation, you're accountable for the delegation and really to be assured that folk know their roles and responsibilities." SCN</i></p>	<p><u>Visibility and communication with relatives</u></p> <p><i>"I think its important making yourself visible to patient's next of kin as well and maybe just saying, "Oh, how are you today? Are you quite happy with the care? Sometimes you can get quite a lot out of patient's family as well or their next of kin."RN</i></p>
<p><u>Corporate responsibility wider than NMAHPs</u></p> <p><i>"My responsibility does not end with professional responsibility for the NMAHP teams." END</i></p>	<p><u>Supportive challenge and understanding</u></p> <p><i>"To give support to the Lead Nurses but also to really understand and, where necessary, challenge." DND</i></p>	<p><u>National improvement programmes and local adverse events</u></p> <p><i>"I think particularly around patient safety. When I'm saying patient safety, I'm thinking about specific programs. Our quality assurance, excellence in care kind of derivative, patient safety work, so the</i></p>		<p><u>Responsible for the staff delivering care</u></p> <p><i>"On a local, every day level, I would say that I'm responsible for the people at the coal face".SCN</i></p>	<p><u>Questioning the fairness of level of responsibility</u></p> <p><i>"If a patient really deteriorates quickly, like every nurse, but we don't have doctors on site so sometimes you think, 'Well, is that really fair that we have all that responsibility on our shoulders?" RN</i></p> <p><u>Staffing</u></p>

		<p><i>likes of Scottish Patient Safety Program, risk/adverse event management, all of that, and I would say even broader than just the General Manager but the general management structure so with our Locality Managers as well, they do not see a responsibility around that on a day to day operational basis."</i></p>			<p>"If someone phoned in sick, for example, we'd have to phone around and see if someone would be willing to do an extra night shift. We take that responsibility on ourselves even despite the Charge Nurses will be away home for the day, we have to cover our own backs and look through the off duty and find someone." RN</p>
				<p><u>Care assurance and documentation</u></p> <p><i>"So, care assurance, so we're responsible for checking the quality of the documentation that they're under certain standards."</i> SCN</p>	
				<p><u>De-escalation by listening and valuing what people say. Communication with relatives</u></p>	

				<p><i>"I think you have a responsibility... if there's something that isn't right, you have a responsibility to act on that. I'm a great believer in going and speaking to the person. Sometimes if you do it face to face, speak with a relative about something that's happened or a carer or whoever, you can actually de-escalate anything just by talking to folk but actually listen to them and make them feel listened to and valued." SCN</i></p>	
				<p><u>Indecision based on previous experiences in hierarchy.</u>  <i>Whereas, there's certain things, yes, I'm responsible for. I make a decision but then it gets to a certain level and I think, actually, there's some things that I feel I better run that past them. I don't</i></p>	

				<p><i>know whether it's because things have come back to bite me on the bum previously so I think, okay, I better learn from mistakes, or whether you feel 'am I passing the buck', which you're not but you're damned if you do, damned if you don't.</i></p>	
	•			<p><u>Autonomy in relation to direct care decisions but not when potential organisational reputation damage</u>  <i>She's responsible for delivering the care but not responsible enough to pick up the pieces when it goes wrong.</i></p>	
<p><b>Perceptions and experiences of accountability</b></p> <p>Board ←————→ Point of care</p>					

## ***Abstraction and interpretation***

The final stage of the analysis process was abstraction and interpretation of the data. This required the development of categories followed by the development of an analytic framework.

### **Development of categories**

In this process my aim was to consider from the initial themes, subthemes and subsequent matrices of extracts and summaries – what was happening within each theme and subtheme and what was most important to meet the aims and objectives of this study. As guided by Ritchie et al. (2014), this involved taking the data summaries (or raw data if the summarising stage was not undertaken) and listing the elements that appear in the text. This enabled the combination of some summaries from across a number of subthemes. An example of how this was done for the subtheme ‘accountability as responsibility’ is presented in Table 12.

Table 12- Detected elements from subtheme ‘accountability as responsibility’

Data summaries for subtheme: <u>accountability as responsibility</u>	Detected elements
<u>Responsible for professional standards and standards of care being delivered across the system; Challenging decisions to ensure patient care remains a priority in a financially challenged service; Corporate responsibility wider than NMAHPs; Responsibility to empower the largest workforce</u> <u>Responsible for professional standards, patient safety, improvement, older people across nursing; Standards and external scrutiny</u> <u>Supportive challenge and understanding</u>	<ul style="list-style-type: none"> <li>• Focus on professional standards and standards of care at a system level</li> <li>• Challenge decisions to ensure patient priority at Board level.</li> <li>• Role responsibilities are wider than professional agenda</li> <li>• Empowerment of the largest workforce is important</li> <li>• Focus on patient safety, professional standards, quality improvement and older people in the profession</li> <li>• Portfolio is shaped by external influences- HIS</li> <li>• Understanding and challenge of RNs are important</li> </ul>
<u>Supporting staff and being approachable; Driving continuous improvement; National improvement programmes and local adverse events; Individual practice in accordance with the NMC code</u>	<ul style="list-style-type: none"> <li>• Supportive and approachable</li> <li>• Continuous improvement</li> <li>• Portfolio is shaped by national improvement programmes and learning from adverse events</li> <li>• Focus on individual responsibility in the context of the NMC code</li> </ul>
<u>Patient care; High quality care, safe staffing levels and upholding standards</u> <u>Delegation and ensuring (folk) have the capability to undertake their roles and delegated tasks; Responsible for the staff delivering care; Care assurance and documentation; De-escalation by listening</u>	<ul style="list-style-type: none"> <li>• Individual patient care interactions</li> <li>• Patient care, safe staffing and upholding professional standards at a team level</li> <li>• Appropriate delegation</li> <li>• Responsibility as employer for staff</li> </ul>

<u>and valuing what people say;</u> <u>Communication with relatives; Indecision based on previous experiences in hierarchy; Visibility and communication with relatives; Questioning the fairness of level of responsibility ; Staffing</u>	<ul style="list-style-type: none"> <li>• Safe guarding care and quality assuring documentation</li> <li>• Responsibility to families of patients</li> <li>• Hierarchical control influences ability to enact responsibilities</li> <li>• Individual communication with relatives</li> <li>• Burden of responsibility</li> <li>• Sorting out staffing when short</li> </ul>
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The identified elements were then considered to identify any similar or repetitive issues. A couple of the emergent issues were re-categorised under a different subtheme. All related elements were grouped and came under one ‘category’. There was duplication of the emergent issues under the theme ‘RNs’ perceptions of the intent of the hierarchy’ and the other three themes; these mainly related to escalation, assurance and leadership. The decision was therefore taken to remove the theme ‘RNs perceptions of the intent of the hierarchy’ and ensure all emergent issues were categorised under subthemes of the remaining three themes. An example of how this was done for the subtheme ‘accountability as responsibility’ is presented in Table 13.

Table 13 – Categorisation of detected elements from the subtheme ‘accountability as responsibility’

Detected elements	Categories
<ul style="list-style-type: none"> <li>• Focus on professional standards and standards of care at a system level</li> <li>• Challenge decisions to ensure patient priority at Board level.</li> <li>• Role responsibilities are wider than professional agenda</li> <li>• Empowerment of the largest workforce is important</li> <li>• Focus on patient safety, professional standards, quality improvement and older people in the profession</li> <li>• Portfolio is shaped by external influences- HIS</li> <li>• Understanding and challenge of RNs are important</li> </ul>	All elements related to responsibilities at a system wide level: Category name: whole system level
<ul style="list-style-type: none"> <li>• Supportive and approachable</li> <li>• Continuous improvement</li> <li>• Portfolio is shaped by national improvement programmes and learning from adverse events</li> <li>• Focus on individual responsibility in the context of the NMC code</li> </ul>	All elements related to responsibilities for components of the system Category name: intermediary level

<ul style="list-style-type: none"> <li>• Individual patient care interactions</li> <li>• Patient care, safe staffing and upholding professional standards at a team level</li> <li>• Appropriate delegation</li> <li>• Responsibility as employer for staff</li> <li>• Safe guarding care and quality assuring documentation</li> <li>• Responsibility to families of patients</li> <li>• Individual communication with relatives</li> <li>• Burden of responsibility</li> <li>• Sorting out staffing when short</li> </ul>	<p>All elements related to responsibilities at point of care level:  Category name: point of care level</p>
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### **Development of an analytic framework**

This stage concerned the development of analytic subthemes and themes to create an analytic framework based on the categories (Table 14). The categories were examined and the analytic subthemes were derived from the key point or concept that the categories conveyed. In the same way analytic themes were derived from the emergent key points from the analytic subthemes. The development of the analytic framework is presented in Table 15.

Table 14 -Development of the analytic framework

Categories	Key emerging concepts	Subthemes	Key emerging concepts	Analytic themes
Organisational structures NMC Public/ patients  Whole system level Intermediary level Point of care level	Accountability structures, process and accountability relationships  Responsibility for tasks, actions or obligations as they related to the code or level in the hierarchy.	Relationships, structures and processes in which RNs are answerable  Accountability as levels of responsibility	Knowledge and understanding that RNs had about accountability	Knowledge and understanding of accountability
Documentation Complaints/ Adverse events/ DATIX External scrutiny  Meetings Audits  Decision making Challenging colleagues Record keeping and documentation	The way in which RNs enact accountability identified three different contexts in which this is carried out in practice.	Enacting accountability in response to poor care  Enacting accountability to assure care and standards of the profession  Enacting accountability at point of care to safeguard patient outcomes	What RNs perceived about how and why enacting accountability was practiced and the impact in practice	How and why accountability is enacted and the impact in practice
Identity and being valued  Level of knowledge and skills  Relationships of trust and support  Control of responsibilities	Individual and organisational issues were identified by RNs as factors that enable or inhibit acceptance of accountability	RN self –confidence, resilience and autonomy to make open reasoned judgements  Fair and safe working environment	RN self –confidence, resilience and autonomy ( authority to make decisions and freedom to act) in accordance with the NMC Code	Individual and organisational barriers to RNs accepting professional accountability

There were two identified limitations of using FA. First, the method is reported as time consuming and resource intensive. Second, it is believed that the successful use of FA is enhanced if the process is led by a qualitative 'expert' on the method (Gale et al. 2013). This study was undertaken by me and was resource and time limited. However, the study was initially guided by two supervisors, one of which was expert with this approach, and finally guided by three supervisors who concurred with the initial framework analysis. This helped with the credibility of the research process.

### **3.4.8 Establishing trustworthiness of data**

In this section, the steps taken to ensure trustworthiness throughout my research process are presented. Although there are other models for assessing the trustworthiness of qualitative data, I have chosen to demonstrate the rigour in my approach by describing how the concepts of credibility, transferability, dependability and confirmability have been met in this study. It has been noted that these concepts have been successfully used to describe various aspects of trustworthiness in qualitative research (Guba and Lincoln 1981; Lincoln and Guba 1994; Polit and Hungler 1999 cited in Graneheim and Lundman 2004, p. 109).

#### ***Credibility***

Credibility concerns the confidence that can be placed in the truth of the research findings and how well the data and processes of analysis address the intended focus (Lincoln and Guba 1985; Polit and Hungler 1999 cited in Graneheim and Lundman 2004). Three steps were taken to ensure credibility.

First, engagement with participants was focussed on developing trust. Where possible, data collection took place at participants' place of work. Data were collected from a range of participants across the nursing hierarchy which allowed a deeper understanding of the case culture, and built relationships and rapport with participants to be able to get to the truth of their experience.

Second, data collection and analysis stages of this study enabled a deeper understanding of the concept of accountability. Theoretical triangulation before and during data collection (within and across the case studies) allowed data to be considered from a range of theoretical perspectives. Triangulation of the multiple perspectives of RNs from within the nursing hierarchy of each case study strengthened the depth of questioning and data collected and finally the triangulation of my interpretations of the data and that of my supervisors who provided challenge and guidance at each stage.

Third, in undertaking this study as part of a Clinical Doctorate my role as a novice researcher was recognised and the important role of peer/ supervisory meetings. This limitation of my experience was addressed through a continuous process of reflexivity. I kept a reflective diary that allowed me to record my thoughts, ideas, feelings and challenges to discuss. The diary helped me to reflect on my own biases and assumptions and ensure that I took steps to minimise these when conducting the study by discussing any identified issues at supervision sessions.

During my regular supervisory sessions guidance was offered at each stage of the process. Regarding the focus of the study there were several steps taken before and during the systematic scoping review to ensure credibility. An example of this was that prior to conducting the scoping review a preliminary search of the electronic databases, MEDLINE, CINAHL and The Cochrane Library was undertaken for existing reviews of accountability in nursing to identify the terminology used in reporting this concept. Following this, a range of nurses were involved in the identification of the most appropriate search terms to ensure no important concept associated with accountability was missed. The approach of discussing appropriate aspects of the study with colleagues, supervisors and other doctoral students was practiced throughout the research process and enhanced the credibility of my work by keeping my thoughts grounded and focussed (Lincoln and Guba 1985).

My philosophical approach was clearly stated to enable judgement of the methodological and findings robustness (Carolan et al. 2016).

### ***Transferability***

Transferability concerns the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents, enabling a thick description as a way of achieving this (Lincoln and Guba 1985). As the study aimed to explore RN experiences and views across the nursing hierarchy, it was necessary that the design reflected the identification, access and importance of the subunits within each case. An embedded, multiple case study design was identified to ensure that this was achieved by obtaining data from RNs with various perspectives to enhance the richness and thickness of the data relating to accountability. Although each case data are of descriptive worth in and of themselves, the across case analysis enabled similarities and differences to be reported and discussed to enhance the depth of the description.

Participants were selected from out with the HB that I work in to minimise any bias associated with my role as a nurse director. A pilot study was conducted to refine data collection plans, tools and practice interview techniques. I was observed and given feedback on my interview

technique to enhance my approach. Concerning data collection credibility was achieved, as previously discussed, by being aware of my potential biases and managing these appropriately. Interviews were digitally recorded and I kept field notes that were referred to during the data analysis stage when clarity was required or if the transcript did not reflect the full message conveyed in the interview.

### ***Dependability and confirmability***

Dependability and confirmability relate to the stability of findings over time and seeks to be cognisant of design induced changes to the data due to decisions made by the researcher during the analysis phase (Lincoln and Guba 1985). Framework analysis was utilised to develop a robust analytic framework to enhance the credibility of my findings and to ensure the study achieved its aim. Data was managed using NVivo to enable an audit trail of the analysis of data. I completed the university on line NVivo course and attended a workshop on NVivo to ensure competence. In establishing the themes, subthemes, emergent issues and categories, data extracts were reviewed and then re-reviewed. Examples of each stage of the analysis process were included in my thesis to ensure transparency and optimise awareness of the rationale for my decisions. The additional step of developing matrices with summaries of the extracts was completed for all subthemes. My interpretation of the summaries into categories was checked and discussed with non- nursing public health research colleagues and my supervisors to ensure the categories were most relevant.

## **3.5 Chapter summary**

This chapter provided an overview of the methodological approach, philosophical underpinnings and methods used for the study. The study had an exploratory design and combined an inductive and deductive approach to understand how RNs relate to the concept of accountability. Framework analysis, a systematic and transparent approach to data analysis was used to identify the findings in terms of themes, subthemes and categories.

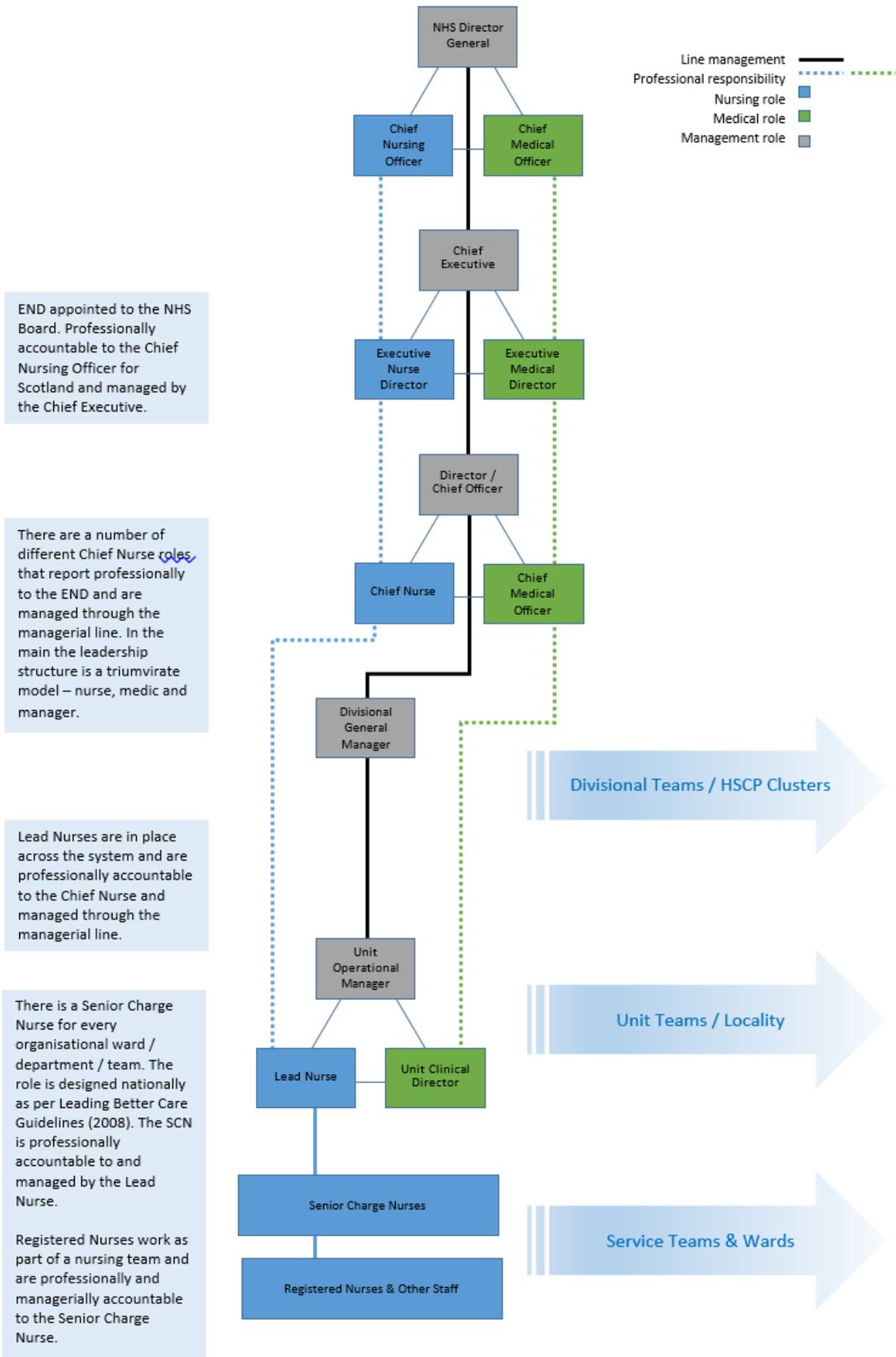
In the following three Chapters, four, five and six, the findings from each case are presented separately. The across case findings are then compared and contrasted in Chapter seven. In each chapter the findings are presented as, Theme 1: RNs knowledge and understanding of accountability (objective 1); Theme 2: RN experiences of how and why accountability is enacted, and the impact in practice (objective 2); and Theme 3: Individual and organisational barriers and facilitators to RNs accepting professional accountability (objective 3).

## **Chapter 4: Case A**

### **4.1 Introduction**

Case A is a large territorial HB in NHS Scotland. The organisational structure where nurses are represented is displayed in Figure 2. These figures illustrate the composition of the nursing hierarchy, the managerial, medical and nursing triumvirate model and the managerial and professional reporting 'lines' for each case. The structures beneath the executive triumvirate are repeated across the organisation to cover all services. Although there is variation in the medical and managerial models in the Health and Social Care Partnerships (HSCP), it remains consistent for nursing. The organisational breadth of each case is not disclosed as it would make the HB identifiable.

Figure 2 - Case A Organisational Structure



## 4.2 Participants

Twenty two RNs from across the six hierarchical layers in Case A participated in interviews or focus groups.

Table 15 – Interview and focus group participants

Health Board case	Nurse participants
Case (A) individual interviews	1 Executive Nurse Director 4 Chief Nurses
Case (A) focus group interviews	3 Lead Nurses/ Nurse Managers 4 Senior Charge Nurses 10 Direct care giving RNs

Demographics of each participant were not collected as this was not an objective of the research. Of the twenty-two participants, two were male and twenty female. Interviews and focus groups were conducted over a two week period in the summer of 2018. Each focus group took place on a different site within the HB representing three different operational sectors. Two of the participants had responsibility for the whole system; one of the participants worked within or had a responsibility for primary care/ community services. The remaining eighteen participants worked within or were responsible for secondary care services. Mode of interview was determined by the availability and preference of participants and is reported in Table 16.

Table 16- Mode of interview and participant code

Participant #	Role	Mode of interview
HBA.P1.END	Executive Nurse Director (END)	Face to face in person
HBA.P2.CN	Chief Nurse (CN)	Face to face over face time
HBA.P3.CN	Chief Nurse (CN)	Telephone
HBA.P4.CN	Chief Nurse (CN)	Telephone
HBA.P5.CN	Chief Nurse (CH)	Telephone
HBA.F1.LN	Lead Nurse (LN)	Face to face in person
HBA.F2.SCN	Senior Charge Nurse (SCN)	Face to face in person

HBA.F3.RN	Point of care Registered Nurse (RN)	Face to face in person
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### 4.3 Theme 1: Registered Nurses (RNs) knowledge and understanding of accountability

Two sub themes emerged from this theme, accountability as levels of responsibility; and relationships, structures and processes in which RNs are answerable.

#### 4.3.1 Theme 1: Subtheme 1: accountability as levels of responsibility

Participants across the hierarchy described accountability as being individually responsible for meeting the obligations set out by the NMC Code (2018a) and the role in which they are employed. Responsibility was mainly described as tasks, actions or obligations. The hierarchical structure meant that RN roles were associated with three different levels of responsibility: for the whole system; intermediary levels of the system; and for individuals at point of care.

##### ***Responsibility for the whole system***

Accountability for the whole system was described by the END as having responsibility for ensuring an appropriately skilled workforce to deliver care across the system. This responsibility was associated with the potential for being answerable for performance in the role.

*HBA. P1.END "I suppose, for me, accountability means that I have ultimate responsibility and carry the can for whatever areas that I have the responsibility for."*

Accountability for the professional workforce was managed through organisational governance processes. Ensuring professional governance across the system was considered important to support RNs within their regulatory scope of practice. There was concern from the END and CNs that accountability was poorly understood and this often caused tension and distress for RNs at point of care. This distress was related to the conflict of meeting regulatory obligations and their desire to achieve the expectations of operational service and other professional groups, particularly medical staff. This concern was partially supported,

RNs demonstrated an appropriate understanding of accountability however also discussed the poor understanding that others had which caused tension in practice.

In addition to professional responsibilities, a number of participants described having accountability for a number of corporate and service responsibilities. Ensuring effective systems of clinical and care governance to assure quality of care across the whole system and communication to the HB was important. SCNs discussed their responsibility for the whole system as having an awareness of 'the bigger picture'. This related to making compromises in areas that they had a formal responsibility in order to meet the needs of the whole system. The most common reference made was in relation to moving members of nursing staff to achieve better staffing levels (across the system), moving patients to achieve the four hour access target and financial constraints.

*HBA.F2.SCN "It's about being responsible for your budgets and being aware that there's a whole bigger picture there."*

### **Responsibility for intermediary level of the system**

There were similar perspectives within the hierarchy that having an appropriately skilled work force was essential to maintaining the quality of patient care. The responsibility and processes of doing this were less transparent. Revalidation with the NMC and eKSF (a web based resource that supports Personal Development Planning and Review) were described as supporting RNs to evidence skills and development needs. However, many participants had never had an annual appraisal to discuss their development needs or performance. The boundaries of individual responsibility for being appropriately skilled and the responsibility of their line manager was discussed by Senior Charge Nurses (SCN). Accountability for enabling the development requirements of staff to ensure an appropriate set of skills across the team was something Senior Charge Nurses accepted.

*HBA.F2.SCN "Nurses are practitioners in their own right. They have a responsibility to identify learning needs. We look at the overall picture and our skill mix and what we want, the training needs of our staff and where we want them to be, they have to identify if there's an area they're not sure of and they need more learning."*

The challenges of accessing education to meet individual responsibilities to maintain the knowledge and skills needed to deliver safe and effective practice were discussed by all participants, and are presented in the subtheme 'knowledge and skills'.

The closer participants were to the point of care, the more the focus of accountability became about having the responsibility to ensure an acceptable number of nurses (registered or not)

rather than appropriately skilled team on a shift by shift basis. RNs discussed a sense of lack of control and power to influence decisions that ultimately affected individual accountability.

*HBA.F3.RN "We could be sitting there with 22 IVs all with lines, all with ports, everything, we've got all these things to do, there's five discharges, and no matter how much she fights to keep our staff, we're never going to... she can't win when she knows it's her boss. When it's her boss telling her, "No, you have to send someone there"*

Responsibility for the delivery of care within a financially constrained organisation was highlighted by participant HBA.P3.CN despite having no budgetary accountability there was a collective responsibility to ensure value for money.

*HBA.P3.CN "I'm also accountable within the management team within [\*] (service named) obviously for the delivery of safe, effective, person-centred care, but also for components of people management and ensuring value for money, and all the other issues within that as well."*

In a subsequent focus group HBA.F2.SCN (who do have accountability for budgets) the level of scrutiny they have to apply, to ensure value for money, was explored. A conversation ensued that related to ward supplies and supplementary staffing costs. The conflict between having an appropriate workforce to deliver care and a requirement to meet financial responsibilities was discussed by the participants. Within the group there was a recognition that organisational finances were constrained. The desire to do the right thing by patients, their teams and 'the bigger picture' created a sense of internalising conflict for individual participants to reach a compromise. A demonstration of enacting accountability to maintain safety was discussed in HBA.F2.SCN.

*HBA.F2.SCN "It is a positive culture but we're under more scrutiny than ever before in terms of our budgets and we're being asked to trim times if we've got rota gaps of sickness and we use bank staff, we're being asked to trim half hours off shifts and things like that."*

Being accountable for leadership and role modelling was important to SCN participants. Setting the direction of the team, underpinned by evidence based practice and taking the team with her were the reasons provided by one participant to why she became a SCN.

***Responsibility for point of care level of the system:***

Participants in HBA.F3.RN related accountability to direct care giving tasks, working within the NMC code and the consequences of error or risk of error.

*HBA.F3.RN "I would say being responsible for the actions and tasks that you perform day to day."*

On further probing of the use of the word 'consequences' this was clarified as being associated with making a mistake and the consequence of individual blame. The first reference to the NMC code for this group was made in relation to their responsibility for safeguarding patients and the public, demonstrating an awareness of this aspect of the code and its association with the risk of blame to them as individual registrants.

*HBA.F3.RN "I would say accountability has a negative connotation to it and we've all agreed with the code that we abide by that we are accountable to safeguard the public and the patients that we're looking after. I think there's a negative aspect if you do make a mistake. It's a blame culture ... who made the mistake."*

#### **4.3.2 Theme 1: Subtheme 2: relationships, structures and processes in which RNs are answerable**

The findings in this subtheme are presented under the category headings: internal organisational structures; NMC; and patients and relatives.

##### ***Internal organisational structures***

All participants could describe the professional and managerial structures in which they practiced from point of care to the HB. Thus, supporting the view of one participant that the professional structures are clear to the nursing workforce.

*HBA.P2.CN "we have clear professional structures within this organisation from point of care to Board. I think I would be confident to say that most of the nurses within the organisation would recognise those"*

Within this structure RNs managed by an RN have one hierarchical reporting 'line'. This was identified as point of care RNs and SCNs. RNs managed by a non RN have both a managerial reporting 'line' and a professional reporting 'line' (Figure 2). RNs were able to name their SCN and Lead Nurse (LN) and were unsure of their CN and END. SCNs named all RNs in their hierarchical structure including the END. Having this contact appeared to be important to SCNs.

*HBA.F2.SCN "They're all very visible. [\*] (END named), carries out talks regularly. It's 'meet and greet' talks so you can air anything."*

Dual lines of management and professional accountability were raised by most participants. This was described as being concerned with the professional governance of nursing, a regulated workforce, including having accountability for patient safety, quality of care and professional standards. Participants demonstrated acceptance rather than a preference to work within this structure and the importance of influencing to enact accountability with a perspective that management line held the power. The complexity of working within these structures was articulated by a number of participants. The importance of governance structures and processes to fulfil obligations is demonstrated below.

*HBA.P1.END "I think that in many areas, your accountability and how accountability is managed is through a governance process. So, it cannot be just linked to say down the nursing line because it's bigger than the sum of its parts. The importance of a strong governance and reporting structure is absolutely integral to ensuring that the accountability rule is fulfilled."*

Participants discussed the potential conflict of working within split reporting structures (Figure two). This appeared to be mitigated through good working relationships, although within the same interview tensions about holiday cover and roles and responsibilities delegated to the LNs were raised. One issue identified was the need for clarity on the distinct role of the LN. Participants discussed the benefits and challenges of managers being from a nursing background or not. The issue appeared to be related to the relationships and respecting the professional responsibilities and the individual. There was a range of views from LNs about the demand of working within this structure and the priorities of the role. The delegation of work from both the Service Manager and the CN, and the day to day operational management of staff and beds was discussed. The personal burden of not being able to enact the professional responsibilities of the role was described by one participant and supported by the group.

*HBA.F1.NM "I think you tend to get pulled in two directions."*

*HBA.F1.NM "I'll get phone calls to say, "Oh, you're down to one bed, what's your plan, what are you doing about it?" from the Bed Manager."*

*HBA.F1.NM "I trawl through my emails ... then I actually want to do a job as in do all my Datix, do my SSTS or do my report or an SEI...I feel sometimes that I don't actually get any work done, like real work."*

The establishment of Integration Joint Boards (IJB) aligned to each local authority appears to have increased the complexity and effort required to ensure appropriate professional, clinical and care governance. Accepting accountability at HB level was described as ensuring a

collective understanding of work devolved and work delegated to the IJB. This appeared to be complex.

*HBA.P2.CN "If you spoke to a director in this organisation (IJB), they would tell you that they are responsible for all things to do with clinical and care governance. What we have to be clear with them is that does not include the professional accountability."*

### **The Nursing and Midwifery Council (NMC)**

Most participants made reference to the NMC. This concerned a RNs' responsibility to work within 'The Code'.

*HBA.F3.NM "So, all the NMC guidelines, I adhere to and everything that I do at work and out with work is my professional accountability."*

The regulatory function of the NMC was discussed by one RN and the process of making a referral to the NMC. Enacting a process of answerability, following a local disciplinary process was described as 'a bit of a culture here' HBA.P2.CN. RNs were described having difficulty in making referral decisions and therefore registrants were referred as a 'just in case' measure. Disciplinary processes or NMC referrals were not raised by any other participants.

*HBA.P2.CN "I think there's always a fear that nurses have had if they don't refer, or if they don't run it past them, there's this fear that it's going to be them next."*

The punitive nature of the NMC in comparison to the more restorative approach taken by the General Medical Council and Health Care Practitioner Council for registrants was raised. The potential impact that the regulatory body had on creating a culture of blame across the nursing profession was considered significant.

*HBA.P2.CN "Yes, that really struck me and I think that it probably has driven our practice and I think in [\*] (HB named), there are probably some individuals in senior posts who still have that 'let's hang the nurse out to dry'. We're more likely to take people down a disciplinary route perhaps than others."*

### **Patients and public**

RNs were prompted to describe to whom they were most accountable. The NMC; other members of staff; and their manager were listed by most participants. At point of care the main discussion related to patients and relatives and the increased level of answerability in these

interactions. A number of participants shared their experiences of interactions being intimidating and evoking a sense of fear. Mobile devices and open visiting were perceived to be a contributory factor in the increased scrutiny and questioning by patients and relatives. Patients and relatives recording interactions and photographing documentation was raised as an increasing issue for RNs.

*HBA.F3.RN "I think definitely more now than ever than back a few years ago. You'll come into a ward, pick up a Kardex and pick up all the bedside notes and they'll totally scrutinise that and they'll take pictures, they'll question why you're giving things and put you on the spot and want an answer for every single thing."*

The increased sense of accountability in this situation was referred to as prompting a deeper thought process. The impact of increased numbers and presence of visitors on RN's ability to deliver patient care was underpinned by a sense of irritation and frustration. A sense of lack of control and powerlessness was apparent for HBA.F3.RN focus group participants.

#### **4.4 Theme 2: RNs' experiences of how and why mechanisms of accountability are enacted and the impact in practice**

Participants discussed their experiences of enacting accountability. Three subthemes emerged relating to how and why accountability is enacted in response to concerns about poor care and external scrutiny; to assure quality of care and standards of the profession; and to safeguard patient outcomes at point of care.

##### **4.4.1 Theme 2: Subtheme 1: Enacting accountability in response to concerns about poor care and external scrutiny**

Complaints, adverse events and external scrutiny are the three categories in this subtheme. The incident reporting software Datix is referred to by participants and represents adverse events or near misses recorded on the system.

##### ***Complaints***

Complaints were identified by all participants as an important way of monitoring quality of care and culture. One participant acknowledged that a complaint can be part of the grieving process for families and when mistakes are made by RNs. However, the process of identifying the RN involved was negatively associated with accountability and blame.

*HBA.F3.RN "I think there's a negative aspect if you do make a mistake. It's a blame culture almost and as much as there's reflective practice to look at what*

*you've done, it's always finding... who made the mistake. Often, the relatives are maybe looking for someone to blame and they're not so accepting of someone's made a mistake and that happens. It (accountability) definitely has a negative connotation."*

No one described how they were asked to demonstrate accountability in response to complaints, such as meeting with relatives. The main impact in practice appeared to be related to distrust. The importance of being believed was highlighted and the organisational response portrayed a lack of trust and support for the RN, particularly the act of apologising.

*HBA.F3.RN "They put complaints in and they say, "They said this", but you're like, "Well, I didn't say that", and everyone is always going to believe the patient. They're not going to believe their own staff."*

### **Adverse events/ Datix**

Adverse events were described as incidents that have caused harm or a near miss. These events were reported electronically and alerts generated via an email system to named individuals. This ensured significant events were shared at executive level.

*HBA.P1.END "Can I be sure that I know what's going on all over the place? I can't be 100% sure but I can be as near to sure that I mightn't know within a couple of days of something going wrong but assuming it's something that's systematic rather than a one-off, it will be picked up and I will pick it up. I'll either pick it up by looking at... so, I get every single significant event."*

Adverse events, incidents or Datix were mentioned by all participants. Similar to complaints the few participants that discussed enacting accountability in response to adverse events were RNs and SCNs. Reference by other participants related to having the responsibility for managing the process. The inference being that managing 'Datix' was the task that provided assurance. Learning from incidents was considered to be uni-professional and in particular the perceived inability to engage and influence medical colleagues was discussed. The continual rotation of doctors was considered a significant issue in embedding change.

*HBA.F2.SCN "Our nurses reflect on incidents and issues and learning but all we can do is pass information on to the medical supervisors. We're responsible for our ward and everybody in it at the time and what goes on in it really but you can't approach them (laughing). You can to a level but you have to feed information to their supervisors and you don't know... the same things happen all over again."*

Accountability associated with the administration of medicines generated discussion that emphasised care delivery as an individual and collective responsibility shared with medical staff. This introduced the issue of shared accountability at point of care. Participants felt that shared accountability was disproportionately focused on nursing.

*HBA.F4.RN* “I just feel that sometimes it would always be brought back to you. We are the people who give it so they’re always like, “Well, why did you give it?”, and I’m like, “Well, why did you prescribe it if they shouldn’t have had it?” It’s always that they question us as though we’ve given it rather than why they prescribed it.”

### **External scrutiny**

Demonstrating accountability in response to external scrutiny was only raised by one participant. Accountability included informing and explaining to the NHS HB the risks associated with report findings and actions required to meet recommendations. This included holding the head of service to account at the HB Clinical Governance Committee. In one example, the participant highlighted that the initial response to an external report from the service was defensive. Going on to explain, this can often happen with services that work in relative isolation. “People don’t know what they don’t know” underlining the important role of professional governance. Engagement with the service in relation to receiving an appropriate improvement plan and being recognised as the ultimate responsible and accountable executive for the service was described as being challenging. However, the sense of increased individual accountability was raised as enacting accountability would be in response to unknown questions, conducted in public.

*HBA.P1.END* “They then questioned why I was questioning until they realised that if it wasn’t me questioning, it would be the Board questioning. Of course, when I take that paper back to the Board, because I will be, it’ll be me ... the Board don’t see a difference between me and the service. They see that I am the service and I am the person that’s responsible and accountable.”

#### **4.4.2 Theme 2: Subtheme 2: Enacting accountability to assure quality of care and standards of the profession**

The findings of this subtheme are presented under two category headings, meetings and audit.

## **Meetings**

Enacting accountability in meetings was identified by all participants. A variety of meetings were described. Monthly one-to-one meetings were described by CNs, LNs and SCNs, where they enacted accountability or asked RNs to demonstrate accountability. A range of approaches were described. However, all participants stated the main purpose was supportive by creating the opportunity to discuss current issues as well as objectives. One participant described an approach that used the four pillars of the NMC code and a reflective account as part of the meeting. One CN felt that her experience and the trusted relationship with her professional lead enabled her to highlight issues of concern as they arose. These meetings were valued by the participants.

Participants described a range of team meetings relating to professional and operational work, these appeared to range in frequency from monthly to quarterly depending on the area and type of meeting. How RNs enacted accountability was unclear, submitting reports for assurance appeared to be the process although, as identified in the following quote, what level of scrutiny is applied or what action is taken was not apparent.

*HBA.F1.NM "We have LN, CN meetings where we discuss with the CN and the LN as a group, and then we have operations meetings which we have once a month with our GM, CSMs and Lead Nurses. I suppose we answer at clinical governance forums because we give a report of what's happening in our departments. For me, that's me delivering or not in those forums and the CSMs, GMs take the information that we give and do what they need to do with it."*

One CN discussed the range of meetings attended by senior nurses with the purpose being assurance of quality of care and also assurance that the nursing voice contributed to decision making, including one-to-one meetings, a lead nurse meeting, professional practice development, care assurance and clinical governance. Shared responsibility for attendance and communicating from these meetings was discussed by participants.

Ensuring RN contribution was appropriate in meetings was discussed by participants. A lack of self-confidence was demonstrated in how to convey information, due to concern that it may be considered disrespectful or unprofessional. The inference being that this inhibits transparency or raising challenging issues.

*HBA.F1.NM "What the expectations of me are and what do I say at this meeting, who do I say it to or not say it to, do I say it in a certain ways."*

*HBA.F1.NM "It should be quite open and transparent, obviously respectful and professional, but sometimes you have that, 'I don't know whether I'm allowed to say that'."*

Participants in HBA.F3.RN discussed peer meeting which focussed on support and discussing operational challenges. SCNs asked RNs what issues they wished to be escalated at meetings. Attendance was dependent on operational demand and there was no capacity to have regular ward meetings due to staffing levels. There were meetings for SCNs and band six nurses.

Clinical governance or clinical and care governance groups and committees were described at HB level and across the organisation. These governance structures were referred to by participants at LN, CN and END level. SCN and RNs at point of care discussed quality of care, rather than governance.

### **Audits**

The burden and extent of auditing was discussed by the END, SCNs and point of care RNs in relation to care assurance. In contrast, participants in the middle of the hierarchy discussed the importance of audit in relation to care assurance. END and RNs at point of care agreed that auditing was too extensive and focussed on the wrong things. Concern that assurance is related to the process of auditing rather than analysing the results or focusing on areas that require improvement was shared by participants.

*HBA.F2.SCN "Our Lead Nurse audits us, our Clinical Effectiveness Sister audits us, our tutor, our infection control come and audit us, HEI come in and audit us. It's all just about collecting this data and not actually so much about looking at what the problems are."*

A sense of mistrust was conveyed relating to audits for different reasons. For RNs this was related to having to evidence that they were completing audits.

*HBA.F3.RN "I probably do about ten and I put them onto the computer so everybody can check that you have done them; Lead Nurses, Directors, whoever can all check that you've done your audits."*

For LNs and CNs audits for assurance were important however one participant acknowledged a mistrust in the results.

*HBA.F1.NM “audits that were coming in from that ward were coming back at 100%. You think, ‘There’s something not quite right’. I was doing the audits and they were okay, they weren’t great.”*

SCNs concurred that audits had become a ‘tick box’ exercise and that the burden of the volume of audit and lack of control of what should be audited prevented them having the autonomy to undertake relevant snap shot audits to drive improvements for patients and staff. Poor results are associated with poor performance.

*HBA. F2.SCN “You can see sometimes staff get... staff have got a pride that they want to get a high score on infection control, they want to get a high mark, and from that point of view, again, it’s not punitive”*

*HBA.F3.NM “A lot of it is audits and the scores and you’ll know about it if the audit is not good enough.”*

Senior Charge Nurses shared the discomfort they have in discussing poor audit results in the context of their teams trying to do their best in challenging circumstances.

*HBA.F2.SCN “Sometimes the staff feel that you’re attacking them and you’re going to them and saying, “We’re not doing great in that audit”.*

On further questioning as to why they didn’t stop the audits, participants were concerned about the personal consequences of not doing them and demonstrated a desire to support their lead nurses. A perception that to stop doing audits would be considered as poor performance.

*HBA.F2.SCN “This is where my issue is, is the fact that things come in waves and it’s a case of ride the wave or ‘What’s your problem? Can you not deal with it? Are you not time managing?’ Nobody says that to you but the impression is that everybody else is doing it so why can’t you.”*

*HBA.F2.SCN “Or that you’re not performing.”*

A perception that medical staff do not have the same level of scrutiny and that RNs are ‘marked down’ for audit results that are the responsibility of medical staff created a sense of unfairness amongst participants. Examples discussed were medical staff not signing records or completing Adults with Incapacity forms. This sense of unfairness was similar to that described in the management of medication errors. To try and reduce the failure rates RNs reported taking on the responsibility of completing some aspects of the documentation as it was less problematic than failing an audit.

*HBA.P2.SCN “For example, I had an audit of my ward, an assurance visit, recently and we got a very good score but I had to do an action plan for things we were marked down for. When I looked at the things we were marked down for, they were actually medical staff responsibilities but when I’m writing my action plan, I’m having to make an action plan for something that wasn’t actually my responsibility.”*

A lack of control and ownership to assure quality of care was conveyed throughout interviews and focus groups, yet it appeared to be RNs in the nursing hierarchy that were requesting the audits for assurance. Assuring quality of care was very much considered part of the SCN role however they reported the current volume of ‘mandated’ audits prevent RNs having the time to focus on issues that they considered to be more important.

#### **4.4.3 Theme 2: Subtheme 3: Enacting accountability at point of care to safeguard patient outcomes**

The findings of this subtheme are presented under three category headings, decision making, challenging practice and record keeping and documentation.

##### ***Decision making***

Participants described their internal thought processes when making decisions. Although this was not explicitly referred to as accountability it represents a process of internal answerability and therefore a process of ‘internalising’ accountability. Several participants considered their level of personal risk associated with error as a factor in making a decision.

*HBA.F3.RN “It would be your fault if they went home and didn’t have their carer or medicines, or social work didn’t know, or they didn’t have equipment. It would be our fault, it wouldn’t be anybody else’s.”*

One RN, working in a highly specialist service, shared how she accepts the overall accountability for the choice of medications administered. The act of signing the drug kardex heightened the sense of answerability and personal risk for several participants. A lack of self-confidence in her knowledge about the drugs was conveyed by the level of internal questioning she described. This is an example of RNs reluctantly accepting accountability for practice.

*HBA.F4.RN “You’re always thinking to yourself, ‘Should I give this? Is this alright to give with this?’ ...“Oh, should I be giving that with this”, you have to think to yourself, ‘Am I giving the right thing that doesn’t counteract with this and doesn’t work with that?’, and you’re signing your name to it so you kind of have to make sure that you know that you’re giving the right thing.”*

Encouraging RNs to make and enact decisions was important to all SCNs in HBA.F2.SCN. An important feature of this 'encouragement' was that they (SCN) would stand by them (RN) if a mistake occurred. This was often out with the control of the SCN. The process of decision making was framed as a balance of risk. Balancing the risk of not having the appropriate workforce to deliver safe care and making decisions about what aspects of care could be most safely compromised was discussed by participants. Often it was the patient or relative's experience that was compromised which had an impact on the RNs when they went home. RNs discussed the cumulative effects (personally and professionally) of not being able to deliver a high standard of care.

*HBA.F3.RN "I just feel bad all the time. When you've maybe had a bereavement and the Bed Manager's phoning up asking why the patient hasn't been moved and you've got a family in. You're trying to do your best to console them and be there for them through the full journey. It's like they couldn't really care because they're too set on targets."*

### **Challenging colleagues**

This category concerned the ability of an RN to ask a colleague to explain the rationale for a particular decision or behaviour (enact accountability) and accept or challenge that response. Challenging decisions that were made out with and within the context of care delivery were discussed. The ability to challenge colleagues at the point of care appeared to be associated with hierarchical position, being from the same profession and the individual's level of self-confidence. Challenging patients and colleagues who were lower in the hierarchy, for example, student nurses, healthcare support workers and RNs in more junior positions appeared to be something participants were comfortable with. However, examples of this were associated with colleagues not taking their fair share of work or patients not adhering to expectations. Participants were not comfortable to challenge their peers and found escalation an easier solution.

*HBA.F3.RN "If it was something that I wasn't happy with then I would say but if there were other band 5s who I knew hadn't done stuff then I'd go to whoever is senior to them but I wouldn't be sitting questioning the band 6 "No, I don't think you should do that". If there's other band 5s who I know are on the same level as me who are not doing what they should be doing, I wouldn't be scared to go and tell the band 6, "I'm not happy that I do all my work but they don't do theirs".*

The concept of challenging practice seemed to be related to parity of workload and breaching 'rules'. When RNs did describe challenging people the approach was more instructive rather than seeking to understand or explain their rationale.

*HBA.F3.RN "I go in and they're all a bit older (HCSW) , and they go in with patients who are all my age and they're trying to tell them to do something and I'm like, "Well, I feel that if you said that to me then I would be really upset and I would be telling you no, get lost". If you were trying to get me out my bed at eight o'clock in the morning, I'd be telling you to get lost. So, I find myself doing it a lot to the auxiliaries and saying to them, "Well, you've got to have a bit of leeway. These patients are in their 20's. You can't do stuff to them that they don't want to do."*

Similarly an example given by an RN of an interaction with new graduates was approached with "this is the right way and this is the wrong way" as opposed to explaining the rationale and supporting them to make a decision. There was one contradictory example provided by a SCN who discussed challenging decisions relating to patient care with medical and managerial colleagues. This participant articulated the need to be able to back your position up with evidence for it to be an effective challenge.

Examples of challenging practice higher up the hierarchy were related to individuals performance and challenging poor compliance with assurance audits. The opportunity to identify areas for improvement and challenge practice was evident at all layers of the hierarchy. Several participants referred to clinical services that were out of date, institutionalised or 'had just always done it that way' where examples of poor practice were identified when a new professional leader was appointed.

The inability to challenge decisions that have an indirect impact on safeguarding patient outcomes, mainly related to system wide or sector changes that were made to RN roles or their practice environment. As these decisions were usually imposed there was no ability to offer a challenge as the decision maker was unclear. From many participants there was a reluctant acceptance that decisions were made for the benefit of the organisation (system) that directly compromise an RNs ability to safeguard patient outcomes. Participants discussed that they had voiced concern about such decisions but then just got on with it. Some of the examples given were patients arriving in wards that RNs felt they did not have appropriate staffing to care for them; a new care assurance process that SCNs had to take on; and the additional responsibility of being a moving and handling assessor for the ward on top of the SCN role. A current example of a decision taken the week of the focus group was discussed

*HBA.F3.RN "For example, one of the things they implemented in ours was at lunchtime, the soups were to go around separately to the hot meals. We don't have enough staff or enough time to do it. We've got loads of IVs due at lunchtime so we don't have time to have five trained nurses helping to give out the lunches as well as our auxiliaries and answer all the buzzers, and we've got all this other stuff to do. The catering staff were told, "No, you have to do it and the wards have to enforce it" That's the thing, no one was asked."*

### **Record keeping and documentation**

This category concerns both the process of enacting accountability by record keeping and the impact that documentation (paperwork) has on RNs practice.

Record keeping was discussed by all participants relating to their scope of practice. At HB level, the purpose of enacting accountability, by taking written reports to the HB, was to ensure clear communication to HB members and ultimately the public of any issues. For meetings many participants described preparing reports to provide information on operational performance and risks relating to workforce or quality of care. An example was provided by putting concerns 'in writing' when escalating poor care to the END to evidence that an escalation had taken place.

This was not discussed by participants. There were two references made to external scrutiny and the importance placed on documentation during the inspection process. However, fear of failing an internal audit was the most important issue to RNs.

*HBA.F3.RN "it's only showing that the paperwork is done but it's not showing that patient care has got any better at all. It's just tick boxes generally. As long as you've signed something or ticked it to say that you've done. If it's not up to date then that's it."*

The words record keeping and documentation were used interchangeably. RNs referred to record keeping as a task to fulfil as paper work gets audited. Record keeping to communicate clinical decisions and evidence professional judgement was not discussed. However not being allowed to use professional judgement was raised by participants.

*HBA.F3.RN "You're not allowed to use your own professional judgement a lot because you have certain protocols to go through and steps to do so you can't ever just use your judgement on the spot and deal with it because you would have too many repercussions or too many people questioning..."*

A belief that completed paper work was considered more important to the organisation than the actual quality of patient care delivered was shared by several participants. In particular RNs conveyed a need to repeatedly 'prove' that they were doing a good job.

*HBA.F3.RN "I think it's because we're taught that if it's not documented, it never happened. If the paperwork isn't up to date then you can't prove that your patient care has been good."*

One participant described weighing up the risk of not completing the paperwork associated with active care or not delivering the care.

*HBA.F3.RN "your hands are tied, you need to do two lots of paperwork and it has to be done over actually doing your two hourly active care because there's more repercussions because that's something that can get audited. If that patient gets missed by an hour, you kind of have to weigh it up the lesser of two evils."*

Organisational documentation was considered a contributory factor to RNs not being able to accurately complete records. This was mainly related to the volume of documents that required to be completed 'to pass audits' and complete risk assessments. This had to be done in triplicate in some situations. Concern was shared by participants that RNs were taught to complete the documentation rather than effectively keep records of clinical care. Tick boxes were mentioned repeatedly.

*HBA.F2.SCN "It feels like you're taking their decision making processes away from them, a bit of their professionalism away from them and you give them all this work to do, tick, tick, tick."*

The tick box approach to documentation was considered by several participants across the hierarchy to have removed from both the cognitive process of using professional judgement and the ability to evidence this in the clinical record.

*HBA.P1.END "I think we have driven a particular behaviour and I think we have taken away, I believe, from a lot of nurses the independent critical thinking that they should always exhibit because the bottom line is the only person that was responsible for that patient's deterioration not being noticed was the nurse who took that blood pressure and didn't note it."*

Active care (care rounding) was used as an example of the record being more important than the interaction with the patient and removing critical thinking and from RNs

*HBA.F3.RN “No. You stop them thinking for themselves. It’s like prescribed nursing.”*

*HBA.F3.RN “That’s down to make sure we’ve got the documentation to say we have gone to that patient and we have asked them and we have tick, tick, tick.*

*HBA.F3.RN “You’re teaching these new nurses to come in and to follow a set of questions (rules) rather than use their brain to get the whole picture. You’re taking their instinct away from them maybe.”*

The issue of who is responsible for completing all the aspects of the documentation that have not been filled in by RNs in other wards or on other shifts was discussed and considered a frequent occurrence.

#### **4.5 Theme 3: Individual and organisational barriers and facilitators to RNs accepting professional accountability**

Participants across the hierarchy shared their experiences of accepting accountability. This mainly related to their ability to enact individual responsibilities. The factors that facilitated or hindered RNs to do this were explored. Accepting accountability was strongly associated with the concept of autonomy. Two subthemes emerged, individual RN self-confidence, resilience and autonomy to make open reasoned judgements; and having a fair and safe working environment that enables autonomous practice.

##### **4.5.1 Theme 3: Subtheme 1: RN self-confidence, resilience and autonomy to make open reasoned judgements**

RNs at the top of the hierarchy and SCNs displayed self-confidence to do both. RNs at point of care and in the middle of the hierarchy appeared less confident and rarely offered an account unless it was requested. The findings are presented under two category headings – identity and being valued and level of knowledge and skills.

##### ***Identity and being valued***

Having clarity of responsibilities and being valued as part of the team were both important to RN self-confidence. Credibility and having their specific contribution recognised appeared to be associated with increased individual self-confidence. Clarity of role identity appeared fundamental to enabling this. There was a common espoused understanding across the hierarchy of the professional NMC Code (2018) RN contribution. The role and identity of the RN role was less clear in practice. The recent launch of a national uniform for senior nurses was considered a positive move that had enhanced the visibility of senior RNs to the public.

RNs referred to SCNs, LNs, Chief Nurses, Nurse Director, CNSs and ANPs by their role title. Other colleagues were also referred to by role title i.e. Consultants, General Managers or pharmacists. All other nursing colleagues were referred to by their pay grade, reinforcing a lack of professional identity, lack of feeling valued and the hierarchical nature of nursing.

*HBA.F3.RN "You're just a band 2, 5 or 6"*

*HBA.F3.RN "You're just here as a nurse, they don't care that..."*

*HBA.F3.RN "You don't have that respect anymore, do you?"*

*HBA.F3.RN "No, you're just here to work and that's it."*

*HBA.F3.RN "Workhorses (laughing)."*

On further probing this perception was mainly related to 'the organisation', society and the media. Most of HBA.F3.RNs felt valued by their SCN this was associated with support, trust and getting help. Being valued was also associated with having credibility and being listened to. The impact of being heard increased self- confidence to contribute.

*HBA.F3.RN " Maybe sometimes when you're having a team meeting if they take on board something... if you've maybe had a concern with a patient over discharge, if you feel someone is not suitable for discharge, you've flagged it up and that's been taken on board, something has been done and referral signposted."*

*HBA.F3.RN "Yes, that's quite empowering. It doesn't happen often."*

There were a range of views on why the identity of RNs was considered less clear than that of other professional groups. The role of senior RNs was considered to be managerial or professional rather than clinical. Despite the aspiration that senior RNs would be clinically credible and visible, this was not how they were perceived or how they practiced. Point of care RNs were clinical, SCNs wished to be recognised and practice as clinical experts however found this increasingly difficult to deliver due to additional demands. Beyond the SCN role the clinical contribution was not evident. A number of senior RNs described 'helping out' when there was a safety issue. This was described as moving patients or helping with meals.

Taking on additional responsibilities and an inability to say no was felt to contribute to a loss of identity. A number of participants considered RNs to be more comfortable to work within the 'rules' than to challenge. RNs described the 'organisations' fear of something not being done outweighed RNs saying 'no'- the moving and handling assessor role was an example of this. SCNs also described carrying out a large amount of administrative work that could be delegated to allow them to be more effective. In contrast, medical colleagues were perceived to be collectively more autonomous and stronger at saying no.

*HBA.F2.SCN "I think, as nurses, we tend to be fairly compliant. We tend to work within rules, regulations, and standards. That's familiar for us. As I say, doctors tend to do their own thing. The other thing that I think doctors do, and this is not a particularly positive view of nurses by saying this, they come together. Doctors are close allies."*

*HBA.F1.NM "I guess it does come down to the nurses or the nursing structure to deal with issues a lot more than it does the medical structure so we do take it on because sometimes there's no choice."*

Role identity at the top of the hierarchy was clear and a sense of being valued was evident. For Chief Nurses, ensuring a shared understanding of their professional identity, particularly in the health and social care partnerships was ongoing. For RNs, in middle management and hybrid roles, their professional identity was less clear with many responsibilities being similar to that of a service manager and examples of covering for managerial colleagues when on leave consuming all their time. There were also joint service manager and professional posts. SCNs were most challenged by their perception of what their identity should be and what it actually felt like.

*HBA.F2.SCN "I think sometimes we're our own worst enemies when it comes to the profession because I think sometimes we just take on too much. Whereas other professions that we work with, perhaps physios or OTs, I think they have more of a professional identity and they're clear about what they will and won't do."*

The demands on the SCN role were described by all participants, including HBA.F3.RN who said none of them would ever wish to become a SCN.

*HBA.P3.CN "I do feel that we're really getting close to setting them up to fail...everything seems to be, "We'll just get the Senior Charge Nurse to do that", and it's not just coming through the professional line from CNO, I don't mean that, but it's locally as well".*

For point of care RNs there was a recognition of how the role was evolving, mainly driven by medical staff shortages. This was considered by many to place an additional burden without additional resource and although enhancing skills was desired without the appropriate resource it would have a negative impact on other responsibilities.

*HBA.F2.SCN "I said 'no' for my team and it was something quite small really. It was venepuncture and cannulation and I said, "No, we're not going to train*

*you for that because you can't take that on in your role. Your role is too vast and you can't just keep taking on more."*

*HBA.F2.SCN "You train them and they are the sole people who have to do it. That's what will happen. That's what happened with IV antibiotics. When I first started, we didn't make them up, the pharmacy made them up and then the junior doctors made them all up and they were always late and then it became a nurse's role. It was a shared role. It's now a nursing role."*

The specialist identity of nursing was perceived to be further compromised by RNs being used as a 'pair of hands'. Inpatient settings frequently required RNs to move from their area of practice to maintain safety, where RNs did not feel they were effective. A further example of having a specialist RN identity was shared in relation to prescribing and the importance of developing and maintaining expert identity.

*HBA.P1.END This is one of the areas that I do think is causing confusion - if you take independent prescribing and effectively now nurses, pharmacists, whatever, have the whole breadth of drugs that they can prescribe but they can't if they're not an expert in that area, so they can only do it if it's in that area.*

### **Level of knowledge and skills**

Self-confidence in individual knowledge, skills and opportunities for development were related to accepting accountability. There was concordance across the hierarchy that Continuous Professional Development (CPD) was essential to developing accountability. The time and ability to reflect and discuss care was also mentioned as important. The way in which CPD was undertaken and what knowledge and skills were required varied across participants.

Individual statutory and mandatory training was discussed by participants at point of care and SCNs. Although attempts were made to protect time to complete this training many participants described having to do it in their own time. Most of these training requirements were provided online and considered a tick box exercise. The importance of networking and peer discussion was recognised by all participants and the closer RNs were to point of care the more difficult this became. The knowledge and skills of student nurses and new graduate RNs was discussed. A recent change in Case A was a protected two week induction for new graduates to support them transition into their RN role.

*HBA.F2.SCN "Learn pro...the fact that they can come up with a system devised whereby the tick box is done whether it's in your time, their time. There's no*

*peer discussion ... you're just sat there in front of a computer. Just because every year, somebody is repeatedly doing something because it needs to be done on a yearly or two yearly basis doesn't necessarily make it beneficial. It just becomes 'oh, learning'*

Access to CPD and reflection at point of care appeared to be heavily reliant on medical and clinical nurse specialist colleagues enabling multi-disciplinary education and reflection opportunities. These sessions were based on clinical cases and delivered in the ward, both of which appeared to increase the opportunity for RNs to participate.

*HBA.F3.RN "The medical team are very good at telling us all about the new drugs that are happening and they do training on lots of things. So, we're very lucky that we get all of that only because their specialist nurses are very good and they'll come to tell us things and explain to us. I think if we didn't have that, we would be so clueless because our patients would probably know more than us."*

Participants across the hierarchy discussed that maintaining contemporary knowledge and skills was each individual RNs responsibility. In practice the majority of participants were reliant on being updated by others. Where this level of support was not available it was unclear how RNs remained up to date. One RN shared an example of the impact a personal tutorial from a senior nurse had on her self-confidence in relation to a new patient condition. SCNs displayed a frustration that developing their team was really important to them but they were distracted by other managerial tasks. Difficulty in maintaining their clinical expertise was also discussed as access to CPD was limited.

*HBA.F2.SCN "That's part of our job, isn't it, balancing your clinical... keeping your clinical skills up and your managerial responsibilities, that's the hardest bit is trying to strike that balance."*

*HBA.F2.SCN "I mean, we're all very good at ensuring the rest of the staff get on the courses and do their competences and stuff but for us, we should be allowed to do the same thing, so making sure we're attending courses to keep up to date. That then helps us do our job effectively."*

Senior RN knowledge was mainly developed through conversations within the hierarchy, with their respective medical and managerial triumvirate and attendance at national meetings. Influencing and negotiating skills were considered important. For LNs CPD requirements were less clear. LNs described being confident at SCN level and then just expected to be able to

do everything involved in a LN role. The career pathway after LN was also discussed as not being clear causing people to move in to managerial roles for career progression.

CPD for RNs was recognised as lacking following graduation. Participants acknowledged that following graduation a large proportion of the workforce has no further development. The importance of creating development pathways aligned with education was considered to be a significant issue for the profession to debate.

#### **4.5.2 Theme 3: Subtheme 2: Fair and safe working environment that enables autonomous practice**

The findings are presented under two category headings – relationships of trust and support and control of responsibilities

##### ***Relationships of trust and support***

Relationships of trust and support were associated with RNs having the self-confidence to accept responsibility, in particular having a voice and being heard. Exploring this further these relationships were most important with peers, medical colleagues and their professional or managerial line manager. Feelings of trust and support were dependent on visibility and demonstrating care towards others. In the absence of visibility and a demonstration of care, a narrative of lack of trust and unsupportive developed, particularly with RNs at point of care.

*HBA.F3.RN “Our Consultants are very good and if one of them is on downstairs at the weekend, they’ll pop into the ward and just see that we’re okay.”*

The impact of not having trust and support on accepting accountability was described by a CN.

*HBA.P5.CN “I know with a recent example, ... if they didn’t feel supported and had to put their head down and people weren’t listening and they were being yelled and bawled at and nobody wants to know, you just either go off sick or you keep your head down and do your best.”*

Relationships of trust and support appeared to be of particular importance to enable RNs to practice autonomously and know that they would be supported if something went wrong.

*HBA.F2. SCN Absolutely, and you encourage your nurses to do that. I encourage my nurses to make decisions once they’re ready, to make decisions if they risk assess, so if they look at the situation and it seems like the best way to go at the time with the least risk, do it, make the decision.*

*HBA.P2.CN "I think we're kind of hard on ourselves sometimes. I think that we defend it in a way by saying this is about zero tolerance, so you're either fantastic, or you're not and we'll boot you out. If pressure was put on a doctor, all of those tribes banded together ... Nurses don't behave like that. In fact, nurses probably do the opposite. I think sometimes nurses are quite critical of each other and don't join in to be supportive"*

Developing relationships through peer meetings was valued by participants who mainly described these opportunities as a safe space to discuss problems and 'have a moan' which appeared to enhance resilience by venting.

*HBA.F3.RN "That's usually a good way of venting things and just picking peoples' brains, other band 6s, because we can have a horrible job sometimes being a band 6 because you get everybody nipping your ear upwards and downwards."*

For some RNs the ability to be meaningfully visible and approachable appeared to be more challenging. Leadership communication skills appeared to be important to enhance RN self-confidence.

*HBA.F1.NM " I think sometimes that's hard trying to get the balance between being the boss and being somebody that's approachable and is there to support and help. I think sometimes if you're too pally then you've crossed the line and I think you're better being a bit detached."*

### **Control of responsibilities**

An important issue for point of care RNs, SCNs and LNs was their lack of control over decisions that negatively affected their ability to accept accountability. These issues were associated with having safe working conditions. CNs and END appeared to have more control over their environment. The most common example raised by all participants across the hierarchy was not having adequate staff to deliver care. This had a consequence of staff not getting breaks, with a cumulative effect on resilience and self-confidence. However, other issues were also identified that may be easier to resolve.

Having time protected to ensure appropriate record keeping and administrative tasks are completed was lacking for RNs. Comparisons were drawn with other professional groups and perceived as unfair. One RN described the loss of this protected time being an impact of 12 hour shifts with minimal handover time.

*HBA.F3.RN "With other disciplines, physios, OTs, they have their allocated time to go off to their room and do their notes before they go home on time or early. The nurses try and grab five minutes to write notes but you're interrupted."*

Another issue that affected SCNs and RNs at point of care was a lack of medical staff continuity. Doctors in training appeared to be inconsistent in their capability and were often only in the area for short periods of time which created additional work for the teams to support them.

Managing patient flow was an issue for RNs and SCNs and compromised the care of patients. LNs described a lack of control of their daily demands, with the management of patient flow and staffing often taking over their day and the professional governance part of the role being compromised.

*HBA.F3.RN "There's other occasions that patients have just arrived on trolleys from wherever and you've not been informed about and that doesn't help you feel professional when you're like that, "Sorry, I don't know who you are"*

The concept of collective responsibility for care was discussed by RNs and SCNs. The perception that although the responsibility was collective, RNs carried the burden of individual accountability. This created a tension between professional groups and reduced RN self-confidence to make autonomous decisions.

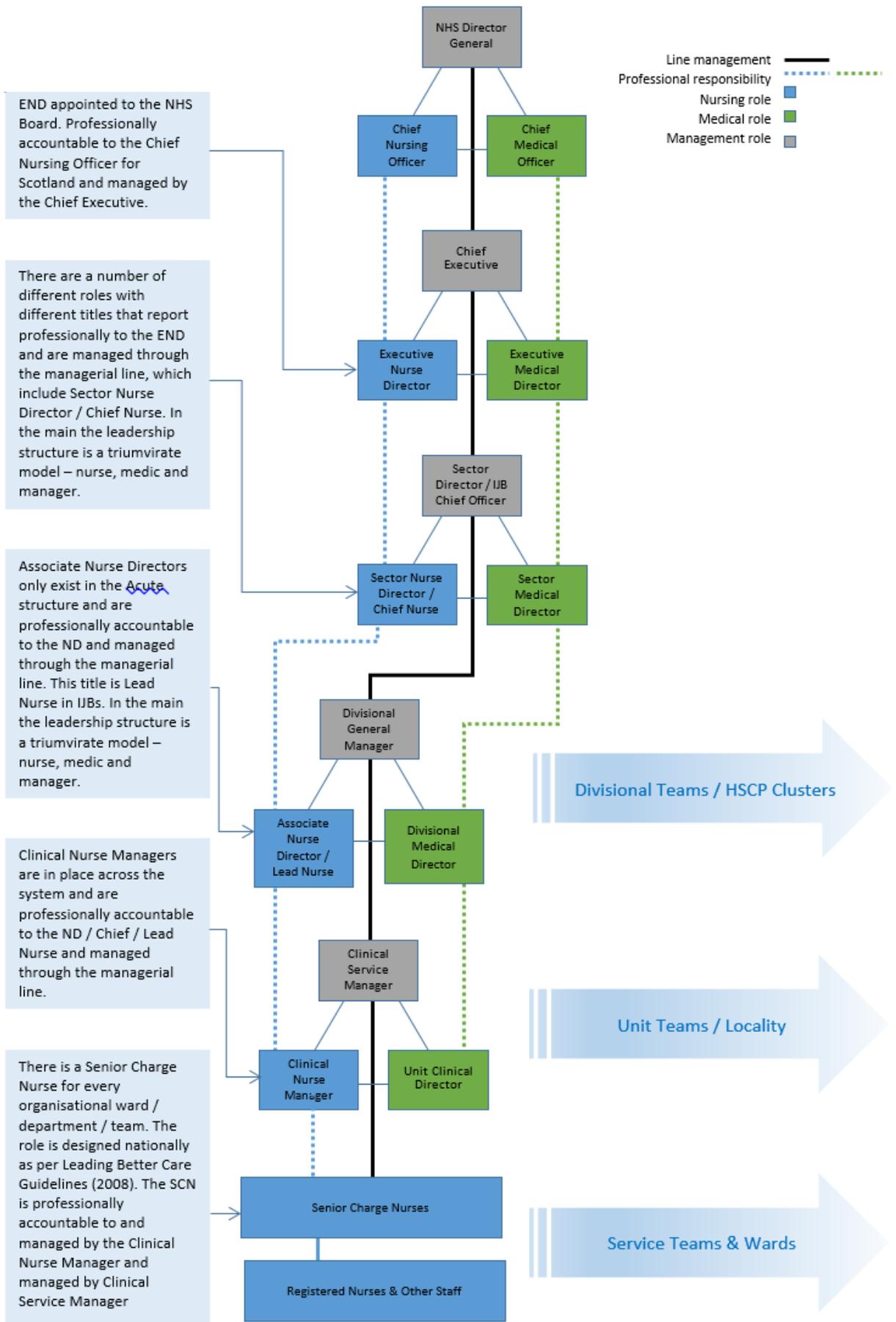
The findings from Case A are synthesised, analysed and presented as across case study findings in Chapter 7.

## **Chapter 5: Case B**

### **5.1 Introduction**

Case B is a large territorial HB in NHS Scotland. The organisational structure where nurses are represented is displayed in Figure 3. The purpose of including this figure is to show the composition of the nursing hierarchy, the managerial, medical and nursing triumvirate model and the managerial and professional reporting 'lines' for each case. The structures beneath the executive triumvirate are repeated across the organisation to cover all services. Although there is variation in the medical and managerial models in the Health and Social Care Partnerships (HSCP) it remains consistent for nursing. The organisational breadth of each case is not disclosed as it would make the HB identifiable.

Figure 3 - Case B Organisational Structure



END appointed to the NHS Board. Professionally accountable to the Chief Nursing Officer for Scotland and managed by the Chief Executive.

There are a number of different roles with different titles that report professionally to the END and are managed through the managerial line, which include Sector Nurse Director / Chief Nurse. In the main the leadership structure is a triumvirate model – nurse, medic and manager.

Associate Nurse Directors only exist in the Acute structure and are professionally accountable to the ND and managed through the managerial line. This title is Lead Nurse in IJBs. In the main the leadership structure is a triumvirate model – nurse, medic and manager.

Clinical Nurse Managers are in place across the system and are professionally accountable to the ND / Chief / Lead Nurse and managed through the managerial line.

There is a Senior Charge Nurse for every organisational ward / department / team. The role is designed nationally as per Leading Better Care Guidelines (2008). The SCN is professionally accountable to and managed by the Clinical Nurse Manager and managed by Clinical Service Manager

Divisional Teams / HSCP Clusters

Unit Teams / Locality

Service Teams & Wards

## 5.2 Participants

Sixteen RNs from across the six hierarchical layers in Case B participated in interviews or focus groups.

Table 17 – Interview and focus group participants

Health Board case	Nurse participants
Case (B) individual interviews	1 Executive Nurse Director 2 Chief Nurse/ Nurse Director 3 Associate Nurse Directors
Case (B) focus group interviews	2 Nurse Managers 3 Senior Charge Nurses 4 Direct care giving RNs

Of the 16 participants, three were male and thirteen female. Interviews and focus groups were conducted over a two week period in the summer of 2018. Interviews and focus groups were conducted over three sites. One participant had responsibility for the whole system, one of the participants worked within or had a responsibility for primary care/ community services. The remaining fourteen participants worked within or were responsible for secondary care services. Mode of interview was determined by the availability and preference of participants and is reported in Table 18.

Table 18- Mode of interview and participant code

Participant #	Role	Mode of interview
HBB.P1.END	Executive Nurse Director (END)	Telephone
HBB.P2.CN/ND	Chief Nurse/ Nurse Director (CN)	Face to face in person
HBB.P3.CN/ND	Chief Nurse/Nurse Director (CN)	Face to face in person
HBB.P4.AND	Associate Nurse Director (AND)	Telephone

HBB.P5.AND	Associate Nurse Director (AND)	Telephone
HBB.P6.AND	Associate Nurse Director (AND)	Telephone
HBB.F1.NM	Nurse Manager (NM)	Face to face in person
HBB.F2.SCN	Senior Charge Nurse (SCN)	Face to face in person
HBB.F3.RN	Point of care Registered Nurse (RN)	Face to face in person

### **5.3 Theme 1: Registered Nurses (RNs) knowledge and understanding of accountability**

Three sub themes emerged in this theme, accountability as levels of responsibility; relationships, structures and processes in which RNs are answerable; and RN perceptions of the intent of hierarchical accountability from point of care to HB.

#### **5.3.1 Theme 1: Subtheme 1: accountability as levels of responsibility**

Participants within the hierarchy described accountability as being individually responsible for meeting the obligations of the NMC Code (2018a) and the role in which they were employed. Responsibility was mainly described as tasks, actions or obligations. The hierarchical structure meant that RN roles were associated with different levels of responsibility. Three levels were identified and, the findings are presented under the category headings – responsibility for the whole system, responsibility for components of the system; and responsibility for individual patients.

##### ***Responsibility for the whole system***

Accountability across the whole system for professionalism and the professional activity undertaken by nurses, midwives and allied health professionals was described by the END. In addition to this the END was responsible for the operational running of a number of services i.e. [\*] (Hospital named), Prison Healthcare, Complaints services, Nurse Bank and Public protection. The challenge and requirement to balance having an appropriate work force, maintain safety and also reduce supplementary staffing was a core responsibility of the END.

The difficulty to meet these challenges and the sense of vulnerability to assure that the system was safe was described as being a 'bit hairy' at times.

*HBB. P1. END "I guess one of the biggest challenges is, keeping things safe, given the pressure on the systems...how am I going to reduce agency whilst recruiting enough staff to reduce the vacancy gap whilst trying to ensure that wards are safe. How do I know that we are recruiting enough nurses, or if we're not recruiting enough, what else am I doing to address that?"*

There was acknowledgment by the END that patient harm can occur and the typical organisational response is to question the END in relation to awareness of the issue and what was done either through a professional or operational route.

*HBB.P1.END "Although I've got this professional role across the board, what I have to constantly remind board members of is that individuals are accountable. They're registered practitioners and that although there are mechanisms and processes in place to try and ensure that we don't allow people to do harm, things will still happen, and actually I can't always control those things."*

Similarly participants in HBB.F2.SCN discussed their responsibilities for individual RN practice in their teams. There was agreement within the group that individual RNs should be accountable for their own practice, however in practice the SCN was often blamed when issues were identified.

*HBB.F2.SCN "I think also, as a Senior Charge Nurse, in a sense you're also accountable for what your team do because you need to be aware of... their education needs need to be met as well. So, if they do something that's not right then, in a sense, we are then held accountable also."*

*HBB.F2.SCN "I don't like that fact that the buck stops no matter what with the band 7. We all take that responsibility on but it's unfair if a band 5 or a band 6 knowingly does something they really shouldn't be doing, they can then say, "Well, actually I've not been shown this way by the band 7".*

### **Responsibility for intermediary level of the system**

All participants described having individual professional responsibility for components of the system. These responsibilities mainly related to having a safe and effective workforce, assuring the quality and safety of care, governance and service redesign.

*HBB.P4.AND “So, I am directly responsible for how we develop services, how we govern them, and how we maintain safety, so that’s what I see as being accountable”.*

One participant made reference to accountability for their behaviour in a senior professional and managerial role.

*HBB.P2.ND “I have an accountability for the way that I behave and the way that I practice as a Senior Nurse and as a Senior Manager. Equally, I have the responsibility to assure and ensure that there’s safe, competent, skilled, quality practice for those who are providing direct care through the Associate Nurse Directors by our dialogue, by the mechanisms we have in place to assure ourselves of quality and safety, both from a patient and a staff point of view because we have a responsibility to our staff as well as to our patients.”*

Participants within the hierarchy, excluding the END, SCN and RNs at point of care, described a change to their responsibilities in 2015 to exclude having financial responsibility for nursing. This was prompted by a move to a general management structure. Despite this structural change, RNs continued to describe having the responsibility for maintaining an appropriate workforce to deliver safe care. This included decisions relating to the requirement, or not of using supplementary staffing or over recruiting into vacancies. RNs discussed having to account for the financial decisions being made but not having the authority to make changes without significant additional effort and negotiation.

RNs above SCN level mainly held ‘professional advisory’ roles. There were a small number of exceptions to this, and RNs had both managerial and professional responsibilities. Having budgetary responsibility was considered to enhance authority and control.

*HBB. P3. CN “Services I line manage, you feel that you’ve got more control over because you’re not just working through influence, you’re working through authority as well, and you’re both professionally accountable and operationally accountable, so you’re not having to negotiate with somebody to put your advice into place.”*

Benefits of being in a professional advisory role only were identified as not having to be as reactive as operational managers and also having the time to assure quality of care and standards of practice.

*HBB.P5.AND “Having the time to actually have more visibility I probably uncovered quite a lot of things that were lacking and also looking at training and education and finding out by talking to staff about what is the real need or*

*requirement for education. That's been a real positive. I think the thing that I've found hardest has been stepping back from the operational line, not having budgetary responsibility. That has been difficult and I have felt a little bit disempowered."*

It was clear from participants that not having the operational responsibilities for nursing including finance had increased the time to spend on professional activities however it had also reduced their authority and sense of empowerment to be flexible with the nursing workforce to meet clinical demands. The scope of responsibilities (including the geographical spread of services) was also considered a factor in being able to meet the responsibilities of the role. This required RNs to have good working relationships through the professional and operational management lines.

SCNs described their responsibility for patient flow on their site and the impact that managing this had on their ability to meet other requirements of the role. The responsibility for flow was felt to sit disproportionately with the nursing workforce and medical colleagues did not engage. The burden of three bed meetings a day had a negative impact on the SCN role. In particular being asked to explain why patients had breached the four hour target, patients that were or were not identified to board and a lack of patients being discharged – these responsibilities were described as being a collective responsibility but only RNs were answerable.

*HBB.F2.SCN "That room will be 99.5% full of nurses, Charge Nurses and even band 6's, and the other half will be non-clinical managers. They'll ask us, "Why is there no discharges?" We're nurses, we don't dictate the discharges. That's a doctor job. There's no responsibility getting put on the doctors. They turn around and say, "Nurses, you need to go and tell the doctors".*

*HBB.F2.SCN "Doctors never pitch up despite the fact that we've often voiced that concern. No, they don't pitch up, they're obviously too busy."*

### ***Responsibility for point of care level of the system***

RNs at point of care and SCNs described accountability as having a responsibility for the care and experience of individual patients. They also described their personal accountability for supporting colleagues. As part of this accountability reference was made to signing documents for the purposes of people checking things are done; for example, medication administration.

*HBB.F3.RN "It means that you are basically in charge of making sure that certain aspects of patient care are done correctly, that you are responsible for certain things and that's why you have to sign off certain things so that people*

*coming back and checking, for example, medication and things like that, people making sure that they get their prescription right.”*

A RN discussed a recent experience of being in charge of the ward and how this had enhanced her understanding of the whole system, where usually her focus of responsibility was on the care of a small group of patients. This appeared to empower her to make more autonomous decisions.

*HBB.F3.RN “I just realised how small one ward is in the context of the whole hospital. So, then realising that my role, yes, everyone’s role is integral, but just realising how small a cog you can be in the big machine that is the [\*]. That was a shock to the system. I think it puts a bit of context on what you’re accountable for, your own actions and you don’t need to keep asking everyone for very little things”.*

A participant in HBB.F3.RN described her experience in joining the NHS a year ago from the care home sector. This RN, with more than ten years’ experience, described having a set of skills (venepuncture) that she was not allowed to practice until completing the local health board training. Aspects of her RN professionalism felt restricted and the group discussed that this would not be the case for other professionals. This perspective aligned with the END view that RNs are individually accountable for their practice and demonstrated that governance systems are not established to support this level of autonomy.

RNs discussed the importance of being able to deliver high quality care. One RN described her inability to deliver the level of care her patients deserved and the managerial and administrative burden of the SCN role to have pushed her to retire from her SCN post and return as a RN.

*HBB.F2.SCN “That is one of the reasons that I am retiring. I can’t do it anymore. I can’t jump through their hoops anymore. Sometimes, patient will say, “Oh I have never seen you. Are you the Charge Nurse? I have never seen you”. I absolutely adore looking after patients and I want to make sure that they get the best care possible. More and more, I am being expected to do other things. So, I have had it!”*

RNs within the hierarchy discussed their accountability to speak up against poor attitudes and behaviours that could impact on patient and staff safety.

### **5.3.2 Theme 1: Subtheme 2: relationships, structures and processes in which RNs are answerable**

This sub theme relates to the relationships within in which RNs are answerable. The findings are presented under the category headings -internal organisational structures; NMC; and patients and relatives.

#### ***Internal organisational structures***

All participants could describe their managerial and professional structures in which they were accountable. A structural change in 2015, to a general management structure had impacted on RN identity and structural empowerment. RNs demonstrated their attempts to manage in the system but overall this re structure was perceived negatively by participants. Figure 3 illustrates the professional and managerial split from SCN to END. The END was known by name across the hierarchy and considered to be very visible by all participants. Direct and indirect accountability relationships were described by the END.

*HBB.P1.END "I think lots of people probably think they hold me to account. So, my boss actually does, the Chief Executive, but the board holds me to account as well, the other person who holds me now to account is the Cabinet Secretary. So, again, there's different levels of accountability. I think that the public probably thinks it could hold me to account."*

END accountability was enacted by taking reports relating to patient safety, patient experience, complaints and other specific clinical risks that emerged through the Health Board Clinical Governance Committee. Reports relating to workforce were taken through the Health Board Staff Governance Committee. These structures allowed the scrutiny of risks by Health Board members.

Participants described their accountability relationships within the professional nursing hierarchy and also across their leadership triumvirate as shown in figure 3. The majority of participants described good working relationships with their medical equivalents however also acknowledged that they were not equally held to account.

*HBB.P2.ND "I'm held to account by my line manager who is the Chief Operating Officer, because we're in a general management structure, so I'm part of her triumvirate. Myself and the Medical Director, probably to a lesser degree, are held accountable and responsible"*

The role of clinicians in general management positions was discussed as having benefits and draw backs. The benefits related to having an understanding of the system and clinical responsibilities. The draw backs were considered to relate to making decisions that sat with the profession based on out of date knowledge and not respecting the contribution of everyone in the team. What was consistently reported by participants was the need to have good working relationships. The need to have a professional reporting line was considered to be important to ensure appropriate challenge and support from another registrant who recognised and practiced within the same regulatory framework.

*HBB.P4.AND "I would have a really big problem if there wasn't a split and I was reporting everything to my direct line manager who then may not have the level of expertise to advise me when it's something that I don't know and it's really a professional issue. If I need advice then I want to go to somebody that understands the nuances of the profession."*

Participants discussed the impact of having both a professional and managerial structure of accountability. The responsibilities of the Clinical Nurse Manager and Service Manager were considered to be in conflict and appeared to impact on the SCN role to manage the tension and expectations of both. The use of the word 'pummelled' demonstrates the sense of pressure carried by the SCNs.

*HBB.F2.SCN "Professionally, you have got your CNM and for the service you have got your service manager. Usually, they never agree."*

*HBB.F2.SCN "So, you are normally getting pummelled by both of them, is what it means because one is a clinical and one is finance driven, I guess. So, they are both at you to achieve and to perform."*

*HBB.F2.SCN "They are as supportive as they can be given the fact that they are then getting pummelled from somebody else. Ultimately, I guess, it is the government. If you are looking to apportion blame, ultimately, it is them that want the four-hour targets to happen and no matter how unrealistic they are that is what they want to happen. That is what has become a priority, rather than what is actually happening for the patient. I think, we are kind of the buffer, if you like, between the hierarchy and the patient. So, most of the time as Charge Nurses you are trying to deflect problems and stop things getting out of hand."*

## **The Nursing and Midwifery Council (NMC)**

RNs at point of care, SCNs and NMs made reference to the NMC. NMs described RNs main accountability relationship as having responsibility to the NMC and their role (as NM) was to make enacting that as easy as possible. SCNs discussed the expectations of being able to maintain their professional requirements relating to effective practice and the need for ongoing education and development as being unachievable. The expectation that all of this was to be done in your own time was considered unrealistic.

*HBB.F2.SCN "That's in the code of conduct. The NMC tells you that you're responsible for your own education and development. However, the reality is that you don't actually have any time."*

Nurse Managers discussed being answerable to the NMC when they made referrals for other registrants. A recent experience presenting a case to the NMC had been particularly difficult for the NM and the team that attended as witnesses.

*HBB.F1.NM "I was thinking that actually I had one of my members up in front of the NMC in May there with some of the staff from one of the wards. The staff found it extremely difficult. NMC hearings are not pleasant."*

A similar perspective that the NMC was only associated with when things go wrong was corroborated by point of care RNs

*HBB.F3.RN "You only really talk about the NMC when things are going wrong or, as I say, if they've got new legislation or whatever that they want you to read."*

## **Patients and public**

Only RNs at point of care described being answerable to patients and their families, other RNs within the hierarchy described having an accountability to the public but gave no examples of being directly answerable. There was an acknowledgement from participants that although interventions were daily tasks for RNs, for patients they may never have experienced it and will be curious and therefore will ask questions. Contributing factors to increased questioning from the public was considered by RNs in the context of the Patients' Charter and legal frameworks for patients such as, consent. Society was described as having much more involvement in decisions and the public no longer just take the word of professionals

*HBB.F3.RN “years ago patients just... you were a nurse or a doctor and if you said it, that was gospel and they just took it on board. Now, they have, rightly so, a right to question what we’re doing and why we’re doing it.”*

RNs were positive about giving explanations to patients and families. Being able to give appropriate explanations was considered by RNs to reduce the anxiety of patients. Responses had to go beyond just telling patients what an intervention was for to actually describe how and why it was an appropriate treatment. This prompted a sense of more accountability for RNs and the opportunity offer explanations. It also highlighted any knowledge gaps that they could address.

*HBB.F3.RN “ Instead of just asking , “What is it for?”, they’re going to ask how it’s going to help them so it’s giving us more accountability for what we’re going to give. So on our part we are reviewing our knowledge as well when the patient is asking. It sometimes helps highlight a gap in knowledge”*

## **5.4 Theme 2: RN experiences of how and why mechanisms of accountability are enacted and the impact in practice**

Participants discussed their experiences of enacting accountability. Three subthemes emerged relating to how and why accountability is enacted- in response to concerns about poor care and external scrutiny; to assure quality of care and standards of the profession; and to safeguard patient outcomes at point of care.

### **5.4.1 Theme 2: Subtheme 1: Enacting accountability in response to concerns about poor care and external scrutiny**

Complaints, adverse events and external scrutiny are the three categories in this subtheme. The incident reporting software Datix is referred to by participants and represents adverse events or near misses that were recorded on the electronic system.

#### ***Complaints***

How accountability was enacted in relation to complaints was dependent on the position of the RN in the hierarchy. All RNs mentioned complaints and in general they were described as an important opportunity to improve. RNs at point of care described enacting accountability by trying to resolve issues before they became complaints with families and patients. This was previously described in Theme 1: Subtheme 2 (patients and relatives). Enacting accountability for SCNs and NMs involved investigating complaints, drafting response letters and managing the actions identified. SCNs reported that they were answerable for the performance of their

team and any environmental issues. Having to provide an apology within the context of a complaint was disputed by participants in HBB.F2.SCN. This appeared to relate to offering an apology for issues that were a consequence of the system rather than the 'fault' of their team. An apology was perceived as confirmation that something avoidable was done and this was considered to mainly sit with nursing teams.

*HBB.F2.SCN "I very rarely say sorry because actually I don't think I am sorry for things I can't control but I'm told to say sorry in an apology because someone is not happy."*

Enacting accountability above SCN level resulted in several outcomes; using complaints to identify areas at risk of delivering poor care; ensuring learning was identified and reporting complaint themes and response rates through Clinical Governance structures. Another further consistency within the hierarchy was RN accountability to ensure a culture of honesty and transparency to optimise learning. An example of how one AND responded to complaints evidenced the level of importance placed on feedback.

*HBB.P6.AND "I have to say I think it was unlucky that she found it dirty because I've never seen this particular ward dirty and I checked under every bed, I checked under chairs and it was all to a pretty high standard. However, when I actually checked the server, there had been an unfamiliar Domestic two days previously, which coincided with this poor nurse's visit."*

Of particular interest with this complaint is the correlation with the SCN perception that although issues were repeatedly reported on Datix there was nothing that could be done and that individuals carry the responsibility for system issues ( in this case the temporary domestic). SCNs had discussed the proximity of beds as a falls risk and an ongoing issue for the site that had been repeatedly reported.

Complaints relating to professionalism and RN attitude were acknowledged by a number of participants. This concurs with the hierarchical collective leadership drive to enhance these in practice. Enacting accountability to address complaints was described as supporting practitioners to understand the impact of their language.

*HBB.P6.AND "I went up to speak to the member of staff so she could actually tell me who she was and I said, "Do you know how you came across?", and she said, "Oh, I had no idea that that's how I came across". I said, "So, sometimes it's worth listening to ourselves, if that's what you would want to hear from someone that was speaking to you". She actually emailed me the following day and said, "I'm so sorry".*

Enacting accountability for complaints was evident throughout the hierarchy. At a whole system level the END was described as being very involved in complaint response assurance and understanding the themes. Themes and actions required were discussed at the Nurse Director group.

*HBB.P3.CN/ND “Complaints are probably a big thing, and adverse event reviews. It’s probably going back to your earlier question actually- that’s what I am held to account for. In terms of complaints, I’m the line of governance that signs off on complaints and then they’ll go to the Director of Operations. So, the Clinical Nurse Managers or the Clinical Directors or the Consultants will answer the complaints and then they’ll come through me, and then they go to [\*] (Director named) for sign off, and END gets sight of the themes that come out of complaints.*

### **Adverse events/ Datix**

Enacting accountability in relation to adverse events featured in most interviews within the hierarchy. ‘Datix’ was often used as the verb of recording an incident. The data contained within the Datix system was a key way in which RNs within the hierarchy enacted accountability to assure the quality and safety of care. Assurance was mainly achieved by having an overview of what was being recorded, emergent themes and how teams were responding to change.

SCNs and NMs were consistent in their view that recording issues on Datix should be positive but the volume meant variable impact on practice depending on the issues being identified. Incidents that created a risk to organisational reputation were considered to be acted upon. Recording incidents was considered to be a defensive practice. RNs within the hierarchy described having to ‘datix’ everything ‘just in case’ it was investigated or a claim was made. RNs, SCNs and NMs considered the volume of incidents that were therefore recorded meant that the important things were being missed. In addition there was no feedback, and no evidence of any change being apparent to the reporter.

*HBB.F2.SCN “When I started in the [\*] (service named) three years ago, they had three hundred and odd Datix. Most of them have just been answered in the last eight months, of which 95% were sent back with ‘this is too old to investigate’, of which myself and the other manager have done I have not had one replying back, saying, “This is not appropriate”. So, for me, why do we*

*Datix things if nobody is looking into them. If someone trips you Datix it. If someone bangs a bed with their hand you Datix it.*

A further reflection of SCNs was that some people chose to 'datix' an issue rather than having a conversation with a colleague that may be difficult. Even if a conversation took place people felt the need to follow it up on Datix, which was interpreted as mistrust. Adverse events were described as being 'investigated' by most participants despite the concurrent narrative about supporting RNs to be open and transparent. The impact of this was described by SCNs and the lack of consideration of context of care in the process.

*HBB.F2.SCN "You feel like you have done wrong, during the investigation and because of how they conduct it, this is how I feel as a person myself, but when they conduct the SAEs you need to answer. They don't even look to see what happened and what was going on. For example, if there was a shortage of staff, or there was sickness. They just want you to be answerable and accountable for that SAE or that incident that happened."*

Enacting accountability at END and CN/ND level included 'signing off' adverse event reviews that involved and challenging the adequacy of reports and actions. Feedback to teams and taking a proportionate amount of time to discuss outcomes and share learning was acknowledged as difficult to achieve but efforts were evident across the system to prioritise this through governance structures.

*HBB.P5.AND "We don't get a huge number of serious adverse events (SAEs) but the ones that we do get tend to be quite complex and there's a lot of learning from them. We're not actually feeding that back or presenting it back to our teams properly. It's a bit squeezed onto the agenda, not really giving the detail around the learning and about the closing off of the actions and about that just bigger discussion. So, that's something that we've put into place".*

Contrary to not providing feedback an example of the positive impact of supporting teams to find solutions using a quality improvement approach was discussed by NMs. This related to prevention of pressure ulcers and skin integrity at time of transfer for patients being identified as a theme in one area and giving ownership to the team to resolve the issue.

### **External scrutiny**

Enacting accountability in response to external scrutiny was implicitly referenced by RNs discussing the national programmes that underpin Health Improvement Scotland (HIS) scrutiny being part of their responsibility. In particular RNs described their accountability in

meeting the care of Older People in Acute Hospitals (OPAH) and Health Associated Infection (HAI) standards. The attainment of national standards for both were discussed as key features in governance and professional meetings. The response of individuals and the media coverage of published external reports was discussed by RNs at point of care and NMs as having the greatest impact rather than the inspection itself. At the time of data collection a culture report on Case B was published. The impact on RNs of the response of a senior manager to media coverage was described by point of care RNs.

*HBB.F3.RN "We got slated in the press at the beginning of the week and [\*] (Director named) felt it and you could see she felt it but "we did well and we are still doing well", and she boosted her staff no matter whether we've had a rubbish day or we've had 25 breaches in the last hour, she still focusses on the good things we do. "We're still a good team and you all work really hard". She really does care, she knows every member of staff by name."*

A contrasting approach was described by NMs although this was caveated as being in 'the old ways'. This response by middle management to an issue being identified remained with the NM several years on.

*HBB.F1.NM "At the time, it was handled very badly because the person who came with the inspection had said to me, "You are accountable for this", you know, in a cupboard – I'll never forget that – and that's the kind of stuff where you see the behaviours come out. However, I was given my place by the inspection team and a couple of senior managers from the board came along and sat with me and said, "You don't have to fall on your sword", so I got support which I would be expecting from that level."*

The Mental Welfare Commission were referred to positively by point of care RNs. At the time of data collection a visit was expected. Participants described this as routine and a way of reviewing care plans, treatment and discharge plans are in place. The approach on one site was to conduct a local inspection process to both seek assurance but also to normalise the process with staff.

*HBB.P2.CN/ND "So, we go to a site and we go and visit wards and we'll look at all of the OPAH standards and all of the HEI standards, so we check for PVCs or hand hygiene or PPE, and dignity and respect, and look at patient's notes and documentation. That's something that we do to try and help ourselves prepare for when we get inspections."*

## 5.4.2 Theme 2: Subtheme 2: Enacting accountability to assure quality of care and standards of the profession

The findings of this subtheme are presented under two category headings: meetings and audit.

### *Meetings*

Enacting accountability to assure care and standards of the profession took place using a number of approaches which included meetings. Meetings ranged from five minute board huddles, management and professional 1:1 meetings to Board level statutory governance meetings. RNs within the hierarchy valued their 1:1 meetings and found them supportive.

*HBB.F1.NM “I like the 1:1, you can go into detail about all the different measures. It makes you feel a bit better as well, more assured that what you’re doing is meeting the approval of your Associate Nurse Director as well so that’s a reassurance to you because if you’re not, that’s the time where they should be saying, “Have you looked at it this way or tried that way?”, or based on their experience, “I’ve seen this being done, what about that?”, and that’s how to do it.”*

One-to-one meetings were variable in their format with management 1:1s generally being more formal and structured than professional 1:1 meetings. Data consistently described at SCN level and above as being part of 1:1 conversations were workforce data, in particular sickness absence and vacancies, finance, complaints and adverse events. Point of care RNs did not have regular 1:1 meetings but did have an annual appraisal. RNs that participated from mental health made reference to supervision for RNs at point of care. SCNs tried to facilitate this on a monthly basis. An example of a huddle was described by a participant to discuss quality and finance outcomes and explain the data to staff.

*HBB.F3.RN “We have a new board with percentages of our performance each month and arrows that say if we have gone up or down. We also have a monthly poster on what we have spent so staff can understand what we have spent. We bring staff to the board, when we have the chance, to discuss the data. It’s not hard to understand if you do it with them.”*

SCNs, NMs and ANDs described meeting where they were required to explain and justify the financial position in their area of responsibility. This supports the view held by ANDs and NMs that although the responsibility of financial decisions was removed from them they were still held to account for the outcome.

*HBB.F1.NM “We have finance meetings every month with the Service Manager, with the Accountant, with the Assistant Service Manager, and with the nurses in charge of the ward. We go through their financial statements and pick up if there’s anything that’s jumping out or if they’ve gone over is to understand, and then that’s where I come in, why they’ve gone over.”*

Enacting accountability in peer meetings was described positively by participants within the hierarchy. The purpose of these meetings ranged from information sharing, verbal assurances, support and sharing learning. The informal approach to these meetings was welcomed and RNs felt free to discuss difficult issues.

*HBB.P3.CN/ND “It’s not a formal meeting, I don’t minute it, so it’s more about what are the things that are on your radar just now, anything you’re concerned about, anything you want to share, that type of thing.”*

Professional standards were mainly considered to be meeting the professional expectations as set out in the NMC Code. Regulatory aspects were mentioned by one participant as part of their governance meeting structure where RN conduct, capability and access to education were discussed and understood. Sector/ site formal clinical governance meetings were described as evolving and in particular in the context of Integration Joint Boards. Trying to make the time to review adverse events and complaints was a consistent theme.

*HBB.P6.AND “ For Clinical Governance, we had a period in our intensive care unit where we had three episodes of bolusing of noradrenaline which had caused harm to patients but it was a user error and it was an education gap. So, it’s those sorts of things about closing that loop and evidencing that actions have been taken.”*

Attendance and output from meetings was highlighted as being reviewed by one AND with the Associate Medical Director. The importance of ensuring people were not removed from clinical areas to attend meetings that didn’t add value was something that had been fed back by staff and they wished to address. Alternative ways to seek assurance rather than meetings were being explored rather than continuing with historical practice.

### **Audits**

Audits were described as being one part of assuring care. Only three participants and one focus group made reference to audits. There was consistency amongst participants that audit had to be triangulated with more objective data and being in clinical areas and talking to staff for assurance. The focus of assurance within the hierarchy was placed on reviewing the

outcomes rather than the process of auditing. Although RNs discussed auditing it was not described as problematic or a burden by participants. There were different approaches taken on different sites. In mental health services the responsibility for audits were placed with the clinical teams and issues could be escalated by NMs when required.

*HBB.P3.CN/ND "In Adult Acute, we've got a tool called SCAMPER that we use ... so, they'll audit 10 records every so often and there's certain things within that. Its things like making sure the patient's got a care plan, making sure of the legal status and all those kinds of things. In terms of those audit reports, they tend to be managed locally. What we've not got in place yet is the escalation of those up to my level, so I am reliant on the Clinical Nurse Managers ensuring that that's done.*

Audits were considered to be subjective and not reliable in giving assurance in isolation.

*HBB.P4.AND "We do loads of audits and things like that. Stuff gets revealed sometimes by audit but more often it is by other means, it's by luck you find out things by audit because... especially when you come to somewhere that's always reporting 100%."*

One point of care RN described the perception that unless RNs understand the purpose of audits and can see the impact in practice they are difficult to engage.

*HBB.F3.RN "I have started to give out audits (to other staff) I did them because they weren't being completed or it was just tick, tick, tick. Ownership of the data important and understanding. People need to see why they are being done"*

### **5.4.3 Theme 2: Subtheme 3: Enacting accountability at point of care to safeguard patient outcomes**

The findings of this subtheme are presented under three category headings, decision making, challenging practice and documentation.

#### ***Decision making***

There were complementary perspectives in Case B on the importance of directly enacting accountability through decision making at point of care or indirectly enabling this to take place through leadership behaviours. There was a consistency in the narrative from NMs and above within the hierarchy that the nursing profession had to take ownership of decision making

rather than letting it happen around them. Senior RNs presented two contrasting perspectives of decision making by RNs at point of care.

*HBB.P3. CN/ND "I think, in general, they would always put the patients first, always, and then probably try and justify things afterwards, and I'm quite comfortable with that. As far as I'm concerned, patient safety, patient care comes first and then we can sort out if there's budgetary issues after that. I think my experience here is that that's the way it operates. They wouldn't stop themselves from doing something just because of budget if it was the right thing to do for a patient"*

In contrast, another participant described RNs to be fearful to decide to do something different if the particular situation requires it, to deviate from guidelines. This was thought to relate to history and a fear of being disciplined and perhaps being referred to the NMC. RNs were considered to be risk averse and subservient. This perspective was considered to be potentially related to how nurses were previously 'trained' to do a task and now they were 'educated' to make decisions.

*HBB.P2.CN/ND "Should we do it this way or not, I will ask the Doctor. I think a lot of this comes from the power dynamic of medicine traditionally being very male, nursing being very female. So, I think we've got a lot of history to get over. We weren't encouraged or taught to think or make autonomous decisions, we thought we did but we didn't"*

The latter view was not corroborated by RNs at point of care. The descriptions at point of care were more positive about RNs enacting accountability in relation to decisions, although it was acknowledged as being difficult to do if it opposed other colleague's views. There were several examples described by RNs at point of care of decisions being made to maintain safety, quality of care but also to enhance patient experience. Within one site there was a connection between the trust and empowerment described by the senior RN and the practice described by RNs in regards to doing the right thing.

*HBB.P3.CN/ND "I think it's really important is being able to know what's going on elsewhere and being able to try it in your own area, and not having to seek permission to try new things. I mean we don't want any loose cannons flying off but I think within parameters, you have to give people the freedom to go and do things."*

Although this decision was of minimal risk if it had gone wrong there were other examples on the same site of this autonomous approach to decision making. One point of care RN

described her rationale for not adhering to the black and white rules that some of her colleagues enacted with one particular patient. It took more effort and was a lot more challenging to defend with colleagues but she could evidence the impact it had on him and his family. She was very clear about enacting accountability to deliver person centred care. In contrast SCNs and ANDs described an inability to enact decisions without negotiation. There was also a perception that medical staff enacted decisions without any engagement or consultation with other staff.

*HBB.F2.SCN "We have got lots of thing that we can do, but if I want to change something in my department I would have to get the NM to approve it. I would have to get a Consultant to approve it. I would have to make sure the Band 5 and 6 would be on board with me. Even if it was clinically proven by research that this will work there is always going to be something. It might be me saying 'no' to someone else, but we have got to jump through a lot of hoops if we want that."*

An example on a different site where decision making had not resulted in the correct outcome was discussed by an Associate Nurse Director (AND). The point of care RNs were described as junior and the situation was a difference of opinion about the severity of illness in a patient. The RN recognised and recorded concerns but were unable to communicate this effectively to the Hospital at Night (HaN) team. The RN decided not to escalate to the Consultant on call, the rationale for this was she did not feel she would be listened to and a fear of phoning the Consultant at home. When the SCN came in at 06.45 she phoned the Consultant and the patient was admitted to ICU. This example described by RNs was to evidence corroboration within the hierarchy of the supportive approach being taken to support RNs and medics to learn rather than taking a punitive approach.

*HBB.P4.AND "The team had a really tough time", but the nurse had phoned them eight times. In some ways, that was a good learning scenario because they didn't respond appropriately. We had a discussion about it and the RN then went back and spoke to the medical staff, so it wasn't ignored, it was dealt with. So, hopefully if you keep having those kinds of learning curves care will improve."*

The level of preparedness of new graduate nurses to make autonomous decisions in an acute care setting was discussed by several participants with examples of graduates having no or minimal exposure to secondary acute care environment during their undergraduate programme. Medication safety and decision making were both described as being lacking at point of registration with the NMC and increased support being needed in the first year of

registration. This perspective was supported by a RN (with three years' experience) who described the benefits of having been on a decision making course.

*HBB.F3.RN "If someone is becoming unwell, it's like, "Ok, I can understand why that has gone on"...while I can't do a vast amount about it, I can escalate quickly if something needs done or if someone is needing bloods or an ECG or something and someone says "Well, why did you do that?" I can be like, "because of this, this is why I did that. "It's just being able to back up what I'm doing with information and I have found that really, really helpful."*

Both the END and SCNs described RNs as using their pay band or terms and conditions to justify why they shouldn't make decisions. With particular decisions being 'above their pay grade'. This resonated with similar comments within the hierarchy about working to enhance professionalism. This was mainly in the context of making decisions that would potentially cause conflict, particularly with medical colleagues or other staff.

*HBB.P1.END "nurses use pay and conditions, and other ways of deflecting things away from them in terms of their accountabilities or responsibilities in a way that I never certainly did or people of my ilk certainly never did when we were in the service, as it were. I would draw it out and say that there's almost an issue around professionalism which strikes me to be something that I find almost unacceptable."*

### **Challenging colleagues**

Enacting accountability by challenging colleagues was something that was raised by the majority of participants. This mainly concerned challenging decisions that impacted on patient safety or nurse work load. There was an overall view within the hierarchy that challenging practice, particularly of medical colleagues, had improved (in comparison to years gone by) but there was still an imbalance of power with medics which influenced RN decision to challenge and the effectiveness. Challenging managerial colleagues appeared to be less difficult. Medical colleagues were considered to be better at challenging successfully. The professional expectation that RNs should challenge to maintain safety was clearly understood by all RNs. As previously discussed, escalation was one way to do this.

*HBB.P5.AND "I professionally feel that if I see something that I think is somebody not practicing within their code of conduct, I know the expectation is then that I would challenge that, whether it would be at the moment or whether it would be a conversation at another point."*

Challenging colleagues face to face was not something RNs were comfortable with however there was evidence of it taking place. RNs at AND level and above described being confident to challenge. This was a combination of having the skills to challenge effectively and appeared to be associated with authority associated with positional power. Despite this there were still examples of challenging being unsuccessful and involving senior medics to manage medical staff.

*HBB.P2.CN/ND "There was a Registrar who had this lovely beautiful rock on... she told me I was ridiculous to ask her to take it off and to decontaminate her hands "Of course I can decontaminate my hands. I just put gloves on anyway". It doesn't matter who I am, the fact that I was challenging her .where's the research, where's the evidence for that then. I spoke to the Executive Medical Director and said, "Will you write to her because this isn't acceptable?", and so he did."*

For RNs at point of care challenging colleagues was evident. The impact of how this was received by the recipients was a factor in building self-confidence to challenge. Most RNs described trying once and if that was poorly received either giving up or escalating.

*HBB.F3.RN "I can challenge it and I do challenge it sometimes and I try and do it in a very nice way, not at the time when it's happening because I don't think that's helpful but maybe later on, I'll mention it or I'll just say collectively about attitudes towards patients. For some more junior nurses the patient safety and their safety goes out the window because they feel intimidated by the way things get done."*

The purpose of the challenge and who was being challenged appeared to influence RNs. Where challenge was considered as part of creating a safe environment to discuss concerns challenging was well delivered and usually well received. Where the purpose was to demonstrate power or control there was no recognition of the importance of the way the challenge was approached.

*HBB.F2.SCN "I regularly have doctors come to me in the morning and say, "Could you just take that blood?" My response is, "Absolutely. I will go and take that blood. You just go and do that bed-bath that is required to be done because, whilst I am doing your job, there is actually nobody doing mine". So, they tend to back-off quite quickly at that point because they realize that it is not going to happen. It has taken years and years of practice for me to be able to say, "No. I am not doing that. You need to do it."*

It was easier to challenge junior staff and staff within the nursing profession. Issues that presented an obvious patient safety issue were easier to challenge than behaviour and attitudes of colleagues. Creating a culture where challenge was positively accepted was mentioned by several participants. A more positive example was described following a situation where it became apparent that a nursing team did not have the collective confidence to challenge medical decision making that was considered suboptimal. The CN/ND discussed the issue with medical and nursing staff together and listened to the team's perspective and then shared her observations with this and offered the most recent evidence. This approach was successful. In addition it was then recognised that the team needed to be able to get to that place without escalation and so a different approach was put in place- at the time of data collection this was demonstrating positive outcomes.

*HBB.P3.CN/ND "So, this is a sledgehammer to crack a nut but I've identified then actually what can we do to empower the nurses within there, so I'm going to put a clinical academic post in there that'll support a more proactive research type approach to how rehab patients are being looked after and then I'm going to put a Nurse Consultant in for that as well which will support the decision making"*

### **Record keeping and documentation**

This category concerns both the process of enacting accountability by record keeping and the impact that documentation (paperwork) has on RNs practice.

Record keeping and documentation was raised by five participants. There was consistency that time to complete records to an appropriate standard was inadequate. Despite this record keeping did not appear to present a significant challenge to RNs. Reference was made by RNs at point of care that "finding time to update Trakcare is challenging". This was usually done at the end of a shift. One AND made reference to the impact that twelve hour shifts had on handover times and time to appropriately record information in the patient record. Through the Care Assurance Standards (CAS) documentation was one aspect identified needing to be improved.

*HBB.F3.RN "At the moment, what I'm finding is people are getting the paperwork done but it could be done better. They would probably do it better if they had more time without the interruptions because you're having to do all this paperwork when you've got someone knocking at the door, interrupting you and you're back and forward. That's the most frustrating thing and that has been highlighted to my manager."*

Communicating effectively at the time of care transitions was discussed by NMs in relation to themes identified from adverse events. This was about written records that described the assessment and plans of care for the patient. An example was given that demonstrated RN approach to amending documentation to support improve clinical practice.

*HBB.F1.NM "What we came up with in that area was a 'think pink' sticker. When a patient is admitted to the ward, within four hours, their skin integrity has to be checked so it's checked and written down. All it is, is a tick box 'right heel, left heel', etc. and they would tick if it was blanched, non-blanched, red, broken, so we knew what their skin integrity was like on admission. It is protecting yourself sometimes to have this tick box that you have done the care, because if the complaints come, what is going to back you up"*

### **5.5 Theme 3: Individual and organisational barriers and facilitators to RNs accepting professional accountability**

Participants across the hierarchy shared their experiences of accepting accountability. This mainly related to their ability to enact individual responsibilities. Factors that facilitated or hindered RNs to do this were explored. Accepting accountability was strongly associated with the concept of autonomy. Two subthemes emerged, individual RN self-confidence to make autonomous decisions and accounting for the decision; and having a fair and safe working environment that enables autonomous practice.

#### **5.5.1 Theme 3: Subtheme 1: RN self-confidence, resilience and autonomy to make open reasoned judgements**

Within this case the END displayed self-confidence to make, enact and account for autonomous decisions. ND/CN and ANDs displayed self-confidence to make autonomous decisions and account for them. The implementation of these decisions required increased influence and negotiation in particular if there were financial implications. NMs, SCNs demonstrated a willingness to make autonomous decisions, however were unable to do this. RNs at point of care described self-confidence to make autonomous decisions relating to patient care. The factors that facilitated and hindered this are presented under three category headings – identity and being valued; level of knowledge and skills; relationships of trust and support.

## ***Identity and being valued***

Being identified as a clinical professional was important to all participants. Of particular interest to participants was the identity of undergraduates, SCNs and ANPs. Clinical professional identity was most strongly associated with RNs at point of care and ANPs. Being identified as a clinical professional was important to NM, AND and ND/CN self-confidence, however the authority and control that management positions offer was considered beneficial in the context of Case B. An example of lack of professional identity was provided by one participant's observation that nurses above SCN level are referred to as 'managers', in comparison to medics in the equivalent hierarchy, up to and including Medical Directors are referred to as clinicians.

The consequences of undergraduate education were discussed in relation to identification with the nursing profession. Comparisons were drawn between previous models of education (or training) experienced by other RNs and the current undergraduate programme. A perceived lack of self-confidence to make decisions related to lack of identity as a homogenous professional group. This was compared most frequently to the strength in which medical students strongly identify themselves with the medical profession. The social aspects of the current undergraduate experience were discussed as a possible contributing factor to a lack of a professional community and therefore a lack of strength of professional identification. In addition, the diversity of the workforce and roles in which nursing can contribute, was also considered to impact on self-confidence to make decisions at point of graduation.

*HBB.P1.ND/CN "When I trained, we were cohorts and mostly women who were in their late teens, early 20s. We all lived in halls, we all lived on site, we lived in a nurse's home, and we had our own little community. Whereas now, it's very diverse, it's very different and that's a good thing. I know we're trying to move away from a hospital-based model but actually that is the reality is a lot of care still happens in a hospital, to somebody who is in their third year and has never worked in a hospital because that does equip you with a lot of fundamental skills to practice wherever you are."*

SCNs described a desire to have national clarity of their identity and scope of practice to enable autonomous decision making. There was consistency of opinion across the focus group that the expectations of Leading Better Care (2008) were not supported by the organisation. SCNs described the need for them to be enabled to be clinical leaders and not managers. There was a demonstration of willingness to accept accountability for decisions however the co-dependency of each part of the organisation made this difficult to achieve.

*HBB.F2.SCN "I reckon, every Charge Nurse would love to be allowed to give a free reign of what your ward needs and how you can develop your ward without interference. Obviously, that is going to be within your scope of budget, but to do what you want. Run things by your service and say what you are doing so that they are involved"*

All SCNs described looking for alternative roles within and outwith nursing. This was most strongly associated with not being able to achieve satisfaction through delivering care or supporting their teams to deliver care.

*HBB.F2.SCN "I still want to look after patients. I still want to see how the staff work and why the staff struggle if there is a struggle or some shortfalls that they are not happy about. If things are not done, why aren't they done? Not just to come and give instructions, but you don't know what was going on, on the floor because that is where you can work it out."*

The identity of advanced practice and specialist roles were discussed by participants. This was considered a very attractive role and strongly associated with autonomy and clear responsibilities associated with clinical care. Ensuring the identity of these roles remained embedded in nursing was important to individuals in the roles however due to most roles being developed in response to medical shortages and through medical monies this was difficult to achieve.

Nurses were described as compliant by several participants within the hierarchy. The changing identity of the nursing profession and greater expectations of nursing students when they graduate was discussed by the END. This appeared to relate to a perception that nursing has been traditionally 'accepting' of terms and conditions as part of professionalism and this is changing. This also related to shift patterns. A loss of connection with the wider profession and a sense of belonging to something bigger than a ward or team was mentioned by several participants.

*HBB.P1.END "Oh, I'm not doing those shifts", or, "I'm not doing night shift", or, "I'm not doing weekends", and the response to that is, "Well, why did you go into the profession".*

Being valued appeared to impact on RN self-confidence in two ways- supporting resilience and that their individual contribution makes a difference. This related to RNs at all levels of the hierarchy. Examples of what made RNs feel valued were provided by most participants. RNs at point of care discussed the importance of feedback from patients and relatives to having a sense of value.

*HBB.F3.RN "At the end of the day when you are tired and you hear something positive from a patient, it's like "Okay, I've done something right, I'm going home now."*

Other RNs described being asked for their opinion, appraisals and 1:1 meetings as interactions that made them feel most valued.

### **Level of knowledge and skills**

Level of knowledge and skills influenced the self-confidence of RNs to make autonomous decisions. Knowledge about how to deliver care as opposed to having knowledge about why the care was required was evident. RNs at point of care demonstrated pride and a sense of being respected for being able to carry out tasks with a high degree of skill.

*HBB.F3.RN "I feel like Consultants do have a certain level of respect for nursing colleagues. They have a certain level of reliance on us to be able to do our jobs properly. I think although they don't phrase it very well, they are well intentioned saying "I need you to do this ...for patients". I think although it's not entirely autonomous you recognise the importance of doing your job well."*

Enhanced self-confidence to make decisions related to the increasing professional expectation to challenge practice and being confident in decision making processes based on research and evidence rather than following instruction without thought.

*HBB.P2.ND/CN "So, the positive bit is it encourages decision making, it encourages constructive challenge, criticism, thought provoking processes, having to think for yourself which I don't think I was ever encouraged to do at all, in fact we were supposed to get in trouble for doing it."*

Being identified as a professional that utilises research and evidence to strengthen negotiation and influencing power was demonstrated by RNs at point of care and senior RNs within the hierarchy.

SCNs described the professional and organisational expectation for them to be clinical experts. This was also something they wanted to do however the reality of the SCN role meant that they no longer had the knowledge and skills of an expert clinician as the majority of the role was focussed on management skills. This impacted on their self-confidence clinically and SCNs felt exposed as were unable to maintain the expected level of competence.

*HBB.F2.SCN "As a Senior Charge Nurse, you tend to take a back seat but then if something goes wrong, you're then held to account by saying, "Well,*

*why did you not know that? Why did you not know the latest regime for...”, so it is difficult to split yourself into two that way.”*

RNs within the hierarchy discussed inconsistency of access to statutory and mandatory training and an expectation that professional development will be carried out in their own time. Having the knowledge and skills to respectfully challenge colleagues varied within the hierarchy from good to poor.

### **5.5.2 Theme 3: Subtheme 2: Fair and safe working environment that enables autonomous practice**

The findings are presented under two category headings – relationships of trust and support and control of responsibilities.

#### ***Relationships of trust and support***

Trust and support was described consistently as positive within the hierarchy. In particular with peers, line manager and professional lead. This mainly related to RNs having the self-confidence to make decisions and know that they will be supported even if the decision was incorrect as long as the intention was appropriate. From descriptions provided by participants this approach appeared to be set from the top.

*HBB.F3.RN “Our Executive Nurse Director is really good and as is our Nurse Director so I think from an approachability about leadership. They’re both visible ...and I think that’s been something that’s been really important to my staff that they know who these individuals are and they’re not just unknown faces. I think that’s really positive and I really like that.”*

There were examples where this was not the case and this was described as a disconnect between the reality of practice and expectations of senior RNs and managers who did not understand the context of care delivery.

Trust and support was ‘most felt’ by RNs who described their colleagues and managerial and professional leads as approachable and confidential.

*HBB.P2.ND/CN “We’re quite informal in terms of approach so that door will chap numerous times throughout the day and the Senior Charge Nurses will pop up and say, “Can I have a word with you about whatever”. It feels like people will come to you if they’ve got concerns rather than me having to go out and interrogate people”*

Relationships between RNs and Doctors was considered to have changed over the years by senior RNs. The formality and hierarchical respect between Nurses and Doctors was observed to have been replaced by first names and more informal relationships. The ability to challenge decisions was considered more difficult without clear relationship boundaries. The descriptions provided by RNs at point of care about relationships contradicted this view and described these relationships as really important, however they acknowledged that they were variable and person dependent.

*HBB.F3.RN "If you go back years ago, there was such a hierarchy. You had managers, doctors and nurses they were all split. Now we are a team. Everybody is in it and everybody has a part in it and you don't function without each other. Everybody from domestics to... we've got a housekeeper on the ward, we've got band 2's, band 5's, band 6's and 7's."*

The consequences of not having trust and support were described as reducing self-confidence to make autonomous decisions for fear of getting into trouble. Lack of trust and support was also discussed by participants to make it less likely that they would report an incident.

*HBB.F3.RN "I got shouted at when I first started for doing something wrong. I asked if they could explain but that just made it worse. That has stuck with me. It was quite embarrassing more than anything else and nothing bad had actually happened to the patient. I think having a really supportive team is being able to ask someone to explain something."*

### **Control of responsibilities**

Being able to control the environment in relation to accepting responsibility mostly related to staffing resource. This was consistently mentioned within the hierarchy however it was not a predominant issue in Case B. There were several positive examples given of a culture of RNs being able to make autonomous decisions in parts of the organisation. RNs at point of care described being able to make decisions that were based on doing the right thing for patients and if there were any issues this could be discussed later.

*HBB.P3.ND/CN "We've closed the ward and we're all away to [\*] (area named) for the day". The same ward did 'day at the disco', so now once a month, they've gone and hired the Miner's Club. They've got a local bus company that comes and takes them, and all the patients and their family go to the disco of*

*an afternoon. They never came and asked permission to do that, it was the right thing to do for that patient group, so they do it. We've now built quality improvement around about that and said, "Right, so before you do that, tell us what your outcomes are for the day, tell us what you're trying to achieve, and then tell us if you've achieved that after you've done it".*

In contrast in another part of the organisation there was a sense of having no control over issues that affect the responsibilities of the SCN. The difference in environment mainly related to the co-dependency of parts of the organisation to maintain flow. In highly pressurised areas the ability to control the environment was limited and impacted on sense of autonomy.

*HBB.F2.SCN "We will usually start off on a day with no beds and by the end we might be discharging 70 patients. You have always got basic nursing care, but even sometimes that will be compromised because you will be running short and have to cut-corners. That is just the reality of it."*

As previously mentioned there was a sense of loss of control since the structural changes in 2015 across the ND/CN/AND/NM levels of the hierarchy. This mainly related to having to account for staffing costs and not having the autonomy for making decisions. There were examples provided where RNs felt they could be more cost effective if they were able to control decisions made about the service they were responsible for. This mainly related to having too many managers that did not impact on clinical care.

*HBB.P6.AND "I just feel that we still get asked about money on nursing but we don't hold the budget. It's not the General Manager, it's not the Accountant, it's me, and yet I don't hold the budget (laughing)."*

An inability to control responsibilities relating to education and training for SCNs and their teams was discussed. In particular SCNs evidenced not completing their planned education to maintain safety in their areas of responsibility. The availability of education was considered to be too limited.

*HBB.F2.SCN "you come on duty with your own clothes, you're going to study and you find that you have maybe two band 5's down. You can't leave the patients and attend a study day. If I miss a study day for July, I can't go to a study day until next year and they're all fully booked."*

RNs at point of care described a conflict of trying to manage organisational targets and meet their professional responsibilities as a nurse. This mainly related to an inability to control the volume of patients requiring treatment. There was a recognition that patient experience is compromised

*HBB.F2.SCN "In NHS [\*] (HB named), we historically receive 20 – 25 referrals per week, so we have staffing levels and capacity for colonoscopies for that amount. We are now receiving 60 referrals per week, but we still have the staffing levels and the capacity for only 20 – 25 referrals and we are massively tripping behind and totally breaching."*

There was an expectation that this could be done within current resource by being more efficient.

*HBB.F2.SCN "We cannot say to a patient, "I am sorry, I can't answer your fears about what is happening. I can't talk to you. I can't explain what I am about to do because, time wise, you only have me for half of an hour. So, just shut up and let me get on with it". You can't do that. If a patient comes in scared you have got to speak to them, haven't you? You have got to explain what you are about to do, informed consent."*

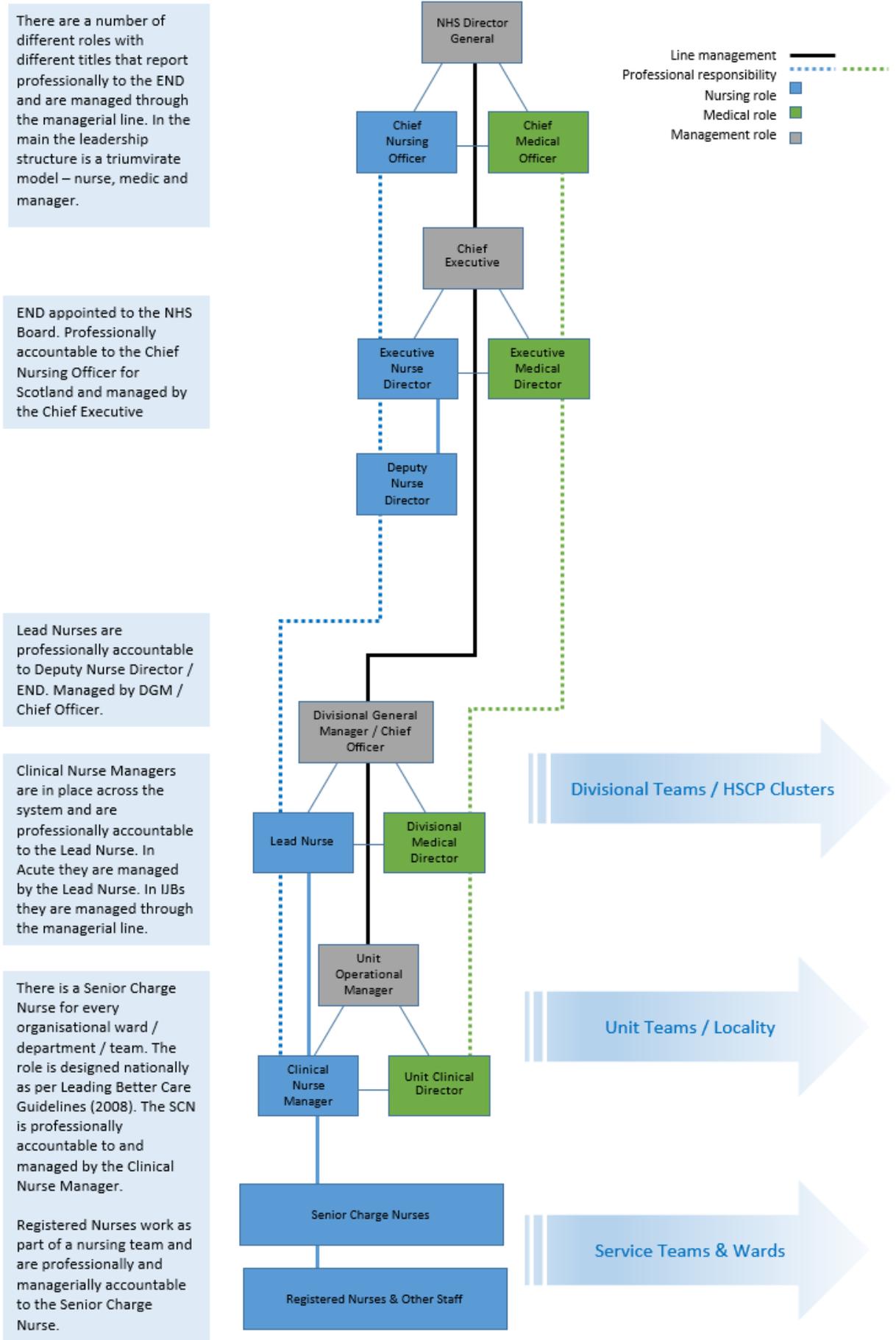
The findings from Case B are synthesised, analysed and presented as across case findings in Chapter 7.

## Chapter 6: Case C

### 6.1 Introduction

Case C is a small territorial HB in NHS Scotland. The organisational structure where nurses are represented is displayed in Figure 3. The purpose of including this figure is to show the composition of the nursing hierarchy, the managerial, medical and nursing triumvirate model and the managerial and professional reporting 'lines' for each case. The structures beneath the executive triumvirate are repeated across the organisation to cover all services. Although there is variation in the medical and managerial models in the Health and Social Care Partnerships (HSCP) it remains consistent for nursing. The organisational breadth of each case is not disclosed as it would make the HB identifiable.

Figure 4 - Case C Organisational Structure



There are a number of different roles with different titles that report professionally to the END and are managed through the managerial line. In the main the leadership structure is a triumvirate model – nurse, medic and manager.

END appointed to the NHS Board. Professionally accountable to the Chief Nursing Officer for Scotland and managed by the Chief Executive

Lead Nurses are professionally accountable to Deputy Nurse Director / END. Managed by DGM / Chief Officer.

Clinical Nurse Managers are in place across the system and are professionally accountable to the Lead Nurse. In Acute they are managed by the Lead Nurse. In IJBs they are managed through the managerial line.

There is a Senior Charge Nurse for every organisational ward / department / team. The role is designed nationally as per Leading Better Care Guidelines (2008). The SCN is professionally accountable to and managed by the Clinical Nurse Manager.

Registered Nurses work as part of a nursing team and are professionally and managerially accountable to the Senior Charge Nurse.

## 6.2 Participants

Twelve RNs from across the six hierarchical layers in Case A participated in interviews or focus groups.

Table 19 – Interview and focus group participants

Health Board case	Nurse participants
Case (C) individual interviews	1 Executive Nurse Director 1 Deputy Nurse Director 2 Lead Nurses
Case (C) focus group interviews	4 Nurse Managers 2 Senior Charge Nurse 2 Direct care giving RNs

Of the twelve participants, two were male and ten female. Interviews and focus groups were conducted over a two week period in the summer of 2018. Interviews and focus groups were conducted on two sites. Two participants had responsibility across the whole system; eight of the participants worked within or had a responsibility for primary care/ community services. The remaining two participants worked within or were responsible for secondary care services. Mode of interview was determined by the availability and preference of participants and is reported in Table 20.

Table 20- Mode of interview and participant code

Participant #	Role	Mode of interview
HBC.P1.END	Executive Nurse Director (END)	Face to face over video conference
HBC.P2.LN/DND	Lead Nurse/Deputy Nurse Director (LN)	Face to face in person
HBA.P3.LN/DND	Lead Nurse/Deputy Nurse Director (LN)	Face to face in person
HBA.P4.LN/DND	Lead Nurse/Deputy Nurse Director (LN)	Face to face in person
HBC.F1.NM	Nurse Manager (NM)	Face to face in person

HBC.F2.SCN	Senior Charge Nurse (SCN)	Face to face in person
HBC.F3.RN	Point of care Registered Nurse (RN)	Face to face in person

### **6.3 Theme 1: Registered Nurses (RNs) knowledge and understanding of accountability**

Three sub themes emerged in this theme, accountability as levels of responsibility; relationships, structures and processes in which RNs are answerable; and RN perceptions of the intent of hierarchical accountability from point of care to Board. Two participants made reference to being accountable in law.

#### **6.3.1 Theme 1: Subtheme 1: accountability as levels of responsibility**

Participants within the hierarchy described accountability as being individually responsible for meeting the obligations set out by the NMC Code (2018a) and the role in which they are employed. Responsibility was mainly described as tasks, actions or obligations. The hierarchical structure meant that RN roles were associated with three different levels of responsibility as presented under the category headings - responsibility for the whole system; responsibility for components of the system; responsibility for individual patients.

##### ***Responsibility for the whole system***

Whole system accountability was described by the END as having responsibility for delivery and standards of care throughout the system. Accountability for public protection was also included in the END portfolio, as well as responsibility for midwives and allied health professionals (AHPs). This responsibility was associated with generating a system of governance that allowed the HB to interrogate standards of care. The generation of information to come through this system was delegated to other RNs in the nursing hierarchy. As an executive director the responsibility for the corporate function and strategic direction of the HB had to be balanced with professional responsibilities, both roles were considered interlinked and at times this felt counterintuitive. An example of this was the importance of asking challenging questions relating to financial decisions that may impact on the quality of care, balanced with a recognition that the HB has to work within set financial budgets. Influencing HB decisions was important to the END and related to the empowerment of nursing in the organisation.

*HBC.P1.END "If I can't or don't influence, I'm disempowering the biggest professional group in the NHS."*

Due to the size of the HB, responsibilities often involved operational business. This had to be balanced with strategic and national work streams for the END. Responsibility for professional standards, education and training, patient safety and improvement, older people was discussed. In contrast to the END other senior RNs only considered nursing responsibilities across the system. The END was responsible for quality of care irrespective of which professional group was involved. This was considered easier to manage due to the positive working relationship with the Medical Director. The burden of this responsibility is evidenced in the quote

*HBC.P1.END "I'm probably 'het' for just about everything that relates to clinical and care governance, HAI, public protection..."*

The difference between responsibility and accountability relating to delegation was a focus of interest in Case C. Delegation was discussed by all participants. On further probing this was initially in response to understanding the role of unregulated staff administering medicines in the community.

*HBC.P2.LN/DND "One of the things we talk a lot about is the NMC actually say you can delegate anything but you remain accountable for it, so for the actions of that individual. You do retain that accountability. If you don't ensure that the person is trained and supported to deliver stuff then you have to take that responsibility."*

### **Responsibility for intermediary level of the system**

LN, NMs and SCNs described their personal responsibility to act in accordance with the NMC code and their responsibility for components of the system. This responsibility mainly related to the assurance of the quality and safety of care, delegation and responsibility when things go wrong.

Responsibilities for SCN and NM were both managerial and professional. For LNs the roles varied concerning whether or not they had managerial responsibility. RNs in LN or Deputy Nurse Director (DND) roles also described being professionally responsible for the nursing workforce across parts of the system, implementing national professional programmes of work such as Excellence in Care and The Scottish Patient Safety Programme.

The responsibility for the quality and safety of care in the Health and Social Care Partnership (HSCP) was unclear. Where HB responsibilities for clinical governance, quality and safety of care were explicit and formally delegated by the chief executive to the END. In contrast, responsibilities in the HSCP appeared to be less formal. Individuals (general manager and locality managers) in the general management structure were considered responsible for quality and safety of care. In practice this did not result in the level of leadership and assurance that the professional leads considered necessary. To meet their professional responsibilities LNs and NMs carried this responsibility by default. This lack of ownership and clarity appeared to cause frustration. The lack of apparent interest from management, general practitioners, social work and allied health professionals to have collective responsibility for quality of care added to this frustration.

Accountability for assuring care was discussed at all levels. Responsibility for the management of complaints, risks, adverse events and workforce forward planning were considered NM responsibilities. A competency framework had recently been developed in Case C and was being tested in a number of areas. This was developed in response to a lack of clarity and need for development support for RNs in NM roles to enhance the role effectiveness. It was also to help managerial colleagues understand the professional aspect of their role in relation to quality of care, support and supervision and improvement.

*HBC.P1.END "I think up to SCN there is a relatively clear understanding of role and function. After that, Nurse Manager, Lead Nurse etc. can all just become another manager by name, title and application. So I say scrutiny, support and supervision is the role of the NM. They currently make sure off duty is right and try to make sure the floor is running. We've got GMs to do that. That's a hard sell because they like running about, the busy thing"*

Ensuring safe and appropriate delegation of tasks was discussed by all participants. One participant discussed that delegation has to go beyond simply not having time to do a task. It has to enhance the overall quality of care being delivered. RN accountability in the context of delegation was well understood by all participants. A particular challenge for one participant was ensuring the same understanding from those that were delegated to.

*HBC. P4.LN/DND " They see themselves all as one team and all being equal within that...we actually had Band 4 staff who were saying that they weren't delegated to , they take their work and go away and do it, and that's dangerous thinking."*

On further probing this difference of understanding appeared to be generated by a lack of understanding of regulation and associated accountabilities. In addition, it was unclear how in practice RNs demonstrated their accountability to reinforce the message.

One participant associated accountability with responsibility for things going wrong. Although there was a recognition that accountability should be something to be embraced to enhance professionalism, the reality of practice was accountability was associated with blame and fear.

*HBC.F1.NM "accountability comes as a blame thing and not if something went wrong then it's a blame that you would be accountable for that, you've done that so you should be accountable. If you follow the rule book, I suppose, so it's very straight, that's what you should do because if you don't do that right and something goes wrong then you're accountable and get into bother."*

The impact of this perception of accountability was discussed by the group and considered to limit practice, the very thing professional accountability sets out to enhance.

*HBC.F1.NM "I think that maybe inhibits a lot of people not to perform as well because of that. There's maybe people that have different values. It's an ownership type thing but because you would be accountable, "Oh, I'm not going to do that, I'll just stick with that", so they maybe don't flourish within their team that they should do because they're too scared to step out of that."*

The perception of being overwhelmed by the scope of responsibilities was demonstrated by the language used by SCNs and NMs. The impact of this was a sense of apprehension related to an inability to meet all the expectations of the role and their team.

*HBC.F2.SCN "I'm failing 'cause I'm not fighting for my staff. I have a constant fear that something is going to happen on my patch"*

From both SCN and NM there was an inference that they felt accountable for everything. Their approach to the accountability of individuals in their teams was at times somewhat paternalistic.

### ***Responsibility for point of care level of the system***

RNs at point of care and SCNs described examples of accountability as responsibility for individual patients. RNs at point of care had similar views to the rest of the hierarchy, that appropriate delegation was important in the context of accountability.

Participants discussed their responsibility as being very much focussed on care delivery and identifying poor care and dealing with it appropriately. The responsibility for medication safety

was considered to be disproportionately the responsibility of the RN rather than medical colleagues. All participants discussed their responsibility to remain up to date with their knowledge and skills. This was mainly done by 'chatting' to peers and searching Google. Access to formal education was considered limited.

*HBC.F3.RN "A lot of trawling the internet myself. The last thing is we've changed from Clexane to Dalteparin (prescribed medications). For years, it's been 'Clexane is the drug of choice', and then all of a sudden, 'as from next week, we're using that'"*

SCN participants discussed a recent example of enacting their responsibilities to address concerns relating to a care interaction with a patient. Having the autonomy to follow up a conversation with the patient by letter was compromised by the need to seek permission and have a letter authorised by a manager.

*HBC.F2.SCN "So, I phoned the Nurse Manager that was on call but they said, "Before you send out anything...", or, "You must discuss this with your Nurse Manager". The Nurse Manager was on annual leave. So, I actually phoned the Lead Nurse and I said, "Look, I've been to see this man, I said I would write a letter", "You need to run that by your Locality Manager before you send it out". I thought, really, you're in this position and that's the things that really frustrate me."*

*HBC.F2.SCN "She's responsible for delivering the care but you're not responsible enough to pick up the pieces when it goes wrong."*

### **6.3.2 Theme 1: Subtheme 2: relationships, structures and processes in which RNs are answerable**

This sub theme relates to the relationships within in which RNs are answerable. The findings are presented under the category headings: internal organisational structures; NMC; and patients and relatives.

#### ***Internal organisational structures***

There was clarity within the nursing hierarchy with respect to whom RNs were professionally and managerially accountable to from point of care through to the END, to the HB and onwards to the Scottish Government via the Chief Nursing Officer Directorate. Within this structure RNs managed by an RN have one hierarchical reporting 'line'. This was identified as point of care RNs and SCNs. RNs managed by a non RN described both a managerial reporting 'line'

and a professional reporting 'line', this applied to nurse managers, LNs and the END. RNs were able to name their SCN, NM, LN nurse, deputy nurse director and END. Everyone had met and spoken with the END. Visibility of RNs at the top of the hierarchy was discussed positively by all participants.

The management and professional reporting was raised by all participants with the exception of focus group HBC.F3.RN. The impact of this structure appeared to mainly affect NM and LN. The purpose of these dual lines of accountability were described as being concerned with the professional governance of nursing, a regulated workforce, although as highlighted previously for NM and LN roles this was difficult to achieve. The complexity of working within these structures was articulated by a number of participants. There was evidence of good and poor working relationships across both managerial and professional hierarchical accountable relationships. One participant discussed the benefits and challenges of her manager being from a nursing background. There were various views and the success of this structure appeared to be related to relationships and respecting professional responsibilities and the individual.

A clear understanding of what RNs were accountable for was evident at point of care and for RNs responsible for the whole system. For RNs in the middle of the hierarchy, responsibilities appeared less clear, particularly in the context of health and social care integration. In addition to the lack of clarity about responsibilities, the structures in HSCP were described as adding duplication and complexity to governance that still had to be worked through.

*HBC.P1.END "I think there's a greyness of accountability and responsibility at the moment because governance structures are complicated due to integration. It can and should be simpler but what it does mean is that we can end up double reporting and having double lines of responsibility."*

The statutory requirement for clinical and care governance structures at Board level (Health Board and Integration Joint Board) forced attendance by necessary members. Beyond this forum a multidisciplinary approach and collective responsibility for quality and safety was less evident across the hierarchy and organisational structures were described as mainly nursing.

*HBC. P3.LN/DND "They're (NMs) really frustrated, in that actually this is part of our professional role but, again, because of the context of health and social care integration, they have tried to make connections with their social work colleagues, with AHP colleagues and that information is not coming to them. So, there's still some professional boundaries."*

## **The Nursing and Midwifery Council (NMC)**

All participants made reference to the NMC and the NMC Code in the context of accountability.

*HBC.P3.RN "When I hear accountability, I think of NMC straight away."*

Revalidation was the main interaction with the NMC that was described by participants. A number of participants described their perceptions of how the NMC functioned as a regulatory body as being remote and unsupportive. There was a sense that the move away from the historical punitive approach taken by the NMC in relation to Fitness to Practice (FtP) to a more local restorative approach made some participants uncomfortable.

*HBC.P3.LN/DND "It's not about them taking a big stick to us but actually if you haven't practiced well in work or actually out of work and that can have an impact on the profession or patient outcomes then there should be something".*

The NMC had recently presented their new strategic approach to Fitness to Practice (FtP) to RNs in Case C and this had given some reassurance to participants that had attended the presentation.

### **Patients and public**

A number of participants across the hierarchy made reference to being accountable to the population served by the HB. This was mainly achieved through the transparency of HB meetings and in the context of being a public organisation accountable to the Scottish Government. For RNs at point of care and SCNs accountability to patients and relatives was less abstract and offering explanations about care and talking to patients and visitors was considered a positive part of the job. These interactions were helpful to supporting the RNs know as much as possible about the patient's needs.

*HBC.F3.RN "I think it's important making yourself visible to patient's next of kin as well and maybe just saying, "Oh, how are you today? Are you quite happy with the care?" etc. Sometimes you can get quite a lot out of patient's family as well or their next of kin."*

## **6.4 Theme 2: RN experiences of how and why mechanisms of accountability are enacted and the impact in practice**

Participants discussed their experiences of enacting accountability. Three subthemes emerged relating to how and why accountability is enacted: in response to concerns about

poor care and external scrutiny; to assure quality of care and standards of the profession; and to safeguard patient outcomes at point of care.

#### **6.4.1 Theme 2: Subtheme 1: Enacting accountability in response to concerns about poor care and external scrutiny**

Complaints, adverse events and external scrutiny are the three categories in this subtheme. The incident reporting software Datix was referred to by participants and represents adverse events or near misses that were recorded on the electronic system.

##### ***Complaints***

Enacting accountability in response to complaints was mainly discussed by RNs at point of care and SCNs. Participants at NM level and above considered their accountability in relation to complaints as an important way of monitoring quality of care and culture when considered alongside other quality assurance data. Processes that ensured END and DND awareness of major complaints about quality and safety of care was described as inconsistent and had prompted the development of escalation guidance as discussed previously.

Participants in HBC.F2.SCN discussed accountability for early resolution to try to resolve concerns as soon as possible, although the autonomy to do this was considered limited due to a perceived need to seek permission from the managerial and /or professional hierarchy. Senior Charge Nurses described pre-emptively offering an explanation to patients and families in response to concerns or a mistake rather than being answerable in response to the complaint.

*HBC.F2.SCN "If something happens speak to the relatives face to face. You can de-escalate anything by talking to folk and listening."*

RNs at point of care described receiving very few complaints and the investigation process being conducted by the SCN and then receiving feedback on any learning points individually or at team meetings. Involving families as much as possible was identified as a way in which RNs enacted accountability by offering explanations and making themselves available to relatives to limit poor patient experience.

*HBC.F3.RN "I'm fortunate that I'm in a work area we don't really get many complaints, very few and far between. If anybody has got any concerns, we try and deal with it at ward level between nursing staff with the patient's relative or the patient."*

SCNs reported that the quality of record keeping to be poor and often highlighted when trying to investigate a complaint. A contrasting view was offered by a point of care RN participant in HBC.F3.RN that their record keeping was praised. However, this quote also reaffirms the perceived defensive purpose of record keeping and accountability.

*HBC.F2.RN “in the past couple of years, had one or two complaints come through and I’m so glad I took the time and documented properly and my Senior Charge Nurse actually praised me. She said, “That’s really good because we’re looking back for evidence and it’s clearly documented in one of your entries that X, Y and Z was completed”. You can see why we need to keep on top of our documentation for accountability reasons.*

### **Adverse events/ Datix**

Accountability for reporting adverse events and learning from them were discussed by participants. Medication errors were the most frequently used example by RNs within the hierarchy and considered to be disproportionately the responsibility of nursing. This was both in relation to the focus on administration versus prescribing but also the way in which medical staff managed the process if an error or near miss occurred, being less formalised and more about learning.

*HBD.F3.RN “Actually, the doctor should be accountable. Maybe they’ve missed something in their paperwork’, but it seems to me that we get the blame for that at times. The Consultant just changes the kardex and chats to the doctor to explain what it should be, they focus on learning.”*

Pressure ulcers were discussed in the context of adverse events and the improvement work that had been undertaken to reduce harm. Following an adverse event the ability to ‘close the loop’ in respect of embedded learning and changes in practice remained challenging. This was an ongoing leadership concern for the END.

*HBC.P1.END “I had been given quite strong assurances that all actions were done. When we looked at the adverse event, it was a maybe, if, but, and they probably do most of the time. I actually had a conversation that I don’t want death by audit but I need the ‘so what’ question answered. Can you show me that that’s taking place in practice? That closing the loop is one thing I’ve become vigilant on”*

An example of the different perceptions across the hierarchy of the response to an adverse event, concerning poor record keeping, demonstrates how one RNs’ accountability can

influence another RNs' acceptance of responsibility. The incident had been addressed with the individual, however, an assurance process had now been implemented across this professional group to avoid a recurrence. The best way to address this incident, across three levels of the hierarchy, was an example differing perspectives of enacting accountability. At LN level this was considered a positive improvement and monthly quantitative data were reported to a performance group for assurance. At NM level the audits had identified some good practice for sharing however the focus was not on the quality of the record and the burden of having no IT infrastructure was a frustration. There was no plan for the audit process to stop and concern remained about the quality of records. For practitioners the most important issue was understanding why they were collecting data and having the opportunity to discuss the audit outcome. Where this did not happen because SCNs did not have access to the data RNs disengaged from the process and a sense of lack of trust and hierarchical control emerged.

*HBC.F1.NM "It was a bit...of a hammer to crack a nut, but one person hadn't been managing their record keeping so by the time it made its way to the END then it would appear that not a single [\*] (speciality named) writes their notes up ever, no trust in other [\*] (speciality named). So, therefore we all have to start these record audits. The report that goes back to our Performance Manager is very much percentages of and I struggle with that because this is about learning about care and not about whether or not we've got so many percentages and the demographic is written correctly in the form."*

### **External scrutiny:**

SCNs and RNs at point of care did not refer to external scrutiny. There were two historical examples of external scrutiny referred to by other participants, Health Improvement Scotland Older People in Acute Hospital (OPAH) and Care Inspectorate joint inspection of services for children and young people.

External scrutiny was both welcomed and feared by the END. This perspective was explained as a preference to know that something was wrong rather than never finding out.

*HBC.P1.END "Actually, with all honesty, if you're not frightened by external scrutiny, you're naïve because I don't think our assurance systems are robust enough. So, anything can pop up and you think, 'I didn't know that was going on'. I welcome inspection because I would rather somebody told me something was wrong than never finding out about it."*

Enacting accountability in response to external scrutiny required improvement plans that gave assurances to the HB that issues identified from the inspection process would be appropriately addressed. The role of non-executives in challenging RNs in the context of scrutiny was considered thought provoking:

*HBC.P2.LN/DND "Healthcare governance is interesting because I'll take papers around older people, around patient safety, around significant adverse events, food, fluid, nutrition, that's a really interesting discussion because you've got your non-exec members of the board whose way of thinking is entirely different from your exec members of the board as well as basically anybody in health. So, if they have no health background, which most of them don't, their questioning is really interesting...they're asking a question that triggers something else in your head that you go, 'Hmm, I should go back and look at that'.*

Two participants described having portfolio responsibilities in response to managing external scrutiny. Record keeping was also discussed in the context of external scrutiny and the burden of more documentation for assurance was reported as being in response to avoiding a poor inspection. The focus of HIS was considered to be focussed on nursing care and the care inspectorate took a much more multi -agency approach.

The impact of external scrutiny was not described positively and this perception appeared to impact on behaviours within different levels of the hierarchy leading to a perception of blame.

*HBC.P3. LN/DND "I also have lived and breathed a HIS inspection at the [\*] (Hospital named) and that's my fear of we can be nice around this and say we're looking for improvement, we need to assure care, but if we're very nice around it at this level, when the older people inspection comes in, unless it's changed drastically, it doesn't feel nice and it doesn't feel that you're not responsible or accountable for it."*

*HBC.P3. LN/DND "It was a really hard time. (I wonder if) ...actually I could get the managers into trouble because we've got into trouble for not giving good care."*

#### **6.4.2 Theme 2: Subtheme 2: Enacting accountability to assure quality of care and standards of the profession**

The findings of this subtheme are presented under two category headings, meetings and audit.

## **Meetings**

Enacting accountability in meetings was identified by all participants in response to the question: “Who holds you to account and how do they do that?” The types of meetings that were described were one to one meetings with line manager or professional lead; Professional peer meetings chaired by the professional lead; Operational team meetings; and clinical and care governance groups and committees.

One-to-one meetings appeared to be highly valued by participants. Planned meetings were described by DND, LNs, NMs, and SCNs, where they enacted accountability or asked their direct reports to demonstrate accountability. RNs at point of care participated in ward meetings approximately every six weeks with other nursing colleagues. A range of approaches were described depending on the participant however everyone thought the main purpose of one to one meetings was supportive. This related to the opportunity to discuss current issues as well as objectives and work plans. One participant described the approach of their line manager prompting reflection and helping her to think differently.

*HBC.P2.LN/DND “the END job is to hold me to account, but also within healthcare governance committee, I’m held to account around the things that I’m responsible for. [\*] (Named) does make you think because by asking questions that you don’t really expect.”*

For some SCNs and NMs a competency based framework was used to structure one-to-one meetings and also to identify development needs. For SCNs the frequency and structure of one to one meetings appeared to vary depending on the nurse manager. One-to-one meetings that covered both professional and management issues appeared to be more structured and planned. The purpose of professional one to one meetings was less clear but the opportunity for reflection, supervision and support were key attributes. A NM described managerial supervision and the gap that she felt now that clinical supervision was not appropriate.

*HBC.F1.NM “I’ve got my management supervision with my line manager and I think what’s missing it’s more coaching which is slightly different than clinical supervision, it would be more coaching it’s about the decision making that I need to make in this role is different to the sorts of decisions I was making as a caseload holder but I think I would still quite like something that isn’t management supervision but there’s nothing concrete in place for that.”*

Participants described a range of team meetings relating to professional and operational work, these appeared to range in frequency from monthly to quarterly depending on the area and meeting. The discussion covered workforce data, adverse events and other issues needing to be communicated from the top down. One LN encouraged SCNs and Team Leaders (Band 7) to take responsibility for coming together and discuss what matters to them as a peer group.

*HBC.P4.LN/DND “the band 7s themselves have a peer support meeting so it’s an opportunity for them to just have some... they make up their agenda and they do whatever. They might have an action learning set, they might discuss clinical supervision, and they do whatever they feel they need to do on their month.*

In the HSCP meetings to discuss the quality and safety of care were described as being difficult. A recent change had meant that NMs were no longer invited to present their reports. Locality managers were asked to present the assurance reports however poor understanding of the topics being presented resulted in lack of assurance. This missed opportunity for NMs to enact accountability by offering explanations frustrated the LNs.

*HBC.P3.LN/DND “There was a decision made that the NMs shouldn’t attend the connecting quality group because the General Manager wanted the Locality Managers to actually take on that role. What I see now is the NMs preparing reports, doing all of the work around it, and then that coming through to connecting quality and now not being supported by anybody from the locality if no one turns up to talk to it in the locality.”*

Clinical governance or clinical and care governance groups and committees were described at HB level and across the organisation. These governance structures were referred to by LNs, DND and END. Enacting accountability at HB level was in the form of questioning from non-executives and the production of assurance reports. SCN and RNs at point of care discussed quality of care, rather than governance and ward/ team level interactions focussed on information sharing rather than offering accounts of care outcomes.

### **Audits**

Audits were only discussed in the context of assurance. Quality improvement was mentioned by several participants but audits were not described as part of the process. A number of participants discussed how auditing was included in the new care assurance process that was being rolled out across the organisation for nursing. The benefits of being able to discuss assurance related issues such as record keeping with the patient and RN was meaningful for both the NM and RNs accountable for the care. Similar data was collected for an audit however

it also provided the opportunity for shared learning and a form of supervision. Evidence of RNs offering an account of the care they were providing enhanced the understanding of those carrying out the care assurance process. It was recognised that previously audits had become the purpose rather than the information it was providing.

*HBC.F1.NM “So, it’s sort of taking the audits that you always did on your standards, on infection control, on your clinical indicators but it’s taking them to the bedside so rather than somebody going around and doing an audit on catheters or whatever then chatting I’ll be saying, “What’s that like for you? Have you had a catheter before?”, and you discuss it and check that they’ve done the safety bundle. In one visit, I’ve probably done about three or four of the audits so then the information is in that care assurance so the girls can just put that in as their data ... because an audit sometimes becomes the purpose is beyond it rather than the learning.”*

Community staff discussed auditing records to understand performance in relation to visits made and particular milestones that are set out nationally. It was acknowledged that an electronic system that captured this data would reduce the burden on point of care staff. This was of particular relevance as in the same interview RNs described not completing clinical records due to lack of time. Auditing documentation was part of the new care assurance process. Aspects of the audit were considered unnecessary and the expectation to document whether or not a patient leaflet is given to patients is not reflective of professional autonomy. Having documentation ticked was discussed as being more important than delivering the task.

*HBC.F2.SCN “I think a lot of the audits and stuff were auditing and checking that the ticks had been put in. We’re not really looking at the quality of the documentation a lot of the time. It’s, “okay, that’s been filled in”. You’re checking that somebody’s said they’ve done it.*

A perception that medical staff do not have the same level of scrutiny and that RNs are ‘marked down’ for audit results that are the responsibility of medical staff created a sense of unfairness amongst participants. Examples discussed were medical staff not signing records or completing capacity and consent documentation. This sense of unfairness was similar to that described in the management of medication errors. To try and reduce the failure rates RNs reported taking on the responsibility of completing some aspects of the documentation as it was less problematic than failing an audit.

### 6.4.3 Theme 2: Subtheme 3: Enacting accountability at point of care to safeguard patient outcomes

The findings of this subtheme are presented under three category headings: decision making, documentation and challenging practice.

#### ***Decision making***

Decision making, underpinned by professional judgement, was considered an important demonstration of accountability. Decision making appeared to be difficult for RNs.

Participants discussed decisions relating to care being changed by colleagues without discussion or rationale. Informal hierarchy based on “time served” was considered to contribute to this and a perception that more experienced RNs were more accountable than junior colleagues and could therefore overrule decisions. RN accountability for decision making related to care and rationale for decision making was considered to get lost.

*HBC.F1.NM “I think it’s improving but I do think there’s that, ‘Oh, well, somebody senior has made a decision and they’re more accountable than me’, well they’re not. Maybe there’s responsibility in a shift that somebody is in charge and taking ultimate responsibility but accountability for care, I think, gets lost.”*

Making and documenting clinical decisions appeared to increase the risk associated with individual RN accountability as answerability. Although there was agreement that appropriate assessments were being undertaken, the analysis to inform decisions was less apparent. Experience and the level of support, including supervision, were discussed as factors that influenced individual RN ability to make decisions. There was also a sense that RNs felt decisions had to be ‘run past everyone’ more than ever, which reduced self–confidence to act autonomously.

*HBC.F1.NM “That, again, brings us back to accountability because people will write fantastic assessments. They will absolutely pick up everything that’s going on but actually they don’t want to put down on paper or verbalise to the family what that actually means for the [\*] (patient type mentioned), so there’s no analysis of what all this assessment. I think the people are scared to put down the ‘so what’ because they’re thinking, ‘Well, then that makes me making this decision.’”*

The consequences of being perceived to make a wrong decision and being held to account impacted on RN self-confidence to make a decision. This perception supported the view that RNs were risk averse and escalated issues that were considered to be within their scope of practice to manage. SCNs and NMs gave similar explanations for why they escalated issues rather than make decisions. SCNs described to avoid 'getting into trouble' and NMs acknowledged a lack of support from them.

*HBC.F1.NM "You're using your skills and your knowledge to make a decision that makes you accountable and I think nurses stop themselves from going forward because we like procedure and then if you're to step off the page, do a bit of professional judgement, I think people are frightened because they're maybe not sure what's underneath them to support them and encourage them."*

The opportunity to discuss clinical decisions and offer an account of the underpinning professional judgement as part of the new care assurance process was considered to be supportive and to enhance learning.

*HBC.F3.RN "Real time feedback at the end of bed with practitioners and patients. It sticks better."*

### **Challenging colleagues**

This category concerned the ability of an RN to ask a colleague to explain the rationale for a particular decision or behaviour (enact accountability) and accept or challenge that response. RNs considered it to be part of their leadership responsibility to challenge and ensure practice was as effective as possible. Examples were provided of challenging RNs in lower positions in the hierarchy, peers and RNs in more senior positions. Creating a culture where challenge becomes part of the professional discourse was discussed by the END. The need for psychological safety and skills required to effectively challenge were considered to be weak at point of care and an important leadership focus for the team to develop.

*HBC.P1.END "I'm not confident that either the Staff Nurse or the Senior Charge Nurse has the skills or the emotional safety to do that. I can't make each ward a comfortable place to be able to effectively challenge, what I can do is try and set some of the conditions"*

Having the skills to respond positively to challenge was considered important to encourage RNs and others to seek an explanation of any aspect of practice. Undergraduate nurses and new graduates were considered by participants to be more confident in challenging. This

challenge was usually framed by their understanding of the evidence. This was perceived positively by participants and was identified as a source of continuous new knowledge for other staff. The inability to challenge decisions related to system wide or sector changes that were made to RN roles or their practice environment. NMs and SCNs discussed their frustration that the top down approach to implementing national programmes of work were not joined up and did not recognise the context or demands of care. Challenging the implementation of new documentation or aspects of data that were considered to be of no added value was discussed by participants in SCN and NM roles. The resilience to challenge decisions appeared to be low and RNs displayed a sense of giving up.

*HBC.F2.SCN "What would happen? Who would notice if you didn't do it?", and I said, "Well, we'll try it then", and I mentioned that to a few folk and then word got around and oh my goodness, I was really labelled as a trouble maker at a meeting. We're still doing it. We're still ticking this box every day. I don't have the courage or the energy to try and fight that again though. I've actually learned to park it now and accept that I can't do anything about it."*

### **Record keeping and documentation**

This category concerns both the process of enacting accountability by record keeping and the impact that documentation (paperwork) has on RN practice. The words record keeping and documentation were used interchangeably. The regulatory requirements of keeping clear and accurate records are set out by the NMC Code (2018a) in statement ten, were not discussed by participants. There were two references made to the importance placed on documentation during an external inspection process and local paperwork being adapted in response to scrutiny. The tick box approach to documentation was considered by several participants across the hierarchy to have hindered both the cognitive process of using professional judgement and the ability to evidence this in the clinical record.

*HBC.F2.SCN "I've just done a significant adverse event with our Health and Safety Advisor and it was two grade 4 pressure sores ...it was the Waterlow. We only used it as an aide to memoir because... In light of the inspection, they brought it back in. Again, that's just tick boxing. We have gone too far with these tick boxes that nobody had actually looked at that patient and looked at the big picture."*

Record keeping was discussed by all participants, relating to their scope of practice. At Executive level the purpose of enacting accountability, by taking written reports to the HB, was to ensure clear communication to the Board members and ultimately the public of any issues.

For meetings many participants described preparing reports to provide information on operational performance and risks relating to workforce or quality of care. When investigations into complaints or adverse events were required, reviewing clinical records formed a large part of the investigation.

Organisational documentation was considered a contributory factor to RNs not being able to accurately complete records. This was mainly related to the volume of documents that required to be completed 'to pass audits' and complete risk assessments. The paperwork that was required to be completed on a first community visit was described as taking over an hour and therefore it is not done consistently or well. In a recent incident it was discovered that the daily visits were being documented however there was no assessment or treatment plan recorded to evidence rationale for care. This concurs with the views of several participants that RNs assess patients but do not sufficiently analyse their assessments and are reluctant to demonstrate accountability by documenting their decision.

*HBC.F2.SCN "I think that they're actually doing the clinical assessment ... if you're admitting a new patient, you're taking an hour to do the paperwork and then you can't always do that if you're dealing with somebody that's really quite ill ... You're building up the trust, the rapport with the patient, with the family. If you're in somebody's house, there's god knows what else going on around about you. It takes a bit of time to do that and then the continuity of that, does the same nurse go in the next day to carry on?"*

Active care (care rounding) was used as an example of documentation being perceived as more important than the interaction with the patient by many participants. There was a false reassurance that because the paperwork has been completed there was an assumption the care has been delivered, when it had not.

*HBC.F2.SCN "There's pressure area care, nutrition, continence, and an RN decides the frequency of this. One of the checks in the pressure area care is the skin checks and is it non-red blanching, or blanching or whatever, but you assume that people are actually checking the skin but actually sometimes they don't understand what it is and they just document the same as the previous person."*

### **6.5 Theme 3: Individual and organisational barriers and facilitators to RNs accepting professional accountability**

Participants across the hierarchy shared their experiences of accepting accountability. This mainly related to their ability to enact individual responsibilities. Factors that facilitated or

hindered RNs to do this were explored. Accepting accountability was strongly associated with the concept of autonomy. Two subthemes emerged, individual RN self-confidence to make and account for autonomous decisions; and having a fair and safe working environment that enables autonomous practice.

### **6.5.1 Theme 3: Subtheme 1: RN self-confidence, resilience and autonomy to make open reasoned judgements**

RNs at the top of the hierarchy displayed self-confidence to both make and account for autonomous decisions. At LN level and below there was less evidence of autonomous decision making. RNs at point of care and SCNs demonstrated a willingness to offer explanations to patients and relatives. The findings are presented under three category headings: identity and being valued; level of knowledge and skills; relationships of trust and support.

#### ***Identity and being valued***

Credibility as Executive Director on the HB as well as the NMAHP Executive Director was important to HBC.P1.END. Being valued as a member of the HB corporate team supported END self-confidence to make and account for autonomous decisions. Taking financial requests to the HB for additional staffing was given as an example of accepting accountability. Participants made reference to the impact of the self-confidence of the END being empowering and building confidence in RNs at point of care. Similarly RNs at point of care demonstrated clarity of identity and a sense of being valued particularly by their teams.

*HBC.F2.SCN "I would say that \*END is a great believer in saying, "You have my permission to do this, go ahead and do it", and that's the kind of person that I would see as a role model."*

*HBC.F2.SCN "I would say our Locality Manager, whether it's because they're not clinical and she is giving me... she says, "Well, that's your job, not mine", and I think she trusts me and her words to me are, "It's your hospital, do what you think".*

RNs in SCN, NM and LN posts were less clear about their identity and specific contribution. This corroborates the view of the END that these roles are not positioned correctly to focus on professional scrutiny, support and supervision. The professional responsibilities in the context of integration were considered to be poorly understood by managerial or non-health staff. This impacted on the ability of RNs in professional posts to accept accountability. One participant discussed the recent introduction of a national uniform for senior nurses had improved RNs

confidence to be clinically visible. Some of these RNs had not been practising clinically for 20 years.

*HBC.P2.LN/DND “We would say to our Nurse Managers, you should be in your areas in uniform working with them if they need a bit of help and doing whatever, and they were always a bit nervous of it. Some of them would say, “But I haven’t been in clinical practice for 15-20 years”, and I think, ‘Well, neither have I but I wouldn’t be scared to go in and I also wouldn’t be scared to ask things’, but some people really are quite nervous about that. The smoked berry uniform almost gives them a let off for not knowing the clinical stuff.*

Support at point of care was important to RNs and they described getting this support from medical colleagues, peers or ANPs. The role of NM and LN were considered supportive in relation to staffing, beds, adverse events and complaints but not for clinical knowledge or skills. The visibility but also clinical credibility of RNs in leadership roles was considered important but very difficult to achieve.

*HBC.P1.END “I actually had to receive direct instruction as an Associate Nurse Director to stop seeing patients and I argued vociferously and was told, “I can get a band 7 or 8A to do that”. Are we not missing the point here? So, I actively encourage but can’t demand that we should probably have something about direct patient care.”*

The national ‘Transforming Roles’ programme of work was discussed by RNs in LN roles and above. This national work to reframe the identity, role and function of RNs was discussed positively as an opportunity to enhance understanding of the RN contribution, particularly in a community setting. There was a recognition of boundary blurring, particularly in community services of support staff and RNs.

Being valued by colleagues, patients and patient’s families was important to participants. RNs at point of care described how a visit from END makes them feel valued.

*HBC.F3.RN “They’re interested and they’re listening, and the fact they’ve taken the time to come and talk to us ...makes us feel valued*

### **Level of knowledge and skills:**

Levels of knowledge and skills appeared to be a factor that influenced the self-confidence of RNs to accept accountability. The continuous professional development of RNs was considered to be career long. Supervision was described as being important for RNs for two

different reasons, to maintain resilience and have the ability to continually develop one self and others. RNs across the hierarchy held complementary perspectives that despite this need, there was an inability to accommodate clinical supervision and education particularly for direct care giving RNs in wards as they could not be released from practice. Medical staff, midwives and AHPs were discussed as having prioritised and protected supervision and education more effectively than nursing. CPD for RNs required separate activities to statutory and mandatory training required by all staff and in the current way services were constructed, this need cannot be consistently supported financially or with time.

*HBC.P1.END “we have never been able to completely meet the NMC requirements on the basis of a lack of CPD exposure and support. I think it [the new NMC undergraduate standards] brings it into sharp focus in our current board setup and with the stuff we’re trying to deliver, it is not sustainable with the workforce that we are able to recruit and retain anywhere in Scotland, in my view.”*

In discussion with HBC.F1.NM, participant’s supervision was considered to positively enhance resilience of staff to continue to be effective in practice and accept responsibility, compassionately and without fear.

*HBC.F1.NM “It’s maybe around about supervision, they can go and have a safe space to talk about the issues that are affecting them at their work to facilitate them to make the decision themselves. It’s somebody that’s done a supervision qualification, they’ve done a module in clinical supervision, or it may be that it happens to be a manager. It doesn’t matter what level of hierarchy they’re at for their clinical supervision.”*

The ability to deliver supervision was demonstrated to be most challenging in an inpatient setting. Where medical staff had protected learning some RNs from theatres and general practice were able to participate. Where RNs were required to arrange CPD or supervision it was reported to be regularly cancelled or deprioritised. Safety was considered to be the priority however there was little recognition of the cumulative effect on safety if RNs do not have access to CPD and supervision.

*HBC.F1.NM “It is around that clinical activity that you can’t just pause, you’re working a 24 hour service. I’m not saying that’s a reason, it’s all the more reason we should be providing it because it’s clinically very busy. The first thing that always goes is training for staff and supervision. It starts to drop off when things get busy.”*

### **6.5.2 Theme 3: Subtheme 2: Fair and safe working environment that enables autonomous practice.**

The findings are presented under two category headings: relationships of trust and support and control of responsibilities.

#### ***Relationships of trust and support***

Relationships of trust and support were described by all participants across the hierarchy in relation to enhancing individual RN ability to accept accountability. Lack of trust and support was also described as a factor that inhibited RNs. Relationships of trust and support with peers and team members were apparent when there was a common understanding of purpose, shared context and experiences.

*HBC.F3.RN “A lot of it is we’re busy, we’re heavy, and the only people that are going to look out for you are each other. There are personality clashes and nobody ever gets on with everybody but at the end of the day, you’re relying on your colleagues to look out for you so you help each other.”*

*HBC.P1.END “Relationship building and professional and inter professional respect will make or break relationships. I am particularly blessed, my Chief Exec’ is fantastic and absolutely gets that the heart of what we are doing is for the patient. That makes conversations significantly easier to have.”*

Being approachable and open to questioning was perceived as a demonstration of support. Taking the time to listen was also considered supportive. The impact of not having supportive relationships or someone that will ‘have your back’ if something goes wrong was described as having a detrimental impact on individuals self- confidence to accept accountability. Medical staff were considered more supportive.

*HBC.F1.NM “I think people are frightened because they’re maybe not sure what’s underneath them to support them and encourage them. The doctors have a different framework, don’t they, and a different way of looking at things more supportively.”*

Supportive relationships between SCNs and direct care giving teams were demonstrated by both groups as being important to the self -confidence of RNs to practice autonomously. However, in contrast to enabling accountability there were examples of SCNs taking on the responsibilities themselves rather than coaching RNs to accept and manage situations.

Empathising with the pressures that their teams faced and feeling the need to over compensate was one rationale provided by SCNs.

*HBC.F2.SCN "I would trust any of my staff with my life, to be honest. I'm really, really fortunate but when they are busy, busy, busy, as they are, sometimes they don't... even a nursing assessment wasn't done on somebody that's fairly complex and I was shocked when I looked at that. They work really hard and they do their best"*

Having the opportunity to make new relationships enhanced RNs' ability to think differently and accept accountability by challenging practice and encouraging change. An example of attending a national quality improvement course and participating in orthopaedic specialist qualifications delivered in another HBs were discussed positively.

There were contrasting views of the level of support and trust provided by the nursing hierarchy. Lack of support was associated with a lack of contextual awareness and having unrealistic expectations. Relationships of support and trust were considered to be present when contextual understanding was demonstrated. When probed on what would make a difference to feeling supported, hierarchical emotional intelligence was discussed. The disconnection within the hierarchy was reduced when RNs at point of care had a spoken with the END and senior team and they felt cared for.

HBC.F2.SCN "Emotional intelligence, if you don't feel valued you don't work well. Say thank you. It's a very lonely place otherwise"

### **Control of responsibilities**

Control was discussed as an enabler and a barrier to accepting accountability. A compelling issue for point of care RNs and SCNs was their lack of control over decisions that negatively affected their ability to accept accountability. These issues were mainly associated with having safe working conditions. RNs at the top of the hierarchy and at point of care appeared to have control over their environment. RNs in the middle were less able to control particular issues that influenced their ability to enact accountabilities. The most common example raised by all participants across the hierarchy was not having adequate staff to deliver care. This had a consequence of staff not getting breaks, and a cumulative effect on resilience, self-confidence and development. An example of a near miss was shared by a SCN due to competing demands of the SCN role and having a case load.

*HBC.F2. SCN “ The other morning I had six visits to do and this is when I was told I had a formal complaint, a Charge Nurse went off, and this was all before nine o’clock (laughing). So, as I’m doing visits, my phone is constantly going. I nearly gave somebody the wrong insulin. I didn’t, but I nearly did and it’s because I was checking, checking, checking. So, you need the time to do that.”*

There was a recognition that more staff to do more of the same would not be a sustainable way to enhance working conditions. There was corroboration across the hierarchy that additional time was needed to enhance the quality of record keeping, education and supervision. Developing the role of HCSWs was discussed by participants across the hierarchy. The need for professional control was considered to be inhibiting these roles in health.

*HBC.P2.LN/DND “I think we’re in danger of being so risk averse and I listen to the people around Scotland who are talking about ‘you can’t have a Healthcare Support Worker... say you’re going into somebody’s house and giving them Digoxin because that’s a judgement because you have to take their pulse’, and I’m like, ‘It’s not a judgement. It’s a pretty straightforward yes or no. If their pulse is this, you give it, if their pulse is that, you don’t.”*

Comparison of the nursing associate roles and support staff regulated by Scottish Social Services Council concerning medication administration in the community was something that would help, with the appropriate governance. RNs at point of care discussed other opportunities to manage time more effectively but believed they did not have the authority to make this change.

*HBC.F3.RN “More staff would be great (laughing). I think that’s maybe just having an extra pair of hands, like little things like taking patients to theatre and back because it takes you off the ward to go and do that which the patient needs somebody to go with that they maybe need to explore who could do that role. Does it need a trained nurse to go with a patient who is elective who has had nothing done to go to theatre?”*

Responsibility was discussed as an enabler by several participants. Having responsibility enhanced RNs’ sense of autonomy. However perceived control from the professional hierarchy and a lack of understanding about the professional agenda was considered to get in the way and ways to ‘get around it’ were found by managers.

*HBC.F2.SCN "I would say our Locality Manager I think she trusts me and her words to me are, "It's your hospital, do what you think". To make small changes and things like that, "It's your hospital", and you think, 'gosh, okay', and that's fine, but then again, we get to this professional lead, Locality Manager type difference and then you think, 'Okay, we'll do that', and all of a sudden, it's like... and quite often you'll see the Locality Manager doesn't understand this professional hierarchy, or not understand but can't get their head around the hierarchy and that's why sometimes she bypasses our Nurse Manager, not being rude or intentional but if she thinks something needs... she knows something or something needs to happen, she'll come straight to me."*

The findings from Case C are synthesised, analysed and presented as across case findings in Chapter 7.

## Chapter 7: Across case study findings

### 7.1 Introduction

In Chapters Four, Five and Six the findings from each case study are presented separately. In this chapter, the similarities and differences between the three cases are presented. In total, twelve key findings were identified under the analytical framework headings: Theme 1: RN knowledge and understanding of accountability; Theme 2: RN experiences of how and why accountability is enacted, and the impact in practice; and Theme 3: Individual and organisational facilitators and barriers to RNs accepting professional accountability.

The study findings indicate that overall there were similarities within and between the three case studies. Some differences across the case studies were identified which could not be solely attributed to the contrasting features of the identified cases. There were examples of individual RNs views that contrasted with the majority of the other participant responses. This was particularly evident within each individual case and in the across case analysis. Overall, ENDS identified the concept of accountability more positively than other RNs in the nursing hierarchy. Within the cases, contrasting perspectives of accountability were most evident across the hierarchy in secondary care hospital sites in Case A and Case B.

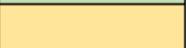
The hierarchical structures of the three cases were similar (Figures 2, 3 and 4) and these were described by some participants as a 'triumvirate' model within a general management structure. This meant that most 'system components' were led and/ or managed by a manager, nurse and doctor. This applied to SCN and above; below that there was no triumvirate in place. Findings from this study indicate that it was unclear exactly how this model worked in practice. In the general management structure, the manager was described as being at the top of the triumvirate and having overall responsibility; however, accountability for quality of care, standards of the profession and safe guarding of patient outcomes was described as remaining with the professionals.

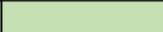
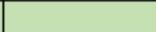
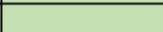
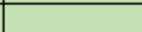
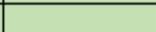
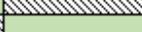
In Case A and Case C (Figures 1 and 3), the professional and management lines of accountability separated at NM level and above. In Case B, this separation occurred one layer below, at SCN level (Figure 2). This separation required RNs to report through dual lines of accountability and removed the management of RNs from the profession into a general management structure. The consequence of this was variable and dependent on the quality of interpersonal relationships and mutual respect. The nursing hierarchy in Case A had five layers, one less than Case B and Case C, which both had six layers. This narrowed the reporting depth from point of care to Board and increased the responsibility scope of CNs. An example of this was that one CN in Case A had professional responsibility for 18 LNs, in

contrast to a LN in Case C who was responsible for two NMs. The expectation on both individuals appeared similar despite the difference in size in portfolios.

The across case study findings revealed similar and contrasting views within and across the three cases. Table (21) presents the three main themes and key findings as they relate to different levels of the nursing hierarchy. In total there were twelve separate findings that emerged from the analysis of data, the detail of which are presented in this chapter.

**Table 21- Across Case findings**

Level not in place	
Similarities	
Similarities	
Differences	

Themes	Findings	Levels in hierarchy	RN role	Case A	Case B	Case C
<b>Theme 1:</b> RNs knowledge and understanding of accountability	1. RNs demonstrated good knowledge and understanding of accountability related to their individual role, level of the nursing hierarchy and personal experience.	Health Board level	END			
			NDs/CNs/DND			
		Intermediary level	LN/ ANDs			
			NM/LN			
		Point of care level	SCN			
			RN			
	2. Two discourses of accountability emerged; accountability as responsibility and accountability as relationships/ structures in which RNs are answerable.	Health Board level	END			
			NDs/CNs/DND			
		Intermediary level	LN/ ANDs			
			NM/LN			
		Point of care level	SCN			
			RN			
3. Collective accountability for quality of care and safeguarding patients not evident in practice.	Health Board level	END				
		NDs/CNs/DND				
	Intermediary level	LN/ ANDs				
		NM/LN				
	Point of care level	SCN				
		RN				

END, Executive nurse director; NDs, Nurse director; CNs, Chief nurses; DND, Deputy nurse director; LN, Lead nurses; AND, Associate nurse director; NM, Nurse manager; SCN, Senior charge nurses; RN, Registered nurses

		<b>Point of care level</b>	RN			
<b>Theme 2:</b> RN experiences of how and why mechanisms of accountability are enacted and the impact in practice.	<b>4.</b> How and why accountability was enacted was related to RN position in the hierarchy.	<b>Health Board level</b>	END			
			NDs/CNs/DND			
		<b>Intermediary level</b>	LN/ ANDs			
			NM/LN			
		<b>Point of care level</b>	SCN			
			RN			
	<b>5.</b> Accountability across the nursing hierarchy focussed on retrospective assurance and answerability this increased the association of accountability with a fear of personal consequences and sense of blame.	<b>Health Board level</b>	END			
			NDs/CNs/DND			
		<b>Intermediary level</b>	LN/ ANDs			
			NM/LN			
		<b>Point of care level</b>	SCN			
			RN			
<b>6.</b> Unclear how RNs enact accountability for safeguarding patient outcomes related to demonstrating evidence based, reasoned decision making, challenging practice and effective record keeping.	<b>Health Board level</b>	END				
		NDs/CNs/DND				
	<b>Intermediary level</b>	LN/ ANDs				
		NM/LN				
	<b>Point of care level</b>	SCN				
		RN				
<b>7.</b> Documentation design and record keeping expectations reduced the requirement and opportunity to enact accountability through effective record keeping and professional judgement.	<b>Health Board level</b>	END				
		NDs/CNs/DND				
	<b>Intermediary level</b>	LN/ ANDs				
		NM/LN				
	<b>Point of care level</b>	SCN				
		RN				
<b>Theme 3:</b> individual and organisational facilitators and barriers to RNs	<b>8a.</b> Acceptance of professional accountability relates to RNs self-confidence, resilience and autonomy	<b>Health Board level</b>	END			
			NDs/CNs/DND			
		<b>Intermediary level</b>	LN/ ANDs			
			NM/LN			

accepting professional accountability		<b>Point of care level</b>	SCN			
			RN			
	<b>8b.</b> Barriers/ Facilitators were RNs identity and feeling valued: level of knowledge and skills; relationships of trust and support; and inability to control various external factors that influence safety	<b>Health Board level</b>	END			
			NDs/CNs/DND			
		<b>Intermediary level</b>	LN/ ANDs			
			NM/LN			
	<b>Point of care level</b>	SCN				
		RN				
	<b>9.</b> RNs in hybrid clinical managerial, clinical leadership/ professional advisory roles were less clear about their identity, contribution and sense of value.	<b>Health Board level</b>	END			
			NDs/CNs/DND			
		<b>Intermediary level</b>	LN/ ANDs			
			NM/LN			
	<b>Point of care level</b>	SCN				
		RN				
	<b>10.</b> RNs level of knowledge and skills was variable and lacking in relation to specialist clinical knowledge that enabled confident evidence based decisions and effective challenge.	<b>Health Board level</b>	END			
			NDs/CNs/DND			
		<b>Intermediary level</b>	LN/ ANDs			
			NM/LN			
		<b>Point of care level</b>	SCN			
			RN			
<b>11a.</b> Relationships that demonstrated visibility, engagement and understanding of the context of practice, enhanced RN feelings of trust and support.	<b>Health Board level</b>	END				
		NDs/CNs/DND				
	<b>Intermediary level</b>	LN/ ANDs				
		NM/LN				
<b>Point of care level</b>	SCN					
	RN					
<b>11b.</b> In the absence of the above a feeling of blame and mistrust emerged and reduced RNs willingness to accept professional accountability.	<b>Health Board level</b>	END				
		NDs/CNs/DND				
	<b>Intermediary level</b>	LN/ ANDs				
		NM/LN				

		<b>Point of care level</b>	SCN				
			RN				
<b>11c.</b> Lack of fairness affected RNs sense of having a professional identity and feeling valued and reduced RNs sense of trust and support	<b>Health Board level</b>	END					
		NDs/CNs/DND					
	<b>Intermediary level</b>	LN/ ANDs					
		NM/LN					
	<b>Point of care level</b>	SCN					
		RN					
<b>11d.</b> Not having parity with other professional groups in terms of autonomy, protected education, supervision and administration time were barriers to enacting professional accountability	<b>Health Board level</b>	END					
		NDs/CNs/DND					
	<b>Intermediary level</b>	LN/ ANDs					
		NM/LN					
	<b>Point of care level</b>	SCN					
		RN					
<b>11e.</b> Different approaches to professional management and governance between nursing and medical staff was considered unfair, particularly in relation to adverse events and behaviours	<b>Health Board level</b>	END					
		NDs/CNs/DND					
	<b>Intermediary level</b>	LN/ ANDs					
		NM/LN					
	<b>Point of care level</b>	SCN					
		RN					
<b>12.</b> The cumulative effect on RNs resilience and self- confidence of not having control of factors such as staffing and decisions made at an organisational level impacted on individual RN accountability for patient care and willingness to accept accountability.	<b>Health Board level</b>	END					
		NDs/CNs/DND					
	<b>Intermediary level</b>	LN/ ANDs					
		NM/LN					
	<b>Point of care level</b>	SCN					
		RN					

## 7.2 Theme 1: Registered Nurses (RNs) knowledge and understanding of accountability

Under Theme 1 there were three main findings (Table 21)

**Finding 1:** Indicates that all RNs demonstrated an appropriate knowledge and understanding of accountability as it related to their individual role, level in the nursing hierarchy and personal experience (Table 21). Nurses' perceptions and experiences of accountability related to three main levels of practice: at Health Board (HB) level; (ENDs/NDs/CNs/ANDs); intermediary level (CNs/LNs/NMs/SCNs); and point of care (RNs/SCNs). In all three cases, SCNs flexed between point of care and intermediary level. At HB level, it was apparent that RNs related positively to accountability and used it to assert their autonomy, whereas at intermediary level accountability was difficult and at times contradictory, and at point of care accountability was mainly associated with blame when things go wrong. There were however exceptions to this in Case B and Case C, where a number of RNs described accountability as answerability but not something they had personally experienced. This implies that when discussing accountability nursing must be cognisant of how RNs relate to the concept which can have both negative and positive consequences.

**Finding 2:** Most participants across the three case studies described two discourses of accountability: accountability as task-responsibility; and accountability as relationships/structures in which they are answerable (Table 21). This study also identified a third discourse of 'blame' across the three case studies at point of care (Case A) and intermediary levels (Case B and Case C). The feeling of blame experienced by some RNs appeared to be related to many contextual factors and perceptions. The distinction was made between actually being blamed and feeling blamed. This was linked to a sense of lack of support and trust beyond immediate SCN level.

**Finding 3:** Collective accountability for quality of care and safeguarding patients was not clearly evident in the study. RNs, particularly at point of care, felt unfairly and disproportionately burdened with answerability in practice (Table 21). In anticipation of 'unfair' answerability, RNs described how their decision making had become risk averse, which often resulted in indecision and deference to others.

### **7.3 Theme 2: RN experiences of how and why mechanisms of accountability are enacted and the impact in practice.**

Under Theme 2 there were four main findings as shown in Table 21. As before Table 21 highlights the comparison of findings across the three cases.

**Finding 4:** How accountability was perceived and enacted was variable across the nursing hierarchy, and mostly concurrent with the three levels of practice (Table 21). At HB level RNs accepted accountability as a positive enabler of autonomy, at an intermediary level RNs described increased tension and conflict with accountability, and at point of care level RNs discussed a range of views but mostly associated accountability with answerability for poor care.

**Finding 5:** It was unclear how RNs across the three cases studies enacted accountability for safeguarding patient outcomes (Table 21). RNs associated evidence based decision making, ability to challenge, and record keeping as important aspects of accountability to safe guard patient outcomes. At point of care and intermediary levels RNs said they were rarely asked to account for their reasoned judgements in relation to these key responsibilities out with the context of responding to complaints, adverse events or assurance processes. This limited the opportunity to practice 'enacting accountability' without fear of consequence.

**Finding 6:** Accountability across the nursing hierarchy was mostly focussed on retrospective assurance and answerability; with the exception of RNs at HB level. This was said to be linked to RNs' sense of increased personal risk and attribution of blame, (Table 21). For most RNs the 'task' of completing audits underpinned most care assurance processes. The validity of audit results and relevance where questioned by a number of participants due to the subjective nature of the process, loyalty to teams and fear of criticism.

**Finding 7:** Suggests that documentation design and record keeping expectations reduced the requirement and opportunity for RNs, at point of care, to enact accountability. The main purpose of record keeping was described by RNs at point of care and SCNs as a self - protective mechanism in anticipation of external scrutiny, complaints and completion of risk assessments for audits. Most participants at all levels of the hierarchy described that extensive box ticking has reduced the ability of RNs to exercise and develop critical thinking and professional judgement skills.

## 7.4 Theme 3: Individual and organisational barriers and facilitators to RNs accepting professional accountability

Under Theme 3 there were five main findings as shown in Table 21. As before, the similarities and differences across the case findings and at different levels in the hierarchy are reported.

**Findings 8: (a)** Suggests that overall acceptance of professional accountability, across all levels of the hierarchy was related to individual RNs' self-confidence, resilience and autonomy (Table 21). The words self-confidence/ or confidence were used by the participants in descriptions of their experiences of accepting accountability, particularly related to decision making, ability to challenge and record keeping. Resilience covered issues relating to being able to recover from and manage the competing demands of their roles. Autonomy related to RNs having the freedom to act. ENDs across the three case studies presented as being confident, resilient and autonomous, and described accepting accountability as an enabler. In contrast, RNs at intermediary and point of care levels varied in their views about self – confidence, resilience and autonomy as facilitators of professional accountability. Descriptions of accepting accountability varied depending on the individual RN and the context of the situation. **(b)** The barriers/ facilitators to professional accountability were themed as being both individual and organisational, to include: identity and sense of feeling valued; level of knowledge and skills; relationships of trust and support; control of external factors that influence safety.

**Finding 9:** suggests that clarity of role identity as a nurse and sense of feeling valued influenced RNs' confidence (Table 21). ENDs and RNs at point of care demonstrated clarity of their role as a nurse. RNs in managerial, professional leadership and advisory roles (intermediary level) were less clear about their nursing identity and the roles appeared to be a hybrid of many functions. RNs in these roles described a sense of 'having no autonomy' or 'legitimate' authority to make decisions, especially in relation to workforce requirements that incurred additional finance. SCNs across the three case studies clearly articulated that their role was mainly administrative. Sense of feeling valued was important for all RNs irrespective of level in the nursing hierarchy, as was having their contributions listened to and acted upon and receiving positive feedback from colleagues and patients.

**Finding 10:** RNs' level of knowledge and skills were described by the participants at intermediary level and point of care as an important factor in maintaining confidence to make decisions, ability to challenge and effectively record care. Many RNs at point of care described their individual responsibility to 'be up to date' and to use evidence based practice. However, many participants said they relied on others and in particular medical colleagues, clinical nurse

specialists and advanced nurse practitioners to inform them of new evidence, policy or practice changes. SCNs discussed their desire to access clinical education, however, beyond statutory and mandatory training, education was focussed on management development. Being able to articulate reasoned judgements and refer to research evidence was thought to increase success when negotiating with managers and medical staff. Clinical supervision, as time to reflect without fear of embarrassment or blame was described to be an important factor in confidence and resilience. Despite this there was a general view that for RNs at point of care this time could not be prioritised over service delivery.

**Finding 11:** (a) Shows that relationships that demonstrate visibility, engagement and understanding of the context of practice, enhanced RNs' feelings of trust and support. In particular, positive relationships with medical and managerial staff was thought to be conducive to a positive work environment and accepting accountability. For most point of care RNs and SCNs, visibility and engagement with senior nurses particularly in the clinical environment increased their sense of trust and support. (b) Importantly, in the absence of this, visibility and engagement, a narrative of blame and mistrust emerged which increased the feelings of personal risk and reduced RNs' willingness to enact professional responsibility and accountability. (c) There was a sense of lack of fairness identified by RNs at all levels, implying that nursing as a profession is still perceived as being less credible and identifiable as a powerful workforce in comparison to the medical profession. (d) Not having parity with other professional groups in terms of autonomy, protected education, supervision and protected administration time were reported as barriers to enacting and accepting professional accountability. (e) The different approaches to professional management and governance of nursing compared to medical staff was considered to be unfair by RNs at point of care and intermediary levels, especially in relation to adverse events and related behaviours. Challenging entrenched beliefs and behaviours was evident at HB level, but at other levels this was more difficult. This perceived lack of fairness appeared to increase RNs' sense of blame and lack of trust and support.

**Finding 12:** Not having control of factors, such as staffing and decisions made at an organisational level that impacted on individual RNs, was said to reduce RN willingness to accept accountability. RNs at point of care and intermediary levels described the cumulative effect of this to negatively impact on their resilience and self-confidence. This also related to a sense of feeling undervalued as concerns that were repeatedly raised were rarely resolved beyond dealing with the immediate situation.

In summary, this study revealed similar and contrasting views across the three case studies. The study findings and implications for practice, policy and research are discussed in the next chapter.



# Chapter 8: Discussion

## 8.1 Introduction

This study aimed to explore how accountability is understood and enacted across the nursing hierarchy and identify how this could be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession. This is an exploratory study, designed to provide new insights into nursing accountability. It is unique in that it adopts a multiple case study design to collect and analyse data gathered from semi structured interviews with RNs from point of care to Health Board. In order to address the study aims, the following objectives were identified in (Chapter two):

1. To explore RNs' knowledge and understanding of accountability;
2. To explore how and why accountability is enacted across the professional hierarchy and the impact of this on practice;
3. To identify factors that facilitate or hinder nurses accepting accountability for safeguarding patient outcomes, quality of care and standards of the profession;
4. To portray a practice framework that prevents poor care rather than accounting for it after the event (Appendix 4).

The overarching research questions in this study were: 'How is nursing accountability enacted from point of care to Health Board?' and 'How can nursing accountability be enhanced to safeguard patient outcomes, quality of care and standards of the nursing profession?'

To the best of my knowledge, this is the first study to explore how nursing accountability is understood and enacted from point of care to Health Board in Scotland or elsewhere. This chapter presents a discussion and synthesis across case findings which are compared to the published literature and policy regarding accountability in nursing. This is followed by discussion of the implications of the study findings for future practice, policy and research. Finally, the strengths and limitations of this study are discussed, followed by recommendations and a conclusion.

## 8.2 Synthesis of findings

In total, twelve key findings were derived from this study (Table 21) and these have been synthesised as three overall findings linked to the objectives of this study.

### 8.2.1 Objective 1, Findings 1-3

**RNs knowledge and understanding of accountability appears appropriate as it relates to their role, level of practice in the nursing hierarchy and personal experience. Two predominant discourses of accountability emerged: accountability as task-responsibility; and accountability as relationships/ structures in which one is answerable. A discourse of nursing accountability as a ‘personal/ professional virtue’, as previously reported in the literature, was not evident in this study. Perceptions of accountability varied across the nursing hierarchy.**

A novel finding from this study was that RNs’ knowledge and understanding of accountability was appropriate as it relates to role, level of practice in the nursing hierarchy and personal experience. This is contrary to previous studies that have reported RNs’ knowledge and understanding of accountability to be poor (Krautscheid 2014; Savage and Moore 2004). There are three possible explanations for this contrasting finding. First, the last UK study to report on RN knowledge of nursing accountability was in 2004 (Savage and Moore 2004). Since then a number of systemic failures in health care have raised the profile of nursing accountability (Francis 2013; Maclean 2014; gosportpanel.independent.gov.uk 2018). In particular, failures at Mid Staffordshire NHS Trust (Francis 2013) have driven a renewed approach to regulation by the NMC (NMC 2015). Second, the policy aspiration set out in the NHS Scotland to have clear and explicit lines of professional accountability for nursing (SGHD 2014). A third explanation is that it could simply mean, that in this study, RNs’ knowledge and understanding of accountability was not seen to be judged on an inability to provide a definition of accountability. Instead the RNs described to whom, for what and how does the concept of accountability relate to them in their context of practice.

A further important finding from this study were the two predominant discourses of accountability that emerged: accountability as task-responsibility to meet professional and contractual obligations and accountability as relationships/ structures in which one is answerable. In contrast to previous literature that has reported a discourse of ‘personal/ professional virtue’ for nursing (Bovens 2006; Hall et al. 2015; Krautscheid 2014), accountability as a professional virtue was not evident in this study. This is an important finding for the profession to debate when calling for more accountability in nursing. This finding suggests that the concept of professional accountability in nursing has changed to reflect the characteristics found in public/ social accountability: “a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the

forum can pose questions and pass judgement, and the actor can be sanctioned” (Bovens 2006, p.9).

### ***Accountability as task-responsibility***

In this study RNs’ responsibilities were described within and across the cases as predominantly relating to the responsibility for care delivery (for point of care RNs) and responsibility for assurance (for intermediary and HB RNs). To meet these obligations of delivery and assurance, responsibilities varied for RNs at each level in the nursing hierarchy. RNs at HB level were focussed on systems of governance and having oversight of professional and clinical risks and imperatives across the HB and Integration Joint Boards; RNs at an intermediary level were focussed on assurance processes, and managing the tensions between professional expectations and the reality of practice context; SCNs and RNs at point of care were focussed on delivering direct care, balancing the needs of individual patients and the wider organisational demands and self-protection from individual blame. These findings corroborate the three layers identified in the nursing hierarchy, each with a different role and function. Although no studies were identified that considered accountability in the context of the full nursing hierarchy, a number of studies looked at individual peer groups and reported similar findings (Hughes et al. 2015; Leonenko and Drach-Zahavy 2016; Young 1999).

In this study, individual RNs’ accountability for care delivery was perceived to be lost, in response to whole system demands. This concerned the hierarchical nature of those with accountability for managing whole system/ intermediary levels of risk where positional authority exceeds individual accountability. Examples of this were provided mainly relating to RNs being moved from their areas of expertise to manage staffing gaps; managing patient flow and risk across the system; and patient care demands exceeding the capacity of RN availability. Previous literature has identified similar issues of conflict pertaining to individual accountability in a context of whole system risk (Choiniere 2011; Manuel Crowe 2014; Young 1999).

Building on previous literature, this study adds to the debate about hierarchical accountability in the context of individual accountability for safeguarding patient outcomes. The concept of hierarchical accountability (one for all) is considered to be the accountability model in most public organisations (Bovens 2006). Where processes of calling to account starts at the top. Hierarchical accountability is defined by the close supervision of individuals who have low work autonomy and face internal controls (Romzek 2000); in contrast, professional accountability systems reflect work arrangements that enable high degrees of autonomy to

individuals who base their decisions on values and practice norms rather than political responsiveness (Romzek 2000). Consideration of the contradictions and tensions of hierarchical accountability in the context of its application to nursing require to be further understood. In this study, managing the tensions of individual accountability in a context of whole system responsibility to deliver safe care was raised by the majority of RNs as a problem. This concurs with previous literature (Leonenko and Drach-Zahavy 2016). The nursing profession requires to understand the enduring impact of hierarchical accountability on individuals and ensure that individual RNs' accountability is recognised and autonomy is not lost at point of care.

In this study, with respect to accountability, many RNs at point of care described their responsibility was to be 'up to date' and requirement to use evidence based practice: however, most participants relied on others, especially medical colleagues, clinical nurse specialists and advanced nurse practitioners to inform them of new evidence and changes to policy and practice. Previous literature identified similar findings to these (Cohen et al. 1994; Semper 2016). Individual responsibility to seek new knowledge through CPD was evident in a small number of RNs. Two RNs, from different cases, described the importance of generating and participating in research to fulfil all professional obligations. SCNs discussed their desire to access clinical education; however, beyond statutory and mandatory training, education was focussed on management development. This finding suggests that RNs do not take ownership of their professional responsibility to remain knowledgeable and competent to deliver evidence based practice, which limits their ability to accept professional accountability. Consideration of how RN ownership of knowledge attainment can be enhanced requires exploration.

### ***Accountability as answerability***

The discourse of relationships/ structures in which one is answerable was described by all RNs, these varied across the nursing hierarchy. Overall, RNs described being answerable through internal structures and processes, answerable to line manager and professional manager, the NMC and patients and relatives. A small number of RNs described being answerable to peers, other staff and answerable in law. A range of meetings were described by many RNs in which they discussed data, workforce issues and shared information. These meetings were considered supportive forums to enact accountability, however many of them were described as transactional and more focussed on operational business, rather than CPD. RNs interviewed considered themselves answerable to multiple audiences however, very few 'accountability interactions' that meet the criteria set out by Bovens (2006) for formal accountability were discussed at interview. This raises an interesting notion of formal and informal accountability. No studies were found that considers the notion of formal and informal

accountability in nursing. Outwith nursing, the concept of informal accountability has been shown to influence the motivation and performance of workers, and to have generated research interest (Roesthlisberger and Dickson 1939 cited in Hall et al. 2015 p.209). The concept of informal accountability is worthy of further exploration in nursing. This has the potential to make clear the purpose of enacting accountability, where sanctions are the anticipated consequence of 'formal' accountability.

In this study ENDS at HB level described their requirement to be accountable (answerable) as an enabler of autonomy. This finding is consistent with previous literature that has identified the relation of structural empowerment, autonomy and authority with accountability (Batey and Lewis 1982; Lewis and Batey 1982; and Hughes et al. 2015). ENDS discussed accountability relationships with the HB, Board level Clinical Governance Committees and the Scottish Government. In describing these relationships the language was consistent and expressions such as 'offering an account' or 'providing an explanation' were used. ENDS described the accountability relationships in which they are answerable to be complex, however, there were no ambiguities in their account of individual and corporate accountability. In contrast, beneath the HB level the ability to assert autonomy and authority across professional and structural boundaries was evidently more challenging, particularly in the context of Integration Joint Boards and when influencing decisions that required additional financial resource. This finding concurs with Hughes et al. (2015) who found variable structural positioning of senior nurses' impacts on levels of inclusion and influence in decision making; ambiguous financial responsibilities and accountabilities; and blurred operational and professional reporting lines.

RNs at intermediary level related to accountability relationships as difficult and at times contradictory and concurs with previous studies (Choiniere 2011; Manuel Crowe 2014; Young 1999). Lack of role clarity and dual lines of accountability that required constant negotiation between HB level and RNs' professional expectations, service delivery expectations and point of care reality contributed to the tensions. According to Romzek and Dubnick (1998), a web of multiple accountability relationships with competing demands aligned to various public sector reform strategies increased tension and demands for individuals. Understanding the role of RNs at an intermediary level is essential for the nursing profession and in particular what defines them from other non-nursing managerial roles.

For a number of RNs in this study accountability as answerability was described as 'blame'. This has been highlighted in previous studies (Manuel and Crowe 2014; Mitchell 2001; Robertson et al. 2010; Hall et al. 2015) although differences across the nursing hierarchy were not examined. This study found that some RNs at point of care, SCNs and NM/LN described an anticipated sense of blame and increased personal risk when discussing how they relate

to accountability. This finding was not consistent across the three cases (Table 21). Some RNs felt personally blamed and described being unsupported and not trusted to do their jobs. Other RNs acknowledged the association of accountability with blame but did not experience this personally. Hall et al. (2015) refers to this as 'felt' accountability, where accountability is based on the perceptions of the 'actor'. RNs at point of care and SCNs described being 'held to account' and 'being answerable'. These perceptions of accountability, ambiguities and impact requires to be further understood if the nursing profession aspires that RNs will 'embrace' accountability (NMC 2017). There needs to be a move away from the negative connotations associated with accountability to a culture of supportive learning and collective responsibility.

A further finding from this study was the contrasting perspectives and experience of RNs across the three cases, in relation to increased answerability to patients and their relatives. In two case studies increased accountability to patients and relatives was described positively, as a 'patient's right'. RNs described being confident to offer explanations to patients and their families and described this process as prompting a deeper sense of thought. RNs described this process as a way of ensuring (and at times 'revisiting') their own understanding of the rationale underpinning the care they were delivering. This finding suggests that offering an explanation rather than being 'called to account' enabled RNs to reflect and enact accountability with a personal benefit for themselves, as a learning and development opportunity. In contrast, RNs in one case study described the additional accountability demands from the public as a distraction and often threatening to them as individuals. Avoidance of 'difficult' patients and relatives was inferred. No previous studies were identified that investigated the impact on RNs perceptions of accountability, as answerability, to patients. However, conflicting perceptions and responses to accountability are evident in the literature (Savage and Moore 2004). In particular, where accountability to multiple different sources for multiple issues co-exists. The positive impacts of accountability such as increased job satisfaction (Sorensen et al 2009) and improved patient outcomes and practice (Semper et al 2016; Nolan et al 2010) contrast with the negative connotation's reported by (Manuel and Crowe 2014; Mitchell 2001; Robertson et al 2010). Beyond the nursing literature, accountability has been related to work tension and emotional exhaustion (Hall et al. 2006) and corroborated by depressed mood at work (Lanivich et al. 2010). High levels of stress have been shown to have a negative impact, whereas moderate levels of stress can increase arousal and interest in work (Ganster and Schaubroeck 1991 cited in Hall et al. 2015). This helps to explain how accountability can be reported to have both negative and positive impacts on individuals. Personal autonomy can minimise the deleterious aspects of accountability on both job strain and job tension (Hall et al. 2006; Hughes et al. 2015; Rashkovits and Drach-Zahavy 2017).

In respect of accountability as answerability, the NMC was referred to by most participants, although not all. RNs at point of care, SCNs and NMs made reference to the NMC most frequently. Most participants did not have a positive view of the NMC and described it as restrictive to practice rather than enabling. A number of participants spoke about the new approach the NMC were starting to take and that this 'felt like it was heading in the right direction'. Two participants mentioned revalidation. Accountability relationships with peers and colleagues were mentioned by some participants but no processes whereby this was enacted were provided.

### ***Collective accountability***

In this study RNs described collective accountability as being largely absent. On further probing the absence of collective accountability was discussed by RNs at point of care, SCNs and NMs who felt that nurses disproportionately carried the burden of care that is a collective responsibility; and that individuals are blamed when errors occur or expectations are not met. Examples were provided consistently across cases for discharge planning, medication management and boarding of patients. At HB level RNs described the complexities associated with working across Integration Joint Boards, Local Authorities and HB governance structures. Collective responsibilities such as for 'population health' were recognised, but accountability was described as single 'organisation', and within that single organisation the accountability sat with one individual. RNs at HB level confirmed their accountability for the professional governance of NMC registrants. A number of RNs described shared responsibility with HB Medical Directors for the governance of healthcare quality. Collective accountability for system wide issues such as complaints and adverse events were discussed across cases. Issues that occurred as a result of the 'systems' inability to manage the underlying cause, often resulted in point of care RNs having to respond to the consequences, for example, poor care experiences where inappropriate staffing levels have been reported for years or no beds available for admissions and overcrowding resulting in a fall or medication error. SCNs in two cases studies considered themselves to be inappropriately answerable for the poor performance of individuals in their teams. The impact of this on RNs was a sense of defeat and reluctant acceptance of accountability as it did not reflect the multiple professional inputs in health and social care. Describing this as shared responsibility and equality of accountability may be a better approach for nursing and others to consider.

## 8.2.2 Objective 2, Findings 4-7

**How and why accountability is enacted influences the cognitive and behavioural responses of individual RNs. Accountability across the nursing hierarchy was mostly focussed on assurance (by audit) and answerability (by reviewing documentation). It is was not entirely clear at times how RNs enacted accountability. This was discussed mostly in relation to demonstrating evidence based decision making, the ability to challenge practice and effective record keeping. The majority of RNs described documentation design, which included extensive box ticking, to have reduced their ability to develop critical thinking skills and professional judgement, and importantly how to convey this in writing.**

### ***Accountability and assurance***

Enacting accountability by assuring standards of care and professionalism or 'Care Assurance' was regarded by a number of RNs to be critical to accountability. This contrasts with previous literature (Surakka 2008), where accountability for performance and finance was emphasised (Batey and Lewis 1982; Lewis and Batey 1982; Choiniere 2011; Sorensen and Iedema 2010). One possible explanation for this increased focus on assurance, in this study, is the political context for nurses in NHS Scotland, which has been partially shaped in responses to systemic failures of care, including NHS Scotland's own Vale of Leven Hospital Inquiry (MacLean 2014). The Scottish Government response to this inquiry included the introduction of a national approach to assuring standards of nursing and midwifery care through 'Excellence in Care' which is nearing completion and is partially implemented across NHS Scotland. The aim is that all NHS HBs and Integration Joint Boards will have reliable and robust processes and systems for measuring, assuring and reporting on the quality of nursing and midwifery care and practice. What is not clear at this point is what 'assurance' actually means in the context of everyday practice and how accountability might be enhanced. What this adds are insights from three case studies to illuminate the factors that facilitate or hinder nurses in the exercise of accountability.

### ***Accountability and audit***

In this study, RNs across the three cases similarly describe using care assurance standards such as pressure ulcers, falls, hand hygiene and Peripheral Venous Catheter (PVC) bundles. Assurance relied heavily on auditing documentation to monitor these standards. However, there was a recognition by most RNs that 'top down' audit alone had a negative impact on

their ownership of audit outcomes, autonomy and validity of the assurances provided. When asked what prevented them from stopping audits there were three reasons given: fear of the consequences; loyalty to their professional/ line manager and personal concern that they would be considered a poor performer. RNs at either end of the hierarchy described the processes of assurance through audit to be of limited value and not sensitive enough to highlight areas of concern. SCNs in each case study described their discomfort of sharing poor audit results with their teams. This related to SCNs' loyalty to their teams with a recognition of how hard their teams were working and that to ask them to do more was unmanageable. RNs at point of care described a feeling of mistrust that was generated by the requirement to upload audits for everyone to see what had and had not been completed. These findings, with respect to discomfort and loyalty concur with Luhanga et al. (2010) in which RNs were reluctant to fail students and cause them distress. With respect to mistrust Manuel and Crowe (2014) identified a sense of mistrust amongst RNs and use of defensive practice as a coping strategy. Across the three case studies RNs at point of care and SCNs were concerned that nursing was scrutinised through audit more than any other professional group.

### ***Accountability and documentation/ record keeping***

In this study RNs' record keeping was considered a task to feed the audit culture before anything else by RNs at point of care and SCNs in all three case studies. It was described as a mechanism of self-protection from external scrutiny and complaints. Similar findings of what was described as 'defensive documentation', was highlighted by Savage and Moore (2004). These findings concur with previous literature that identified tick box documentation moved nurses towards a task orientated administrative function with no autonomy (Choiniere 2011; White et al. 2015). Whilst it is acknowledged that record keeping and documentation is important, a balance must be struck so that it does not become burdensome or removed from the actual delivery of care and professional standards.

The NMC (Code 2018) expectations of record keeping, recording and communication of clinical decisions as a legal requirement were not mentioned by the RNs in this study. Documenting decisions were described by RNs in two of the case studies as increasing their sense of answerability and individual vulnerability. This was also discussed in relation to adding a signature to a document.

### ***Accountability for complaints and adverse events***

Patient complaints and adverse events have been identified as a valuable resource for monitoring and improving patient safety (Keogh 2013; Francis 2013). This study found that how RNs enacted accountability in relation to complaints and adverse events was dependent on the position of the RN in the hierarchy. Enacting accountability for SCNs and NMs across the three cases involved investigating complaints, drafting response letters and managing the actions identified. Having to provide an apology within the context of a complaint was disputed by some participants. This was interpreted as offering an apology for issues that were a consequence of the system rather than the 'fault' of individuals or their teams. An apology was perceived as confirmation that something avoidable had been done. A consequence of this was a sense of mistrust in practice and apportioning of blame to individuals. Learning from complaints and adverse events was discussed by the majority of participants however influencing change in practice was repeatedly described as challenging. If addressing accountability and responses to complaints is not appropriately addressed the opportunity for learning is diminished.

### ***Accountability to safeguard patient outcomes***

Enacting accountability to safeguard patient outcomes was discussed by RNs and SCNs in the study and mainly in relation to task- responsibility. Senior RNs were said indirectly safeguard outcomes through leadership and practice behaviours that create a supportive organisational culture. No previous studies were identified that considered the importance of leadership and culture in the context of RNs accepting accountability. However, there is a plethora of leadership and cultural literature that supports the interplay between senior leadership, organisational culture and patient safety (Wong et al. 2013).

In this study, the confidence and context in which RNs made, challenged and recorded decisions as a way of enacting accountability varied depending on their level in the nursing hierarchy. RNs at HB level describe with confidence their ability to make autonomous decisions, challenge others decisions and to explain/ record their decisions. This process most frequently involved pre-emptively offering an account to others and was often carried out by providing a report to explain data variance etcetera. In contrast, RNs at point of care, SCNs and NMs, across the cases described making individual decisions that required an immediate response to maintain safety that had a direct impact on other individuals. Such decisions increased the risk of being 'called to account'. This study also found, similar to other studies, that RNs' coping strategies to deal with 'high risk' decision making included avoidance of the task and deference to others (Leonenko and Drach –Zahavy 2016; Mitchell 2001).

Another finding in this study was the variance between the professional capability and expectations to embed evidence based decision making in practice. In each case, there were a range of views about the capability of RNs to make evidence based clinical decisions. There was an acknowledgement in one case of historical professional expectations to carry out tasks to a high standard in comparison with current professional expectations to make evidence based autonomous decisions. The RNs in this study generally acknowledged the power of 'evidence based currency' in negotiating and influencing medical and managerial colleagues. RNs who described successfully challenging others used 'evidence' as a tool to do this. Although previous literature has acknowledged the importance of continuous learning to enable contemporary practice (Krautscheid 2014; Nolan et al. 2010; Semper et al. 2016), no literature highlighted the perceived empowerment and confidence described by RNs in this study and the value of evidence based practice in supporting and encouraging accountability in practice. Also, of relevance in this study is a number of RNs at various levels in the hierarchy across the three case studies who identified the importance of continuous post registration education to support clinical decision making and build self- confidence to challenge practice.

### **8.2.3 Objective 3, Findings 8-12**

**There were several other factors to do with the individual, the organisation and the context of care that facilitated or hindered the acceptance of professional accountability. Acceptance of professional accountability was related to RNs self – confidence, resilience and autonomy. Barriers and facilitators were identified to include: identity and feeling valued; level of knowledge and skills; relationships of trust and support; lack of parity with other professionals and an inability to control various external factors, especially those that influence safety.**

In this study RNs who reported being confident also reported being autonomous to practice. Previous studies have identified autonomy as a prerequisite to RNs acceptance of accountability (Batey and Lewis 1982; Lewis and Batey 1982; Choiniere 2011; Sorenson et al. 2009; Rashkovits and Drach-Zahavy 2017). This implies that in the absence of self-confidence, autonomy and accountability cannot be embraced. Resilience, defined as 'the ability of an individual to cope with and adapt positively to adverse circumstances' (Hunter and Warren 2013) was also discussed in relation to professional accountability. This study found four key factors that inhibit and /or enhance RN self- confidence, resilience and autonomy.

### ***Identity and sense of feeling valued***

The majority of RNs described the importance of being identified as a nurse and clinician, and not as a manager. This appeared to be related to RNs' credibility and sense of feeling valued. However, despite the importance of being identified as a nurse, the clinical contribution of the RNs beyond point of care was unclear in this study. At an intermediary level there was more of a focus on managerial/ professional governance functions. SCNs had similar views across all three case studies that their role should be focussed on clinical leadership and developing their teams. However, the majority of RNs across cases concurred that this was not achievable and the SCN role was now predominantly administrative. This finding is consistent with the literature on SCN/ ward manager roles (RCN 2016). The importance of visibility and clinical support in practice was described by most RNs (at point of care) in relation to enhancing their ability to accept accountability. However, senior roles were not designed to accommodate clinical practice. ANPs and CNSs were considered by RNs at point of care to have a very clear clinical identity that was not apparent in the nursing hierarchy. RNs at point of care described clinical support and guidance being provided by medical staff, ANPs and CNSs. Of interest, an example of doctors being identified as clinicians, irrespective of their hierarchical position, was discussed in one case; yet nurses beyond point of care (other than ANPs and CNSs) were described as managers. ENDs and RNs at point of care described their identity as a nurse with clarity and purpose; RNs at an intermediary level, particularly within Health and Social Care Partnerships, were less clear about their identity, contribution and sense of value. This appeared to relate to the hybrid managerial, leadership or advisory nature of the roles. A lack of autonomy and authority was reported by a number of RNs in intermediary roles. This finding is consistent with previous research that calls for clarity of responsibilities for nurse managers in order for them to fully embrace accountability (Surakka 2008; Young 1999).

The sense of feeling valued was important for all RNs in this study. Not feeling this was a barrier to RNs self-confidence and resilience in the face of daily challenges in practice. Examples were given of RNs being frequently moved to clinical specialities which the nurses deemed were out with their scope of practice. RNs reported being used as a 'spare pair of hands' which made them feel undervalued. Sorenson et al. (2009) reports praise and recognition to be positively related to RNs' job satisfaction and acceptance of accountability. In contrast, not feeling valued had a negative impact on RNs.

The way nurses referred to each other across all three case studies were discussed at interview. RNs referred to SCNs, lead nurses, chief nurses, nurse director, clinical nurse specialists and advanced nurse practitioners by their role title. Other professional groups were also referred to by role title: i.e. consultants, general managers or pharmacists. However, all

other nurses were referred to by their pay grade, band 5, band 6, reinforcing a lack of professional identity, lack of feeling valued and the hierarchical nature of nursing.

In summary, the findings from this study pose a real challenge to the current hierarchical model of nursing, in its current format, where senior nursing roles do not retain any clinical practice. In light of the discussion in section 8.2.2 concerning assurance, to move beyond tick box audit and documentation, nursing needs to be able to consider assurance in the context of understanding if care is evidence based and appropriate. To do this the assurer must also have contemporary clinical knowledge and be present. The nursing profession has the opportunity to consider how clinical expertise is retained in senior nursing posts and how these roles can positively impact on RNs ability to accept accountability through clinical practice by reclaiming the clinical identity of nursing from point of care to HB.

### ***Level of knowledge and skills***

This study found that RNs' self-confidence to accept accountability related to their level of knowledge and skills in their specialist area. They described increased confidence to make decisions and challenge others when confident that their knowledge was up to date. An example of this was an RN who had just completed a clinical decision making MSc module confidently articulating to a doctor why a patient should be transferred to a high dependency unit. Before the course the RN said that she would not have had the confidence to challenge medical staff. In this study education for nurses was heavily focussed on statutory and mandatory training delivered electronically. RNs described e- learning as transactional box ticking. This finding suggests a similar issue to that of record keeping, where the focus of accountability is based on the completion of the task rather than the underpinning knowledge that enhances the acceptance of accountability in practice.

This study found RNs within and across cases reported the increasing need and decreasing opportunities for CPD in practice and the negative impact of this on individuals' resilience and willingness to accept accountability. The challenge of accessing CPD activities concurs with previous literature (Choiniere 2011; Semper et al. 2016). ENDs and senior RNs across the three cases discussed their inability to influence protected time for CPD and attempts to influence the appropriateness of statutory and mandatory training were described as 'on going'. Finding innovative ways to get research and education to point of care nurses was described in two cases. Redesigning posts to embed Clinical Academic RNs at point of care was one solution and RNs in the second case were using new assurance processes to combine education with assurance with a form of supervision. The driver for both innovations

was to enhance RN acceptance of accountability by building confidence and resilience at point of care through education and research.

### ***Relationships of trust and support***

The findings from this study confirm the importance of working in an environment of trust and support to enable nurses to effectively safeguard the outcomes of patients, quality of care and standards of the profession. This is not a surprise as the importance of organisational/ unit culture, focussed on psychological safety, support and 'no blame' is widely reported in the context of healthcare policy and research (The King's Fund 2015). However, this remains a challenge for the nursing profession to embed.

This study offers four interesting insights into factors that influence RNs' sense of mistrust, lack of support and sense of feeling blamed. First, RNs conveyed a sense of anticipated blame and mistrust rather than experiencing/observing an explicit action of being blamed, second, relationships that demonstrated visibility, engagement and understanding of the context of practice enhanced RN feelings of trust and support; third, RNs' perception of fairness with other professional colleagues impacted on RNs' sense of trust, support and value; and fourth, in the absence of factors two and three, a narrative of blame and mistrust appeared to emerge which increased the feeling of personal risk and reduced RNs willingness to accept professional accountability. This study found that visibility and interactions with senior RNs within the hierarchy was highly valued and appeared to influence how supported RNs felt and the perception of trust within the hierarchy.

Building relationships of trust and support with peers and RNs in the hierarchy facilitated acceptance of accountability. The majority of RNs described attendance at meetings with peers and one-to-one meetings with professional/ line managers to be supportive and informative. The structures of one-to-one meetings were variable and dependent on the individuals, most appeared to take on a 'coaching' type role, and some RNs described having supervision. Other studies have similarly found professional self- development strategies such as building of positive nurturing professional relationships, maintaining positivity, developing emotional insight, and also becoming more reflective (Semper et al. 2016; Rashkovits and Drach-Zahavy 2017; Nolan et al. 2010). Across the three case studies the nurses that had least access to meeting with peers' and one to one meetings were point of care RNs. Multidisciplinary meetings were rarely mentioned by participants despite relationships being valued by RNs, particularly with medical colleagues. Medical staff were referred to as supportive if they interacted with the nursing staff.

Alongside trust and support, perceptions of fairness impacted on RNs sense of value and their willingness to accept accountability. RNs drew comparisons with other professionals, in regards to protected education, administration activities and levels of autonomy. Perceived lack of fairness in professional approaches to adverse events left nurses feeling as if they carried the burden of risk and accountability for poor care. Despite these concerns it was clear that RNs placed importance on relationships, particularly with medical staff. Understanding how multi-disciplinary teams can be enabled to build relationships based on trust and support may help to address perceptions of lack parity and collective responsibility for care.

### ***Control of responsibilities***

Enduring lack of control, was perceived to negatively impact on RNs' resilience, self-confidence and ability to accept professional accountability. The most common example raised by all participants across the hierarchy was not having adequate staffing levels. At point of care and intermediary levels this had a consequence of staff not getting breaks, and a cumulative effect on resilience, self-confidence and development. RNs at HB level described lack of control of responsibilities at times, however, they used their authority to address this. RNs at an intermediary level also described the demands of their roles being out of their control at times however gave examples of prioritising their workload. SCNs described that to accept accountability they needed to have control of issues that impacted on the environment they were responsible for; this was linked to being included/ excluded from decisions that affected them and their team. In this study, SCNs and point of care RNs described flexibility to respond to changing environmental factors to be part of their daily responsibilities. Involvement in decision making appeared to enhance RNs' sense of control. Despite this SCNs, particularly in two of the case studies, did not feel involved in decisions that affected them or their teams. The consequence of this appeared to be diminished resilience. Maintaining the emotional and physical resilience of RNs would appear to be fundamental to RN self- confidence and acceptance of accountability.

There was a recognition that having more staff to do more of the same was not a sustainable way to enhance working conditions. There was corroboration across the cases that additional time was needed to enhance the quality of record keeping, education and supervision. Balancing the organisational (whole system) requirements to maintain safety such as managing staffing shortages and patient flow was also described as compromising RN ability to accept accountability for patient care.

RNs across the three cases described a lack of consultation when other services such as Facilities and Estates, Human Resources and Health and Safety changed their service

delivery models and RNs having to manage the impact of the change and often pick up additional responsibilities within the clinical team. There were mixed experiences of negotiating these demands successfully, this appeared to relate to skilled negotiation and relationships. Involving RNs in decision making may be one way to enhance the sense of control.

Clearly more can be done by individuals, the nursing hierarchy and the organisation to help enhance RNs acceptance of professional accountability. Based on the study findings recommendations are made to address the barriers to accountability with respect to practice, policy and research.

### **8.3 Discussion summary**

Having considered the individual and across case study findings the interplay between: the nursing hierarchy; RN knowledge and understanding of accountability; how and why accountability is enacted; and RN ability to accept professional accountability becomes very apparent as does the difficulty of separating and considering each in isolation. In Chapter three (section 3.2.3, p. 54) a working theory was asserted to focus the attention of the research purpose to acknowledge the complexity and importance of context to help inform practice (Stake 1995). This working theory has now been enhanced to include the overall findings from this study and is presented below:

The professional discourse of accountability is focused on responsibility with the opportunity for professional deliberation, reflection and use of reasoned judgement, grounded in evidence. This discourse is weak or absent in practice. The emphasis in practice is on answerability and assurance, which for nurses delivering care compromises the acceptance of professional accountability and limits scope of practice. Therefore, current hierarchical accountability challenges the moral implications of professional nursing by focusing on retrospective answerability and assurance. I propose the need for a third discourse of accountability that normalises 'open reasoned judgement' in practice. If RNs are to embrace the concept of accountability, the nursing hierarchy is required to build confidence, resilience and autonomy in the nursing workforce. This theory is portrayed as a model for practice (objective 4) based on the findings from this study (Appendix 4).

## **8.4 Strengths and limitations**

### **8.4.1 Strengths**

This study produced some key findings that have relevance for future practice, policy and research. This is important as it is evident that the concept of accountability is widely regarded by society and policy makers as positive. However, in practice there is little consideration given to the evidence base, which in itself is limited, at point of implementation. This is the first multiple case study that has explored the concept of accountability, and in particular how it is enacted across the nursing hierarchy. The embedded nature of this design provided an opportunity to gain insight into perspectives and experiences on accountability of nurses at different levels of the nursing hierarchy within each case. This study adds to the previous accountability literature, and in particular, offers new knowledge regarding how accountability is understood, enacted and how it can be enhanced in practice. This is particularly important in the context of increasing accountability and perceptions that greater accountability is a good thing (SGHD 2014)

A further strength was the qualitative approach which allowed the researcher to observe how nurses related to accountability and how best to frame the interview questions appropriately. This enabled the use of appropriate language during data collection to ensure that what was being discussed remained relevant and meaningful. This was important as previous literature has reported the concept to be poorly understood. Exploring accountability across different levels of the nursing hierarchy has not previously been done. This study identified that RNs at HB level relate to accountability differently than other RNs and this is important in particular for future policy and practice considerations.

The case study design in itself was a strength. Utilising case study design enabled the identification of findings from each case and also across case study findings. The transferability of the findings to other practice contexts create the opportunity to utilise the findings from this study in a range of health care practice settings. The credibility of the case study findings was confirmed by scrutiny applied by supervisors and colleagues with PHD and peer doctoral students (during presentations of the work).

### **8.4.2 Limitations**

This study had some limitations. First, this multiple case study was designed and carried out through the eyes of a novice researcher who is also a nurse director. Steps were taken to

minimise the impact of any bias that I unconsciously brought to this research but undoubtedly having more than one researcher would have enhanced the opportunity for objectivity and challenge. It is possible that participants were more inhibited in their comments than if the researcher was not in this role, or had more experience in carrying out research. Resources available to conduct this doctoral study were limited. In particular this may have impacted on the trustworthiness of the data analysis. Framework Analysis is optimised with multiple researchers, with at least one having expertise in FA. Interview data was the main source of data collection, corroboration with documentary and observational data would have enhanced the richness of the data. The time and cost to have conducted documentary analysis and observations across multiple case studies was beyond the scope of this doctoral work. Trustworthiness was established despite these limitations and is outlined in Chapter three, section 3.4.8.

Second, accountability was not objectively measured. Instead, nurses described their ability to accept accountability and commented on other nurses' ability to accept it within the hierarchy. It would be helpful to objectively measure RN accountability to understand if interventions to enhance it are working. There are two tools reported in the literature as being able to measure RN accountability (Drach-Zahavy et al. 2018; Sorensen et al. 2009). The findings from this study will enhance any future work to measure accountability in nursing.

Third, this research set out to explore specific nurses' perspectives of accountability as they are mainly present in the nursing hierarchy, others perspectives would also add value. The exclusion of particular groups of nurses who are perhaps considered to have more freedom and control over their work would be an interesting comparative study. Nurses in advanced practice and clinical nurse specialist roles would provide a more holistic view of accountability across the breadth of the nursing workforce. Insights from other professional groups that observe RNs in practice would also enhance understanding of RN accountability beyond the insights of nursing.

Fourth, a challenging part of this study was conveying the meaning of accountability conveyed by nurses and maintaining their confidence. There were a number of "just between you and me" and "off the record" examples given and comments made when the interview had ceased. These comments could not be included and presented a challenge to convey accurate meanings within the narrative available. An additional and optional stage in FA was undertaken by developing matrices with summaries of the extracts (Table 11, p.70). This was carried out alongside reviewing the narrative recorded in my diary and field notes to optimise capturing the meanings conveyed by RNs.

## 8.5 Recommendations

This was the first multiple embedded case study to explore accountability in nursing and its impact on professional practice. Three NHS Scotland Health Boards (cases) were studied and data was gathered from forty nine RNs representing the hierarchical structures (units) from point of care to HB.

This study adds to our knowledge by identifying that Registered Nurses' knowledge and understanding of accountability relates to their role, level of practice in the nursing hierarchy, and personal experience. It was unique in that it contributes to a gap in the literature on how nursing accountability is enacted and its impact on practice in Scotland. Several factors to do with the individual (RNs), the culture of the organisation, and the processes and systems in place have been identified as barriers or facilitators to nurses accepting accountability. Based on the study findings recommendations are made for practice, policy and research.

### Practice

In responding to the challenges of today's NHS, the nursing hierarchy must consider the purpose and impact of accountability when planning how to balance the needs for assurance with building self-confidence, resilience and autonomy in the RN workforce.

- The audit culture for assurance needs to be addressed and owned by point of care teams to ensure the purpose of audit is to identify opportunities for improvement rather than audit being the goal itself. A multidisciplinary team based approach to audit is recommended to ensure the audit process is normalised in practice across the professions, including medicine. There needs to be processes in place that enables conversations about clinical decisions to take place along with audit and patient experience data
- Having greater awareness and understanding what drives the need for assurance in practice, how effective the assurance is and how this could be addressed in a way that also builds resilience and sense of value for RNs is important for the nursing hierarchy to focus on.
- If nursing wishes to address the chronic problem of poor record keeping three issues must be addressed. First, documentation needs to be designed to necessitate RNs to record clinical decisions and reasoned judgements. The purpose, impact and validity of tick box documentation should be considered by nursing in practice. Second, effective record keeping is a skill that requires support and development. The nursing hierarchy needs to give greater consideration as to how RNs might be better supported

to improve record keeping skills beyond point of registration. Third, time and equipment must be prioritised for RNs to enact accountability as a written record of care. Balances and checks need to be in place to help ensure record keeping and documentation does not become overly burdensome or removes from the delivery of care.

- There needs to be a move away from the negative connotations associated with accountability to a culture of supportive learning and collective responsibility. Understanding the role of RNs at an intermediary level in delivering this is essential for the nursing profession. Reclaiming a clinical identity would be an opportunity to enhance visibility, support and supervision at point of care. Thoughts should be given to the clinical contribution of the nursing roles beyond point of care. The importance of visibility and engagement with RNs at point of care with senior RNs to develop trust, and support has the potential to diminish the sense of anticipated blame.
- Understanding how multi-disciplinary teams (MDT) can be enabled to build relationships based on trust and support may help to address perceptions lack of fairness and collective responsibility for care. Attention needs to be given to how MDTs interact regarding education, adverse events, complaints and collective responsibility for care.
- ENDS should give consideration to how they can normalise RNs 'offering an account' relating to point of care clinical decisions and the underpinning evidence. There needs to be greater discussion of the factors that impede professional judgement, including tensions between managing the whole system and managing patient care. Making and explaining open reasoned judgements will build confidence in a 'safe space' to support RNs to give an account when the stakes are potentially higher risk.
- RNs must take ownership of their professional responsibility to remain knowledgeable and competent to deliver evidence based practice. Consideration of how RN ownership of knowledge attainment can be enhanced requires exploration. ENDS must consider the long term effects of not protecting CPD for the nursing workforce. Supervision may address both the issue of self -confidence and resilience.
- Although many of the issues raised for practice to consider come with a resource requirement and this may be challenging, moving away from calling nurses by their paygrades is something that would be cost neutral and may address issues of being undervalued.

## Policy

- The context of accountability in health and social care is complex. Policy makers need to consider the multiple accountability relationships that co-exist. Assurance frameworks should be balanced with outcome data, expert narrative and patient and staff feedback.
- In response to ongoing performance and cultural concerns in the NHS there is a risk that more assurance and answerability will drive policy. The importance of balancing political requirement with the sustainability of the NHS workforce through acceptance of professional accountability is important.
- Understanding the issues that impact on the resilience of the nursing workforce should be a policy imperative. Nurturing and developing a workforce that understands how to maintain both emotional and physical resilience is imperative to the sustainability of the NHS.

## Research

- This study extends previous research by exploring not just the 'what' 'but 'how' and 'why' accountability is enacted across the nursing hierarchy and the personal and organisational factors that help or hinder that.
- The contradictions and tensions of accountability in the context of its application to nursing warrants further exploration. Research which includes evaluation of the enduring impact of hierarchical accountability on individuals is also needed to help ensure that individual RNs accountability is recognised and autonomy is not lost at point of care.
- The concept of informal accountability is worthy of further exploration in nursing. This has the potential to make clear the purpose of enacting accountability, where sanctions are the anticipated consequence of 'formal' accountability.
- This study found that offering an explanation rather than being 'called to account' enabled RNs to reflect and enact accountability with a personal benefit for themselves, as a learning and development opportunity. Research is needed in this area and into what was described as the additional accountability demands from the public being a distraction in practice, and often being threatening.

## **8.6 Conclusions**

In conclusion, this study identified that RNs had appropriate knowledge and understanding of accountability. RNs articulated two discourses of accountability task-responsibility and answerability. This study provides valuable insights into the factors that facilitate or hinder nurses accepting accountability. The findings also supports the notion that it cannot be assumed that the purpose and influence of accountability as perceived and experienced by RNs is as the profession intends. Calls for greater accountability need to be cognisant of the complexity of the concept and the perceptions of the nursing workforce. Based on the study findings a model for practice is proposed to enhance accountability to safeguard patient outcomes, quality of care and standards of the profession (Appendix 4). Such a targeted approach needs to be formally evaluated in future research and practice.

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## Appendix 1: Interview and focus group question guide

*How, for what and by whom are registered nurses held to account?*

- What does accountability in nursing mean to you?
- Could you describe to me the professional structure in your organisation?
- Who holds you to account?
- Can you give me examples from practice of what and how you are held to account for instance direct patient care or service delivery?
- What steps do you take to obtain the information you require to be assured about quality of care? For example in your interactions with direct reports, staff members, interactions with patients, your own observations, and the dynamics of the MDT?

*What facilitates or hinders nurses being accountable for safeguarding patient outcomes, the quality of nursing care and standards of the profession?*

- Empowerment, job satisfaction, authority, being valued and autonomy are reported as being positively related to nurses accepting professional responsibility. What supports you to accept professional responsibility?
- Are these important issues monitored and how do you report/ escalate if they are not being achieved?
- Uncertainty and blurring of managerial, medical and nursing roles and responsibilities and the punitive nature of accountability are perceived to influence nurses not accepting professional responsibility. Can you think of any examples of this?
- Can you think of someone that you would feel comfortable to question, if a decision they made put a patient at risk. What is about that person that makes you feel safe to hold them to account?
- Can you think of someone that you would not question, if a decision they made put a patient at risk? What is it about that person that would prevent you holding them to account?
- Can you think of someone that you would feel comfortable to question, if a decision they made or behaviour they displayed made you feel undervalued? What is about that person that makes you feel safe to hold them to account?
- Can you think of someone that you would not question, if a decision they made or behaviour they displayed made you feel undervalued? What is it about that person that would prevent you holding them to account?

*What would be the crucial components of an accountability framework to help assure professional standards of practice and prevent poor care?*

- A number of studies report hierarchical accountability to be disconnected, disproportionately focused on efficiency and performance -do you recognise this description? What from your perspective can be done to enhance communication and focus on quality up and down the professional hierarchy line?
- Given your experiences what would be the crucial components of an accountability framework that would safeguard patient outcomes, quality of care and standards of the profession?

## Appendix 2 a: Participant Information Sheet (PIS) Interview



*A qualitative case study of how mechanisms of accountability are enacted in nursing and how they could be used more effectively as part of professional practice.*

### **Participant Information Sheet (Date: 27/11/17 Version 2) (Interview)**

You are invited to participate in an interview as part of this qualitative case study. Before you decide if you would like to take part, please read the following information that tells you more about what this involves.

#### **Why have I been chosen?**

You have been identified as a Registered Nurse who is part of the nursing hierarchical structure within your organisation that can add valuable data to this study.

#### **Do I have to take part?**

No- this study is entirely voluntary and you do not have to take part. If you do decide to take part, you will be asked to sign the study consent form (copy enclosed). You will be free to withdraw consent at any time, and you do not have to provide a reason for not wishing to continue.

#### **What is the aim of the study?**

This research study aims to explore nurse's experiences and views on how mechanisms of accountability are enacted and how they could be enhanced to safeguard patient outcomes, quality of care and standards of the profession.

Accountability is defined in the following context:-

Nurses and midwives have earned the right to practice autonomously and can evidence professional practice decisions in the context of legislation, professional standards, evidence-based practice and professional and ethical conduct. Accountability is about maintaining that right through demonstrating competencies that safeguard quality patient care outcomes and standards of the profession. (Adapted Krautscheid, 2014)

### **What will be involved if I take part?**

If you do agree to take part, I will interview you. The interview is expected to last about an hour. You will be asked at the beginning of the interview if you have any questions about the study and, with your permission, we will record the interview to ensure that we retain an accurate account of the discussion. If you do not wish the interview to be audio recorded please indicate this to me and omit this part of the consent form. You will also be asked for any relevant documentation that relates to professional accountability in your organisation for example clinical governance documents, quality indicators, appraisal and supervision templates.

### **Will my taking part in this study be kept confidential?**

Our discussion will remain confidential. When I use the information from the focus group in publications and reports, no names will be mentioned. I will ensure that any potentially contentious views will not be attributable to the individual. Data will be stored on the secure University of Stirling Box drive. One database will be created and will contain your name, email address and telephone number. This personal data will only be accessed by me and will be destroyed 3 months after collection. Anonymised transcripts of the recordings will be saved for a period of 10 years on the University of Stirling secure Box drive to ensure accurate reporting in any future publications.

### **Why should I take part in the study?**

Your views are important to finding on how mechanisms of accountability are enacted and how they could be enhanced to safeguard patient outcomes, quality of care and standards of the profession.

This data will contribute to the development of an accountability framework to guide and inform professional practice.

### **What will happen to the results of the study?**

The results from the interviews will be used by me, sponsored by the University of Stirling. Anonymised information will be shared with my academic supervisors. I will also submit findings for publication in academic journals.

### **Would you like more information?**

More information about the study is available from Caroline Hiscox, Doctoral Student at Stirling University. Telephone 07482393990, email [caroline.hiscox@stir.ac.uk](mailto:caroline.hiscox@stir.ac.uk)

The contact details for my academic supervisors are: Dr Patricia Thomson, telephone 01786473171, email [patricia.thomson@stir.ac.uk](mailto:patricia.thomson@stir.ac.uk) and Dr Joyce Wilkinson, telephone 01786466364, email [j.e.wilkinson@stir.ac.uk](mailto:j.e.wilkinson@stir.ac.uk)

If you would like to speak with someone independent of this study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences and Sport (University of Stirling) email [jaynedonaldson@stir.ac.uk](mailto:jaynedonaldson@stir.ac.uk)

## Appendix 2 b: Participant Information Sheet (PIS) Focus group



*A qualitative case study of how mechanisms of accountability are enacted in nursing and how they could be used more effectively as part of professional practice.*

### **Participant Information Sheet (Date: 27/11/17 Version 2)**

#### **(Focus Group)**

You are invited to participate in a focus group as part of this qualitative case study. Before you decide if you would like to take part, please read the following information that tells you more about what this involves.

#### **Why have I been chosen?**

You have been identified as a Registered Nurse who is part of the nursing hierarchical structure within your organisation that can add valuable data to this study.

#### **Do I have to take part?**

No- this study is entirely voluntary and you do not have to take part. If you do decide to take part, you will be asked to sign the study consent form (copy enclosed). You will be free to withdraw consent at any time, and you do not have to provide a reason for not wishing to continue.

#### **What is the aim of the study?**

This research study aims to explore nurse's experiences and views on how mechanisms of accountability are enacted and how they could be enhanced to safeguard patient outcomes, quality of care and standards of the profession.

Accountability is defined in the following context:-

Nurses and midwives have earned the right to practice autonomously and can evidence professional practice decisions in the context of legislation, professional standards, evidence-based practice and professional and ethical conduct. Accountability is about maintaining that right through demonstrating competencies that safeguard quality patient care outcomes and standards of the profession. (Adapted Krautscheid, 2014)

### **What will be involved if I take part?**

If you do agree to take part, you will be asked to attend a focus group meeting on (XXXXXX) which is expected to last 1 ½ hours. The focus group will be attended by fellow participants who do the same role as you. You will be asked at the beginning of the focus group if you have any questions about the study and, with your permission, we will record the focus group to ensure that we retain an accurate account of the discussion. You will also be asked for any relevant documentation that relates to professional accountability in your organisation for example clinical governance documents, quality indicators, appraisal and supervision templates.

### **Will my taking part in this study be kept confidential?**

Our discussion will remain confidential. When I use the information from the focus group in publications and reports, no names will be mentioned. I will ensure that any potentially contentious views will not be attributable to the individual. Data will be stored on the secure University of Stirling Box drive. One database will be created and will contain your name, email address and telephone number. This personal data will only be accessed by me and will be destroyed 3 months after collection. Anonymised transcripts of the recordings will be saved for a period of 10 years on the University of Stirling secure Box drive to ensure accurate reporting in any future publications.

### **Why should I take part in the study?**

Your views are important to finding on how mechanisms of accountability are enacted and how they could be enhanced to safeguard patient outcomes, quality of care and standards of the profession.

This data will contribute to the development of an accountability framework to guide and inform professional practice.

### **What will happen to the results of the study?**

The results from the interviews will be used by me, sponsored by the University of Stirling. Anonymised information will be shared with my academic supervisors. I will also submit findings for publication in academic journals.

### **Would you like more information?**

More information about the study is available from Caroline Hiscox, Doctoral Student at Stirling University. Telephone 07482393990, email [caroline.hiscox@stir.ac.uk](mailto:caroline.hiscox@stir.ac.uk)

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If you would like to speak with someone independent of this study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences and Sport (University of Stirling) email [jayne.donaldson@stir.ac.uk](mailto:jayne.donaldson@stir.ac.uk)

## Appendix 3: Participant consent form



*A qualitative case study of how mechanisms of accountability are enacted in nursing and how they could be used more effectively as part of professional practice.*

### Consent Form (Date: 27/11/17 Version 2)

**Participant copy**

**Researcher copy**

**Site file copy**

**Researcher: Caroline Hiscox**

1. I confirm that I have read and that I understand the Participant Information Sheet (09/10/17, version 2) for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactory.

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the study period, without giving any reason. If I decide to withdraw from the study before its completion, I understand that my data will not be used.

3. I understand that the data I provide will be depersonalised and that electronic versions of these will be stored on the secure University of Stirling Box drive. One database will be created and will contain my name, email address and telephone number and that only the chief investigator will have access to this. Personal data will be destroyed 3 months after collection.

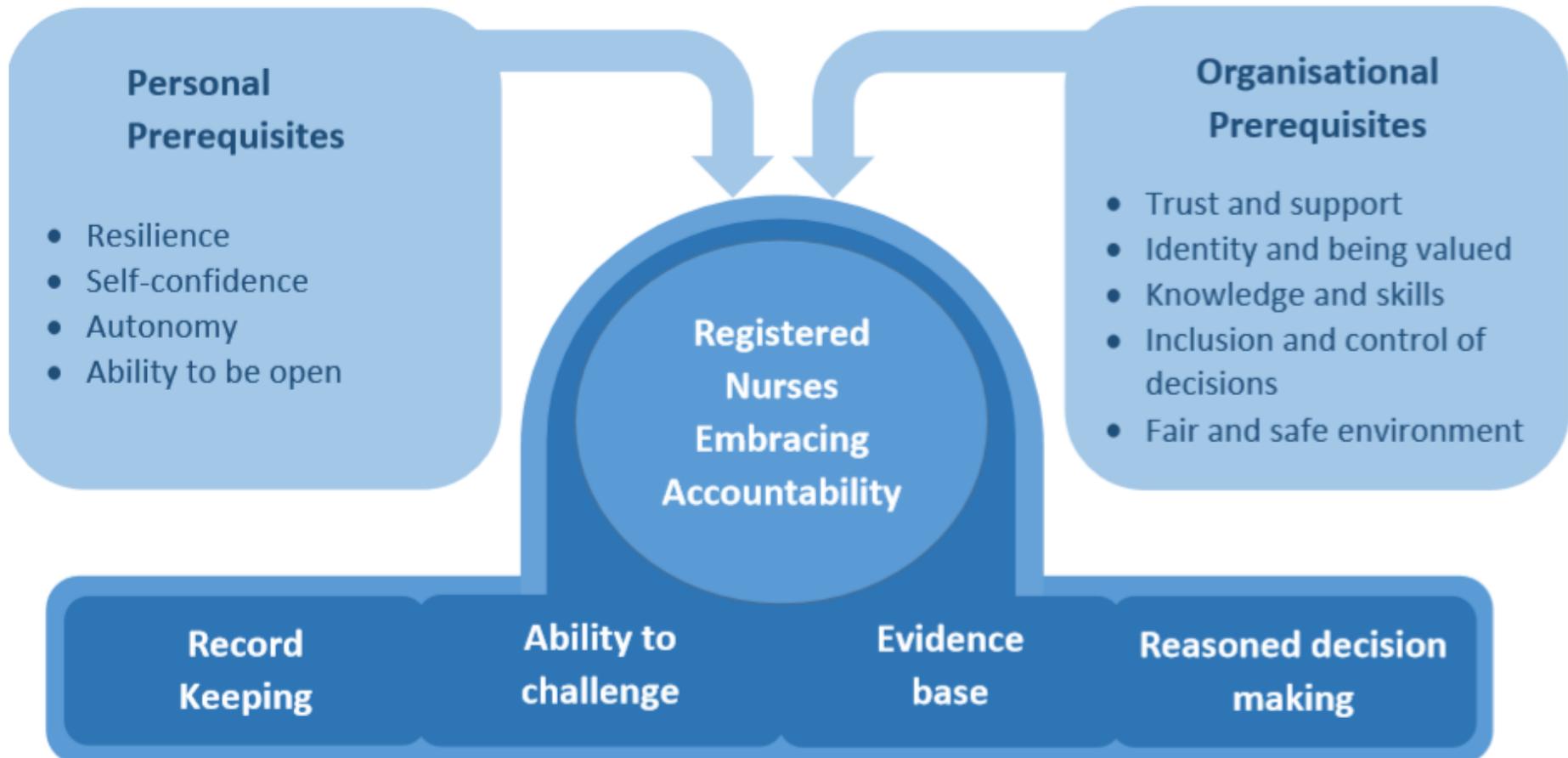
4. I understand that if some of my views are quoted in a report or published papers; this will be done in a way that ensures that I cannot be identified. If this is not possible my permission will be sought or my quotes will not be used. We will ensure that any potential contentious views will not be attributed to individuals.

5. I understand that, subject to my permissions, the interview will be recorded for the purpose of the study and that any recordings will be destroyed at the end of the study. Anonymised transcripts of the recordings will be saved on securely for a period of 10 years to ensure accurate reporting in any future publications.



Model for Practice: Enhancing accountability to safeguard patient outcomes,  
quality of care and standards of the profession

### Making open reasoned judgements with confidence



## **Appendix 5: Draft publication: International Journal of Nursing Studies**

### **Title: A systematic scoping review of accountability research in nursing**

#### **Abstract**

*Objectives:* Accountability on nursing is under examined in the literature. This review focused specifically on nursing literature to gain clarity on studies about accountability in nursing; to help develop an in-depth understanding of how accountability has emerged within this field, and with what purpose.

*Design:* A scoping review was conducted to identify the research literature available in order to map contextually relevant, existing research on accountability that could be used both in practice and to identify further research potential.

*Data:* Initially one database, CINAHL was searched. Following the initial search of CINAHL further searches were conducted in MEDLINE, PsycINFO, Cochrane Library and EMERALD using the same search strategy.

*Results:* Twenty four research studies and one systematic review were identified. Two papers were based on the same research study. Nine studies originated from the United States, four from the United Kingdom, four from Canada, four from Israel, one from Finland, two from Australia and one from New Zealand. The majority of research studies adopted a qualitative approach (n=15), which included a range of methods: individual interviews, focus groups, vignettes, participant observations, case study, ethnography, grounded theory and discourse analysis. Mixed methods were identified in one paper (Surakka 2008). Eight quantitative studies were identified, three of which used the Specht and Rambler Accountability Index (1996) to measure accountability. The only other tool identified to measure accountability was reported by Drach-Zahavy et al. (2018) who used a three –stage validation study to develop and evaluate a three dimensional questionnaire.

*Conclusions:* There is a lack of empirical research relating to the concept of accountability in nursing. Accountability has been studied in a variety of ways depending on the researcher's methodological preferences and definition of accountability. A number of studies fail to make a distinction between accountability and responsibility and continue to use the terms interchangeably. Most research has emerged from out with the UK and it has studied individual nurses or peer groups. Accountability is reported as being poorly understood by nurses. Two main discourses of accountability in nursing were found: personal virtue and answerability. Studies report accountability to be disconnected, disproportionately focused on efficiency and performance, and it is a negative retrospective way to apportion blame and enact control. Empowerment, support, job satisfaction, authority and autonomy are positively related to

nurses accepting professional responsibility. Uncertainty and blurring of managerial, medical and nursing roles and responsibilities and the perceived punitive nature of accountability are said to influence nurses not accepting responsibility. Mechanisms of accountability underpinning professional practice, clinical governance, and care assurance are largely unreported in the literature. How accountability is enacted in professional hierarchical structures is unreported.

## **1. Introduction**

Accountability on nursing is under examined in the literature. This review focused specifically on nursing literature to gain clarity on studies about accountability in nursing; to help develop an in-depth understanding of how accountability has emerged within this field, and with what purpose.

Scoping review methodology was selected in contrast to other review typologies that address more specific and narrowly focused research questions. A scoping review can map the key themes that emanate from the research as well as working to clarify definitions and conceptual boundaries (Joanna Briggs Institute 2015; Munn et al. 2018). An initial literature review was conducted between November 2015 and September 2016. An additional search was conducted in December 2018 to update this review and to ensure the inclusion of up to date publications.

## **2. Methodology**

Scoping reviews are useful for examining emerging evidence when it is still unclear what other, more specific questions can be posed and valuably addressed (JBI 2015). A scoping review was done to identify the research literature available in order to map contextually relevant, existing research on accountability that could be used both in practice and to identify further research potential. The scoping review framework designed by the Joanna Briggs Institute (JBI 2015) contains the following six stages: developing the title, objective, and question; background; inclusion criteria; search strategy; extraction of results and presentation of results. The six stages of the framework provide the reporting structure for this review and summary of evidence. It is considered a rigorous and transparent methodology for reviews to ensure that the results trustworthy (Munn et al. 2018).

### **2.1 Stage 1: Developing the title, objective, and question**

The mnemonic PCC: Population, Concept and Context was used to focus the title of the review to allow easy identification of the type of paper it represents (JBI 2015). The population is Registered Nurses (RN) and, accountability is the concept being explored in the context of

health and social care. The question to guide this scoping review was, 'How has Registered Nurse accountability been researched and reported?'

## **2.2 Stage 2: Background**

Professional accountability has been shaped by social norms and involves the development of a social consensus about what is considered as good and acceptable performance (Day & Klein 1987). This still holds today although the context of societal expectations, the nursing profession and healthcare provision have changed significantly. Increased public, political and professional calls for greater accountability have repeatedly been made in response to failures in care, as a means to assure the safe and effective performance of healthcare systems (Francis 2013; Maclean 2014; HIS 2014). Despite these calls for increased accountability there is little know about the impact of accountability on individual or healthcare organisational behaviours.

The professional discourse of accountability underpins safe practice, supporting congruence between nursing actions and standards of care (Shultz 2009). Although accountability is synonymous with professionalism it is also reported in the wider accountability literature as having both constructive and deleterious consequences (Hall et al. 2015). It is apparent from clinical practice, policy and the literature that accountability is important to the nursing profession. Despite this there is no clear consensus about what accountability means for nursing, how it is perceived and how it is demonstrated, in particular how lines of accountability can assure professional standards of practice and prevent poor care.

Prior to conducting this review a preliminary search of the following databases, MEDLINE, CINAHL, The Cochrane Library and Google was undertaken. No existing systematic reviews on this topic were identified. This review was therefore conducted in order to present an evidence-based conceptualisation of nursing accountability that could be used in both future research and in practice.

## **2.3 Stage 3: Inclusion Criteria**

Defining the inclusion criteria, was an iterative process and followed the recommendations of Arskey and O'Malley (2005). This approach enabled decisions to be made once some sense of the scope and volume of the literature was gained.

The framework of Population, Concept and Context (PCC) (JBI 2015) was used to articulate the topic criteria on which papers were would be included or excluded from the review.

Inclusion criteria:

- Population: Registered Nurse at all levels and specialties

- Concept: Nursing accountability and/or social responsibility as both are used interchangeably as - the main context of the article; as the main predictor variable; or as the main outcome.
- Context: Health and social care sectors (public and private), acute care, primary care, mental health, community care, UK and Worldwide
- Primary research and systematic reviews

Exclusion criteria:

- Population: Student Nurses; Midwives; Health Care Support Workers; other professions
- Concept: Patient accountability; Public accountability
- Context: Non healthcare environments
- Theoretical, expert opinion, concept, framework and scholarly papers.

## **2.6 Stage 4: Search strategy**

Prior to conducting the review a preliminary search of the following electronic databases, MEDLINE, CINAHL and The Cochrane Library for existing reviews of accountability in nursing was undertaken in 2015 to identify the terminology used in reporting this concept. The volume of literature relating to nursing and accountability was identified as high. The scope of topics related to accountability was also recognised to be wide. Initially one database, CINAHL was searched. Although this does not reflect the JBI methodology, which states two databases should be searched, it was considered reasonable as a first step. In addition, to mitigate the risk of bias in the identification of key terms related to accountability, a group of five nurse consultants and four chief nurses were asked to identify the concepts that they felt were related to accountability. Both groups were asked to separately 'brain storm' on a flip chart the concepts that they thought of when considering accountability. During interactions with numerous Senior Charge Nurses (SCNs) and RNs delivering direct care, I took the opportunity to ask them what they thought about accountability. This helped inform the choice of terms and combination of terms, as presented in Table 2.

Following the initial search of CINAHL further searches were conducted in MEDLINE, PsycINFO, Cochrane Library and EMERALD using the same search strategy. Boolean operators were used to maximise the penetration of terms identified and 'wild cards' to capture plurals and variation in spelling. Non English language papers were included in the original search. Where these were identified it was determined if they were seminal pieces of work that required to be translated for inclusion. This was done by hand searching papers in English to ensure any content was not missed, if important. No papers required to be translated

following this process. No date exclusions were applied to the search as accountability has been an underpinning concept for nursing since the passing of the Nurses' Registration Act in 1919, when nurses in the UK achieved the status of an accountable profession. The King's Fund, Royal College of Nursing and Nursing and Midwifery Council organisations were also contacted and asked for research relating to nursing and accountability. This produced one additional study (Savage and Moore 2004) that met the inclusion criteria.

Table 2 – Extract of search strategy used in CINAHL (as at December 2018)

<b>Search #</b>	<b>specific term</b>	<b>no. of results</b>
1	nursing	641,576
2	accountability or social responsibility	16,216
3	1 AND 2	3,794
4	decision making	92,349
5	3 AND 4	306
6	behaviour	17,815
7	3 AND 6	13
8	professionalism	5642
9	empowerment	10,989
10	3 AND 8	95
11	3 AND 9	111
12	quality	109, 776
13	3 AND 12	429
14	hierarchy	3,400

15	3 AND 14	7
16	shared/clinical governance	2912
17	3 AND 16	86
18	scapegoating/blame	3274

The process of refining the literature search strategy was conducted in phases over a period of ten months. Initially, a final date of the 1<sup>st</sup> Sept 2016 was set for concluding the search but this was extended until December 2018. All papers that identified nursing accountability and/or social responsibility were reviewed for relevance. The search generated thousands of bibliographic references which needed to be appraised for inclusion in the final review. A combination of EBSCO, REFWORKS and paper files were used to manage these references.

The completed search identified 5205 papers in total. The selection process is summarised using a Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) diagram, as presented in Figure 1.

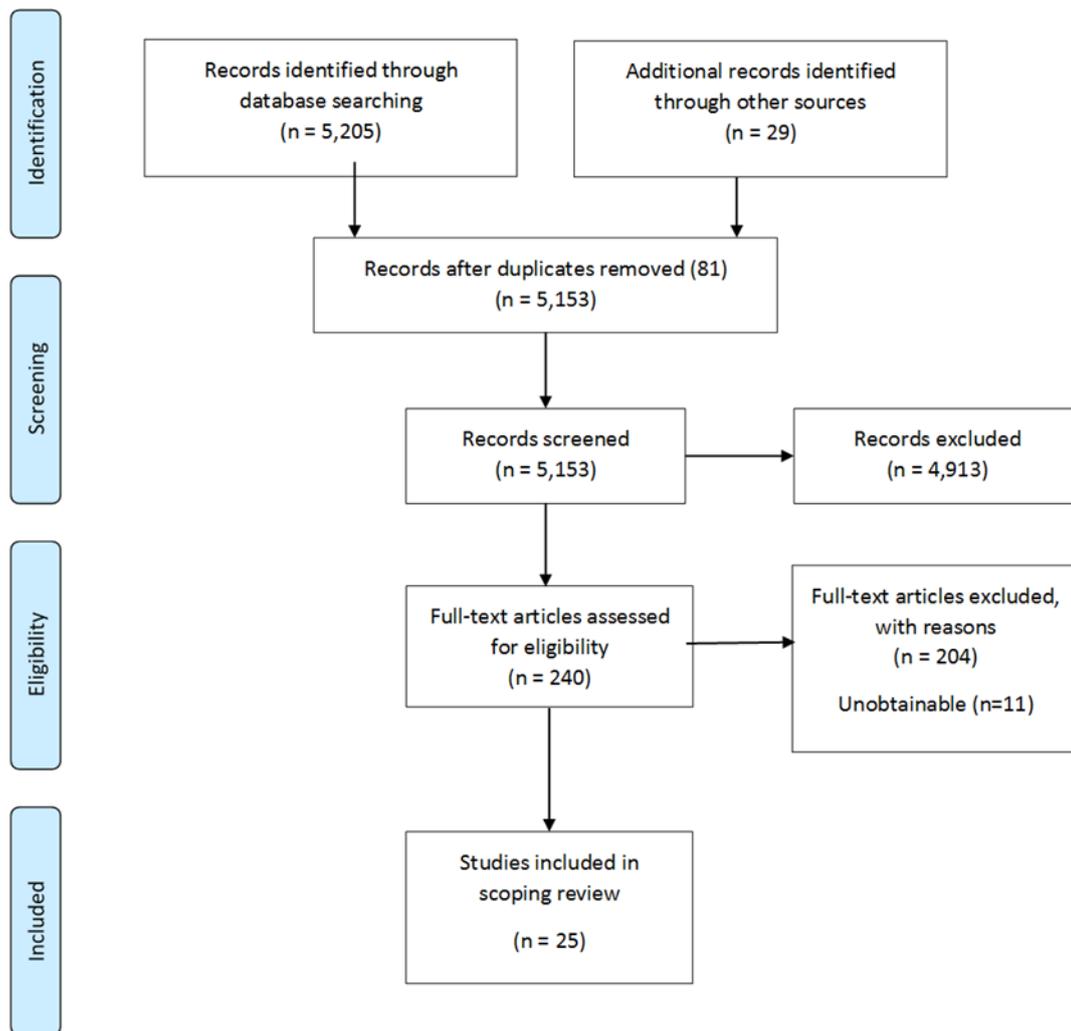


Figure 1- Screening and Identification of Papers for Inclusion Flow Diagram (PRISMA 2009)

Following removal of duplicates, 5153 titles and abstracts were reviewed for relevance. Applying the inclusion and exclusion criteria at the stage of reviewing titles and abstracts was challenging as many papers did not have abstracts or the abstracts were vague. This led to a significant number of papers being read in full to ensure articles were not excluded inappropriately. Following this review stage 4193 articles were excluded. A large number of articles were excluded as initial reference to accountability/ or social responsibility in the abstract only related to the introduction of the article and accountability was not the main concept, variable or outcome in the article; accountability being discussed related to the organisation or the public/ patients, not nursing; articles such as editorials were excluded.

A total of 240 articles were identified as suitable to assess full text for eligibility. Despite a number of approaches to source these studies, 11 were unobtainable. Theoretical, expert opinion, concept, framework and scholarly papers were excluded as the purpose of the scoping review was to map previous research undertaken in this field. Following a full text

review and application of the inclusion/ exclusion criteria, 25 studies were selected for inclusion in the scoping review. Reference lists of empirical research and systematic review papers were reviewed by hand to ensure all relevant papers were considered. No new studies that met the inclusion criteria were identified.

## **2.7 Stage 5: Extraction of results**

To enable a logical and descriptive summary of the results, data were extracted using the following key headings:

- A. Author(s), Year of publication and Title of publication
- B. Country of origin
- C. Study sample/population
- D. Aim
- E. Main construct of accountability
- F. Methodology
- G. Key findings

Although there is an imperative for clarity of the concept being investigated for any study not all studies clearly reported this. Despite this, the way in which accountability was constructed and investigated could be identified from the overall paper. For the purpose of this review, the main construct(s) of accountability was included as a data extraction heading.

## **2.8 Stage 6: Presentation of results**

In total, 25 studies were included in this scoping review. The main limitation of the studies reported was the trustworthiness of the data. This related to a lack of outcomes; and lack of methodological and analytical detail contained within the published reports. The 25 studies retrieved were published between 1982- 2018. Twenty four research studies and one systematic review were identified. Two papers were based on the same research study. Nine studies originated from the United States, four from the United Kingdom, four from Canada, four from Israel, one from Finland, two from Australia and one from New Zealand.

The majority of research studies adopted a qualitative approach (n=15), which included a range of methods: individual interviews, focus groups, vignettes, participant observations, case study, ethnography, grounded theory and discourse analysis. Mixed methods were identified in one paper (Surakka 2008). Eight quantitative studies were identified, three of which used the Specht and Rambler Accountability Index (1996) to measure accountability. The only other tool identified to measure accountability was reported by Drach-Zahavy et al.

(2018) who used a three –stage validation study to develop and evaluate a three dimensional questionnaire.

Following tabulation of the extracted data (using the headings identified in stage 5) it was possible to group the papers. With the exception of one study, which was the development of an evaluation tool (Drach-Zahavy et al. 2018) the studies were grouped according to definitions of accountability (Batey and Lewis 1982; Lewis and Batey 1982; Krautscheid 2014) n=3; those that explored, examined or reported accountability as a finding (Mitchell 2001; Robertson et al. 2010; Surakka 2008; White et al. 2015; Cohen et al. 1994; Koerber- Timmons 2014; Choiniere 2011; Sorensen and Iedema 2010; Manuel and Crowe 2014; Young 1999; Luhanga et al. 2010; Savage and Moore 2004; Semper et al. 2016; and Leonenko and Drach-Zahavy 2016) n= 13; and studies that reported the impact of specific variables on accountability (Hughes et al. 2015; Nolan et al. 2010; Laschinger and Wong 1999; Sorensen et al. 2009; Boni 2001; Rashkovits and Drach-Zahavy 2017; Srulovici and Drach-Zahavy 2017) n=8.

### **2.6.1 Defining accountability**

Three papers, two of which pertained to the same study, defined the concept of accountability Batey and Lewis (1982), Lewis and Batey (1982) and Krautscheid (2014) as summarised in Table 3. Lewis and Batey (1982) proposed a structural definition of accountability. Within their study, Nurse Directors defined accountability as a personal commitment or personal disposition as well as a structural mechanism however, the authors did not include that dimension in their definition. This limited the potential that professional accountability presents to a structural definition. In Krautscheid's (2014) definition, this personal discourse is contextualised to nursing as a professional responsibility. Within their construct of structural accountability, Batey and Lewis (1982) acknowledge the influence of organisational control and power that is inferred by the Nurse Directors and the potential impact this may have on nurses suggesting that accountability could both perform the role of containing nursing practice and be used as a system of control and punishment. The authors provide very little/no information about their methodological approach to data collection, analysis or literature searching, impacting on the credibility of the work.

Thirty years on, a literature review was published which synthesises commonly occurring language and related concepts, to define professional nursing accountability (Krautscheid 2014). This included 19 primary and secondary articles that defined professional accountability in nursing. This definition, "taking responsibility for one's nursing judgements, actions, and omissions, as they relate to lifelong learning, maintaining competency and upholding both quality patient care outcomes and standards of the profession while being

answerable to those who are influenced by one's nursing practice" (Krautscheid 2014 p. 46) which encompasses both the concept of professional responsibility and accountability, inferring that by being responsible you have to be accountable. Both studies consider the concepts of accountability and responsibility to exist on a continuum and that to be accountable you must have the responsibility, authority and autonomy. This research moves beyond the concept of hierarchical accountability and of being called to account, towards a recognition of the contemporary requirements for professionals to offer an account to enable transparency and candour with patients, families and peers.

Table 3- Summary of studies with the aim of defining accountability

Author(s); Year of publication; Title of publication	Country	Study sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key findings
(Batey and Lewis 1982)  Clarifying Autonomy and Accountability in Nursing Service: Part 1	US	n= 12  Nurse Directors in selected small hospitals (200 beds) in the Pacific Northwest.	As part 1 of a 2 part series this report aims to gain conceptual clarity of autonomy and accountability.	Main focus is antecedents and consequences of attitudinal and structural accountability	Results from an initial systematic literature review of accountability and interview responses of 12 nurse directors provided empirical illustrations to extend conceptual development.	The principle antecedents to accountability are responsibility, authority and autonomy.  The main consequence of autonomy is accountability. Analysis of the interview data suggests that the degree of autonomy manifested by nursing departments is related inversely to the extent to which the decisions affect others.  Interview data suggested organisational and individual factors influenced nurse's ability to practice autonomously. The socialisation of nurses was found to increase willingness to use autonomy. Further research is required to assess the relation between information flow and autonomy
(Lewis and Batey 1982)  Clarifying Autonomy and Accountability in Nursing Service: Part 2	US	n= 12  Nurse Directors in selected small hospitals (200 beds) in the	To achieve greater conceptual clarity about autonomy and accountability.	Main focus is structural accountability	Results from an initial systematic literature review of accountability and interview responses of 12 nurse directors provided empirical illustrations to extend conceptual development	Developed the definition of accountability as: The fulfilment of a formal obligation to disclose to referent others. Disclosure occurs so that decisions and evaluations can be made and reckoning carried out. Verbal and written forms of accountability were described- except for budgets accountability was informal.

		Pacific Northwest.				Accountability could be used prospectively, retrospectively or intermediate. The interview data suggested that accountability structures were represented by patterns of disclosure. In cases of violations to a quality assurance plan nurse had to produce a report to deal with it. Recounting reduces autonomy and authority. The most common synonym for accountability was responsibility. The blurring of accountability and control structures is acknowledged and the negative impact of accountability as systems of punishment. Hierarchical accountability – the buck stops here.
(Krautscheid 2014)  Defining Professional Nursing Accountability: A literature Review	US		To provide a reliable and comprehensive definition of professional nursing accountability derived from a synthesis of the literature	Responsibility and answerability	Systematic review of the literature	Professional nursing accountability will be defined as taking responsibility for one's nursing judgements, actions, and omissions and how they relate to lifelong learning, maintaining competence and upholding both quality care outcomes and standards of the profession while being answerable to those who are influenced by ones nursing practice 11 of the 19- responsibility for actions; 8 of 19 responsible to self and others who are influenced by ones actions; omissions; lifelong learning, quality of patient care upholding professional standards were themes that emerged.

### **2.6.2 Exploring accountability**

Thirteen studies explored, examined or understood accountability or reported accountability as a finding were included in this review (Choiniere 2011; Cohen et al. 1994; Leonenko and Drach-Zahavy 2016; Luhanga et al. 2010; Manuel and Crowe 2014; Mitchell 2001; Robertson et al. 2010; Savage and Moore 2004; Semper et al. 2016; Sorensen and Iedema 2010; Surakka 2008; White et al. 2015; and Young 1999) (Table 4). The synthesis of these papers enabled the findings to be categorised and presented into two broad groupings: accountability and responsibility; and nursing disinclined or unable to accept professional responsibility.

#### **Accountability and responsibility**

Savage and Moore (2004) explored how accountability was understood within one clinical team in general practice. The authors reported the understanding of accountability to be confused with participants describing the concept as both a retrospective way of apportioning blame and as something that can motivate good practice. It was also used to describe relationships. The authors proposed that the concept of accountability was 'elusive and ambiguous' in practice and recommended the need for a joint regulatory body statement from the General Medical Council and the Nursing and Midwifery Council to aid clear understanding across medical and nursing professions. The conflation of accountability and responsibility was stated as a limitation of the study. Savage and Moore (2014) identified the difficulty in numerous conversations about accountability as participants talk about their accountability but shift towards the use of the word responsibility. The tendency to use the terms interchangeably was unnoticed by the practice team and it was so subtle that at times it also went unnoticed by the researchers. Both concepts were commonly associated and at times presented as virtually synonymous in the literature.

Two other studies provide explicit examples of the conflation of accountability and responsibility (White et al. 2008 and Surakka 2008). White et al. (2008) recorded accountabilities of RNs to include patient assessment, administering medication, and personal care. The results indicated that the greatest proportion of time was spent on documentation and information review (20.9% and 21.4 %) rather than direct care delivery. Accountability is similarly conceptualised by Surakka (2008) as being at the heart of the nurse manager role. Results from this study indicated four domains: responsibility activities; accountability activities; understanding nursing practice; and outcome orientation, which were then used for the proposed leadership model for nursing management. Although this model links both the concepts of responsibility and accountability, it fails to acknowledge that one concept cannot exist without the other.

In a study to understand bedside nurses and nurse managers' perceptions of accountability and enablers of accountability behaviours (Leonenko and Drach-Zahavy 2016) nurses described accountability, more particularly responsibility, as critically important for the nursing profession and strongly associated with the quality of patient care. Accountability was considered as a personal attribute and although discussed as a positive concept this was only in the context of responsibility and, not transparency and answerability. Choiniere (2011) identified that restructuring and integrating units had resulted in an increased managerial accountability. This resulted in a loss of mentoring and advocacy support which was reported to be deeply missed by nurses delivering direct care.

### **Nursing disinclined or unable to accept professional responsibility**

This review found that nurses were sometimes disinclined or unable to take on the responsibility that has been claimed by the profession. A number of causes for this emerged including: different perceptions of responsibility; blame avoidance; clinical responsibility as something to be avoided; uncertainty linked to professional accountability; and hiding behind the complexity of accountability relationships with medical and managerial colleagues (Mitchell 2001; Savage & Moore 2004; Choiniere 2011; Cohen et al. 1994; Young 1999). For example Cohen et al. (1994) found patients viewed nursing as a task orientated workforce that were rarely observed to practice as autonomous, responsible professionals. Similar findings emerged from qualitative study by Mitchell (2001) who found a lack of RNs knowledge in relation to legal accountability and a preference to defer responsibility and blame onto others, mainly managers and medics, rather than accept their responsibility in relation to the law. Manuel and Crowe (2014) also identified that nurses attempt to shift responsibility and use defensive practice to avoid blame. This study of mental health RNs found that clinical responsibility was viewed as something to be avoided rather than a professional privilege, and record keeping was used as the mechanism to shift responsibility to medical or managerial staff. Cohen et al. (1994) identified nurses reporting both seeing staff provide unsafe care and seeing the results of inadequate care and not challenging these staff members, although some said they "ought" to discuss these incidents with the people involved.

Subtle inferences that nurses find it difficult to define what they are responsible for and therefore, accountable for were made by several authors. Surakka (2008) reported that nurses were relied upon to fix every problem from clinical issues to plumbing and engineering- and they did...find the solutions. This suggests that greater clarity is required on what nurses are responsible for and what that focus should be. Similarly, Young's (1999) identified the complexity of accountability and conflict experienced by managers (from a nursing background) trying to deal with system flow from a perspective of budget silos. The authors highlight the conflict of professional accountability for individual patient care and accountability

to the employer for utilitarianism and the system. The participants in the study by Young (1999) acknowledged that their responsibility for the system compromised high quality care at an individual level and potentially compromised the position of nurses responsible for care delivery.

The orientation of nurses to accountability as an outcome was identified in two studies. For example Koerber-Timmons (2014) explored nurse educators' perceptions of issues and strategies related to teaching effective patient care documentation. 'Internalising' accountability emerged as the core category. A new theory with four competency levels of accountability in practice emerged to include sub-themes (a) progressing levels, (b) reflecting on conflicting roles of nurse educators, (c) accepting transitioning, and (d) engaging and empowering through leadership. This theory of internalising of accountability offers a potential opportunity to consider the different levels of professional responsibility at which nurses' practice. Further, Robertson et al. (2010) explored how RNs deployed discursive strategies to deal with unspoken professional concerns around the events leading to a patient suicide. In this study the words accountability, blame and responsibility were never articulated, only alluded to. The authors concluded that the nurses' orientation to accountability simply serves to reinforce the professional and political discourse of control.

Table 5 - Summary of studies that aimed to explore accountability

Author(s); Year of publication; Title of publication	Country	Study sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key Findings
(Surakka 2008)  The nurse managers work in the hospital environment during the 1990s and 2000s: responsibility, accountability and expertise in nursing leadership.	Finland	n= 155  Nurse managers working across a range of Finnish hospitals	To describe and compare characteristics of nurse managers work in different hospital environments at different times	Accountability as a professional behaviour and as responsibility	Longitudinal study Triangulation of qualitative and quantitative content analysis of diary and focus group data	A leadership model was proposed that differentiates accountability and responsibility activities in leadership.  Definitional guidance was not provided.  The nurse manager work was themed as responsibility activities such as organising, cooperating and communicating, it was felt that such activities could be delegated or postponed; supporting staff, assuring skills and developing performance were identified as accountability - related activities. These were described as activities that could not be delegated and require the nurse manager to be available at all times. In addition to responsibility and accountability activities direct and indirect care were included.  Accountability and responsibility were reported as different tasks not on a continuum.
(White et al 2015)  The examination of nursing work through a role accountability framework	Canada	n=35 RN n= 17 HCA  A convenience sample of RNs and HCAs on 2	To describe the amount of time RNs spend on key clinical role accountabilities and other work activities	Responsibilities ie patient education described as accountabilities	Qualitative  1:1 observations Activities captured using the palm pilot Function analysis	This study identified that RNs spent considerable time on bio medical assessment and relatively little time on other aspects of care and considered the role of Licensed Practical Nurses (LPN)  The data were categorized according to clinical role accountabilities. The data indicated that RNs spent greatest time on documentation and information

		medical wards in large teaching Calgary hospital.	through work analysis data.			review; individual nursing interventions and medications were next and then least time was spent on psycho- social- cultural –spiritual assessment and support. The coordination role of the RN was more within the discipline of nursing than with other professionals. Claimed to be unique in its consideration of RN roles using an accountability framework- the framework used was not identifiable.
(Cohen et al 1994)  Knowledge and Presence: Accountability as Described by Nurses and Surgical Patients	US	n= 24 ( of each) patients and nurses	For informants to discuss what was important to them related to a recent surgical intervention and hospitalisation	Knowledgeable, competent practice is a hall mark of professional accountability.	Phenomenological study. Interviews conducted 24-48 hours after discharge	The nurses in this study did not meet the expectations of their regulatory code in relation to knowledge and presence and thus make accountable practice difficult if not impossible.  Perceptions of patients and nurses of 2 major elements of accountability were knowledge and presence, although the focus on categories within these differed.  Key factors to enable accountable practice were identified as individual patient knowledge, professional knowledge, teaching/providing information/ leadership.  Some nurse explored what they would do to get this knowledge others made no attempt to gain core information such as patient history and diagnosis.  Barriers such as staffing, equipment and time were identified as preventing nurses speaking with patients or reading charts.  Education was discussed equally often by nurses and patients. Nurses focused on the structures,

						<p>process and barriers. Patients focussed on the outcomes.</p> <p>Nurses discussed both seeing other staff provide poor care and seeing the impact of inadequate care. Very few confronted staff. Many felt they lacked credibility with patients.</p>
<p>(Mitchell 2001)</p> <p>A qualitative study exploring how qualified mental health nurses deal with incidents that conflict their accountability</p>	UK	n= 23 nurses who were undertaking a professional studies module	To explore how qualified mental health nurses deal with critical incidents that conflict with their accountability	Accountability as answerability to multiple fora ( NMC, law, public, employer) and as personal accountability	<p>Qualitative: new paradigm research</p> <p>By using written critical incidents nurses were able to describe incidents that were important to them and were able to write them down in their own time.</p>	<p>From the data analysis the majority of conflict is between doctors and nurses. The impact of this affects the nurse -patient relationship.</p> <p>Patient aggression and lack of support from the nurse manager and medical colleagues led to the adverse events. This was further impacted by the nurse's lack of knowledge about their legal accountability. The main learning points from the critical incident were a requirement for roles and responsibilities to be clear and the relationship with accountability.</p> <p>The author identified that education was required and the nurses identified team support, clinical supervision and debriefing as helpful. Nurses are unsure of their responsibilities, in particular in relation to legal responsibilities.</p> <p>Clinical supervision and debriefing; team support and education will all enhance accountability</p>
<p>(Robertson et al 2010)</p> <p>Accounting for Accountability: A Discourse Analysis of Psychiatric</p>	UK Scotland	n=2 Registered Mental Health Nurses	Explore how RNs construct and orientate to accountability when talking of the	Giving an account / transparency	Discourse analysis of interview data	<p>The word accountability was never used by the nurses however discourse analysis has identified that the nurse's stories are orientated to accountability and therefore inferring that accountability is an important issue for them. Accountability is accepted and is considered a burden to nursing</p>

Nurses Experience of a Patient Suicide			experiences of a patient suicide.			Internalising accountability in relation to suicide may feel like blame.
(Choiniere 2011)  Accounting for Care: Exploring Tensions and Contradictions	Canada	n= 63 RNs	Examine nurses accountability (1997-2001) related experiences with the managed care reforms and to more clearly expose and understand the tensions and contradictions	Discusses both accountability as a mechanism of control and as a professional value	Qualitative Interviews and focus groups	<p>The majority of RNs report that managed care changes to their practice environments are interfering with their ability to provide quality patient care rather than enhancing accountability; They report a dramatic rise in stress levels; the merging of units has reduced access to managers and a change from nurses managing nurses has resulted in reduced supervision, advocacy and mentorship. Nurses describe how the focus of nurse managers is no longer on the nurse patient relationship.</p> <p>The introduction of rationalising technologies such as tick charting and standard reporting forms moves nurses from the patient toward the administrated functioning of the unit. Instead of the espoused greater autonomy and accountability nurses are suffering a deepening disconnect with their ability to demonstrate accountability for patient care.</p>
(Sorensen and Iedema 2010)  Accounting for health-care outcomes: implications for intensive care unit practice and performance	Australia	n=15 clinical managers and n=29 nurses	To understand the environment of healthcare, and how clinicians and managers respond in terms of performance accountability	Responsibility for performance	Qualitative Interviews, focus groups	<p>Good communication and MDT process was described as contributing to patient care- no systems or processes were evident to support this.</p> <p>Although healthcare teams were regularly cited they were not routinely constituted. Care is found to be individual, subjective and medical rather than team based and deliberative.</p> <p>Managerial focus on abstract goals such as budgets detracted from managing the core business of clinical work.</p>

						Fractures identified between clinical units and managerial domains as well as within the clinical unit.
(Koerber-Timmons 2014)  Value based teaching: a grounded theory of internalising accountability in teaching documentation.	US	n=16 nurse educators from a baccalaureate nursing program	This study included two main purposes: (a) to explicate the issues and strategies of nurse educators teaching of nursing documentation while transitioning from paper-based to an electronic health record format, and (b) to generate an explanatory theory of teaching nursing documentation and its negative or positive influences of student learning of the competency.	Professional value	Grounded theory	The concept of accountability was frequently expressed as a finding from this research.  Internalizing accountability emerged as the core variable/core category through classic grounded theory data collection and analysis in a simultaneous fashion. The main concern was for the nurse educator to accept increased accountability to produce competent students.  A new theory emerged with four sub-categories and components also emerged and include (a) progressing levels, (b) reflecting on conflicting roles of nurse educators, (c) accepting transitioning, and (d) engaging and empowering through leadership.

<p>(Manuel and Crowe 2014)</p> <p>Clinical responsibility, accountability, and risk aversion in mental health nursing: A descriptive, qualitative study</p>	<p>Australia</p>	<p>N= 10 RN nurses working in mental health</p>	<p>Examine how mental health nurses understood clinical responsibility and its impact on their practice</p>	<p>Accountability as a continuum of responsibility</p>	<p>Qualitative Semi structured interviews</p>	<p>Three themes emerged from the data to describe participant's perceptions and experiences of clinical responsibility: being accountable; fostering patient responsibility and shifting responsibility.</p> <p>Being accountable – referred to participants taking responsibility for their practice, which involved weighing up the patients' needs against blame in the organisations culture of risk management.</p> <p>Most participants regarded accountability as a response to an adverse event and associated it with blame. In the nurses descriptions accountability was explained as being aware that their practice could come under scrutiny and was related to a life threatening event occurring rather than something related to day-to-day practice.</p> <p>Shifting responsibility-this described a culture of defensive practice fostered by the organisations approach to risk management. The strategies undertaken included writing handover not verbal. Some used documentation to cover themselves others to pass decision making to a medic as they did not wish to take the responsibility.</p>
<p>(Young 1999)</p> <p>The Bed Crisis of Winter 1995-1996 in the British NHS: An Illustration of Accountability Issues</p>	<p>UK</p>	<p>n=5 Middle managers who were RNs</p>	<p>To explore the practical complexity of accountability in healthcare by focussing on a particular bed crisis.</p>	<p>Accountability as answerability and responsibility</p>	<p>Case study</p>	<p>The 5 managers seemed to work across 4 domains of accountability- professional, public, pecuniary and personal.</p> <p>These areas often conflict. Government targets were viewed as a hindrance at times of crisis. Professional accountability constructed as as legal and professional code.</p>

						The impact of devolved budgets on creating divisive accountability was raised.
(Leonenko and Drach – Zahavy 2016)  “You are either out on the court, or sitting on the bench”: understanding accountability from the perspectives of nurses and nurse managers.	Israel	n=23 RNs	To understand implicit and explicit perceptions of accountability from the perspective of bedside nurses and their managers and to identify factors that facilitate accountability behaviours		Qualitative semi structured interviews	<p>Accountability as a continuum of responsibility is vital to professionalism. Transparency was considered important but bedside nurses mentioned the discomfort that this caused for fear of retribution.</p> <p>Accountability is one option for behaviour, which is often punished by managers. A nurse who decides to behave accountably shows loyalty and commitment to the profession and patients, but exposes herself to social sanctions even to the point of being a victim of bullying.</p> <p>Answerability was perceived as unjust and frightening.</p> <p>Extreme language used when describing enacting accountability behaviours</p> <p>The gap between responsibility and authority as a barrier to accountability behaviours, nurse managers did not support this view.</p> <p>Accountability is perceived as a personal attribute and can be shaped by unit accountability. Bedside nurses reported accountability to patients, nurse managers reported being accountable to the organisation.</p> <p>Only one of the components of accountability – responsibility was perceived as essential and positive by all interviewees.</p>

						Nurse managers can cultivate accountability by making nurses feel important and valued.
Savage and Moore 2004)  Interpreting accountability: an ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance.	UK	5 GPs; 4 practice nurses; 2 community nurses; a practice manager, administrator and 6 receptionists	To explore how accountability was understood within one clinical team of clinicians working in general practice following the introduction of clinical governance.	Accountability as responsibility and answerability in the context of professionalism	Ethnographic study using interviews, vignettes and participant observations.	How accountability was understood:  Accountability and responsibility conflated.  The study found accountability elusive and ambiguous; described as retrospective and for apportioning blame; it was also described as something that can motivate good practice and implies a readiness to take the consequences of action. Accountability was used to describe some relationships.  The nature of relationship between accountability and decision making: Some practitioners were seen as more accountable than others. Accountability was considered to sit with those that had most expertise even if not present at decision making. If a lack of previous patient contact or lack of knowledge existed (nurse taking on a medical task) less accountability existed. Blame inferred Documentation was viewed both, as a way to protect and expose practitioners to litigation.
(Luhanga et al 2010)  The Preceptorship Experience : An examination of ethical and accountability issues	Canada	n=22 preceptors	Examine ethical and accountability issues that considered the challenges for preceptors when working with students	Accountability as answerability and responsibility.	Qualitative Interviews	Preceptors acknowledged their accountability for safe care as well as facilitating student learning. They reported that if a student was unable to demonstrate safe practice it is they (the preceptors) responsibility to intervene.  Trust and honesty were raised as behavioural problems. Student confidentiality was raised in respect of sharing performance information from

			whose clinical practice was unsafe			<p>previous placements. Evaluation and failure to fail was discussed.</p> <p>Although the preceptors were focused on patient safety they did not fail students with marginal results. A number of contributing factors to this were- lack of preceptor experience, reluctance to cause students to incur personal costs, personal feelings of guilt or shame, complacency about taking on the additional work, lack of robust tools to objectively evaluate and a perceived shortage of nurses and requirement for more graduates.</p>
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### **2.6.3 The impact of specific variables and accountability:**

Eight studies reported on the impact of specific variables related to accountability (Hughes et al. 2015; Nolan et al. 2010; Laschinger and Wong 1999; Semper et al. 2016; Sorensen et al. 2009; Boni 2001; Rashkovits and Drach-Zahavy 2017; Srulovici and Drach-Zahavy 2017) as summarised in Table 5. These were learning and performance; reporting structures; job satisfaction; productivity and self-related work effectiveness; peer review; nursing models and missed nursing care. Three studies utilised the Specht and Rambler Accountability Index – Individual Referent (Specht & Rambler 1994) to measure accountability (Boni 2001; Sorensen et al. 2009; Laschinger and Wong 1999).

Boni (2001) identified a significant relationship between hours worked per week and individual nurse accountability; nurses who worked full time had significantly higher accountability scores than those who worked 20 hours or less; nurses in the early years of their current position demonstrated higher levels of accountability and nurses who had been in their positions for 15 years or more demonstrated lower levels of accountability. However, the reasons for these relationships were not identified. Laschinger and Wong (1999) found that nurses perceived their work setting to be moderately empowering. Opportunity was the most empowering factor and perceived access to information the least empowering. Nurses' formal power (structure or status) was not high. Informal power was most strongly related to accountability highlighting the importance of networking widely. When staff felt appropriately supported with sufficient access to resources and information to get their work done they were more likely to feel responsible as professionals for patient outcomes and feel more effective at work. Rashkovits and Drach-Zahavy (2017) identified a similar finding in the context of team accountability. The results showed that nursing teams' accountability was positively associated to time availability, autonomy and feedback delivered with caution.

Further, Sorensen et al. (2009) described the relationship between job satisfaction and accountability among RNs. The majority of respondents agreed or strongly agreed that they perceived themselves as being accountable. Accountability was identified as both an external and internal mechanism. In this study the self-reported nature of accountability using a survey tool was a limitation. The lowest correlation with accountability was extrinsic reward i.e. pay, and the most highly correlated variables to promote accountable practice were autonomy, professional development, interdisciplinary relationships, personnel policies and programmes and professional models of practice.

Hughes et al. (2015) reported the frustration experienced by Nurse Directors (ND) having to deal with non-clinical staff in managerial roles. The management structures which were seen

to hold operational responsibility were driven by fiscal accountability, which made the role of the NDs to assure patient safety and professional standards challenging to enact with only professional and not operational authority. The issue of fiscal accountability was previously highlighted by Batey and Lewis (1982), who described both written and verbal accountability disclosure mechanisms. They found that verbal disclosure was the most common form of reporting, except when financial issues were highlighted. With the exception of budgetary disclosure, disclosure processes were not systematic (Lewis & Batey, 1982). This focus on measurable performance accountability linked to efficiency, determined through standardised, numerically based system metrics such as length of stay and delayed discharges was also evident in Canadian health system reform (Choiniere 2011).

Two studies considered peer review in relation to accountability. Semper et al (2016) evaluated the impact of Clinical Nurse Specialists in delivering a peer review education programme. This programme was positively received despite initial reservations about fear of retribution and embarrassment. Nolan et al. (2010) demonstrated improved patient outcomes and improved responsibility taken on by nurses, after participating in Morbidity and Mortality Peer Review Conferences (MMPRC) to reduce Ventilator- Associated Pneumonia rates (VAP). Nursing accountability was measured by “I” and “you” statements made by small groups of RNs using discourse analysis. Eleven MMPRCs were held over 3 months. There was a significant shift from almost equal I- and you- statements in ‘beginning MMPRCs’ to an increase of I- statements from 24 to 92 (283.3%) and a reduction of you statements from 21 to 11 (47.6%) in mature MMPRCs. Ventilator Acquired Pneumonia (VAP) bundle compliance improved from 90.1% to 95.2%. This study was limited by a lack of follow up to observe if the improvement was sustained. Srulovici and Drach-Zahavy (2017) found nurses’ personal accountability to be negatively associated with missed nursing care, over and above nurse’s overload and socio- demographic characteristics.

Table 6: Summary of studies of the impact of specific variables and accountability

Author(s); Year of publication; Title of publication	Country	Study sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key findings
(Sorensen et al 2009)  The Relationship Between RN Job Satisfaction and Accountability	US	n=857 RNs	To describe the relationship between job satisfaction and accountability among RNs employed by a rural healthcare network.	Accountability as answerability and professional practice.	Descriptive correlational secondary data analysis. Surveys.	<p>Nurse accountability is moderately correlated with overall job satisfaction.</p> <p>The Specht and Rambler Accountability Index has a possible range of 11-44. The accountability scores ranged from 28 to 44, with a mean of 36.56 (<i>SD</i> =4) The majority of respondents agreed or strongly agreed that they perceived themselves as being accountable. Overall job satisfaction using MMSS ranged from 56 to 155, with a possible range of 31-155, with a mean of 104.60 (<i>SD</i>=17.91).</p> <p>Using Pearson's correlation a statistically significant positive relationship was found between nurse accountability and overall job satisfaction at a significance level of &lt;.01. Although significant the correlation was weak.</p> <p>The correlations of subscales that were strongest were control and responsibility; praise and recognition; professional opportunities and scheduling.</p>

						Items focus mainly on responsibility and therefore do not pertain to transparency and answerability.
(Boni 2001)  Accountability in nurses who practice in three different nursing care delivery models.	US	n=21 medical and/or surgical patient care units at five acute care hospital sites in New England.	To describe and compare relationships between perceived nurse accountability and three different nursing care delivery models-team nursing, primary nursing and patient-focused care.	Accountability as a responsibility and answerability for ones actions	The dependent variable, nurse accountability, was measured, on individual and group levels, using the Specht and Ramler Accountability Index. The independent variable, nursing care delivery model, was measured with a researcher-designed nursing care delivery checklist. Nurse demographic data were also collected.	Overall group and individual accountability scores were presented.  Mean group accountability scores were significantly lower than mean individual accountability scores. Significant relationships were detected between group accountability scores and years in current position, and between individual accountability scores and hours worked per week. A weak relationship between group accountability scores and nursing care delivery model was detected with registered nurses who practice in a team nursing care delivery model demonstrating lower group accountability scores than registered nurses who practiced in primary and patient-focused care environments.  Both group accountability and individual accountability scores for each nursing care delivery model remained relatively unchanged when controlling for each of the significant demographic variables. Implications for nursing administration, education, practice and research were presented.
(Semper et al 2016)  Clinical Nurse Specialist Guide Staff Nurses to	California, US	n=900 RNs	To describe the CNS role in developing and implementing a staff nurse	Accountability as hallmarks of professionalism and self-regulation	Evaluation of programme	Peer review is an expectation of professional practice and CNSs have a positive role to play. Positively received in practice.

Promote Practice Accountability Through Peer Review.			education programme to promote practice accountability using peer review principles			Challenges encountered – staff feared retribution and discomfort addressing certain issues or behaviours with some peers.  Strong personalities and fear of engaging in peer review with difficult people.  Cultural and language barriers highlighted. Coaching and support to accept change in culture as peer review is embedded.
(Rashkovits and Drach- Zahavy 2017)  The moderating role of team resources in translating nursing teams' accountability into learning and performance: a cross –sectional study.	Israel	n=45 RNs	To test the moderated – mediation model suggesting that nursing teams' accountability affects effectiveness by enhancing team learning when relevant sources are available to them.	Concept of team accountability and culture of accountability	Quantitative: cross sectional study using moderated mediation analysis.	Considered organisational resources of time availability, team autonomy and team performance feedback.  When performance pressure increases team learning may decrease, since the motivation to perform well interferes with experimentation and learning and is translated instead into greater efforts for doing more of the same rather than improving suboptimal care  Nursing teams' accountability is positively linked to nursing teams' learning and subsequent team effectiveness, when time availability and team autonomy are high rather than low.  In contrast, nursing teams' accountability is positively linked to nursing teams' learning and subsequent team effectiveness, when team performance feedback is low rather than high.
(Srulovici and Drach-Zahavy 2017)	Israel	n=172 focal nurses and n=123 incoming nurses	To test the joint effects of personal and ward accountability	Values of accountability as characteristics of the individual or ward.	Quantitative  Cross - sectional design. Mixed	Personal accountability was negatively linked to missed care, whereas ward accountability was not.

Nurses' personal and ward accountability and missed nurse care: A cross sectional study		across n= 32 wards in 8 hospitals	on missed nursing care.		linear models were used as the analysis strategy.	<p>The importance of considering the source of accountability.</p> <p>Lowest levels of missed nursing care were obtained under both high personal and high ward accountability</p> <p>Misfit between personal and ward accountability resulted in increased missed care.</p> <p>When ward accountability is high and personal low the nurse exhibit behaviours that are a façade and more visible to peers and managers while masking behaviours that are less important.</p>
Nolan SW et al 2010)  Effect of M&M Peer Review on Nurse Accountability and VAP rates	US	n = not reported  RNs volunteering to attend	Evaluate the effect of M&M peer review conferences for VAP on nurse accountability and evidence base VAP prevention	Accountability as a responsibility	Qualitative Introduction of M&M peer process	<p>Accountability increased and VAP reduced.</p> <p>Nursing accountability measured by "I" and "you" statements using discourse analysis. Of the 256 statements counted, 65 (25.4%) were you and 191 (74.6%) were I. The accountability statements were analysed by placing MMPRC's into 3 groups: beginning (MMPRCs 1-3); middle (MMPRCs 4-7) and mature (MMPRCs 8-11). There was a significant shift from (<math>\chi^2 = 24.041</math>, <math>P &lt; .001</math>) from almost equal I- and you- statements to an increase of I- statements from 24 to 92 (283.3%) and a reduction of you statements from 21 to 11 (47.6%)</p>
(Hughes et al 2015)  Structural positioning of nurse leaders	NZ	n= 20 Health Boards Directors of Nursing and CEOs	To analyse the reporting structures of nurse leaders of publicly funded hospitals and	Accountability as reporting lines	Qualitative Semi structured questionnaires	Four themes emerged from the data: Variable positional reporting of DoN and CEO; variable levels of inclusion and influence at Exec level decisions; ambiguous financial responsibilities and accountabilities; blurring between operational and professional reporting lines.

and empowerment			seek both views of nurse leaders and CEOs			<p>Varying levels of visibility and inclusion impact on the structural positioning of nursing and influences authority and empowerment.</p> <p>Structural empowerment of nurse leaders was defined by the factors of opportunity, power and proportion were hindered by dual accountability lines of reporting and lack of financial control</p>
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The three-stage validation study conducted by Drach-Zahavy et al. (2018) included in this review and discussed in the previous section is summarised in table 7.

Table 7- Summary of the three-stage validation study conducted by Drach-Zahavy et al. (2018)

Study	Country	Sample / population	Aim of study	Main Accountability concept( s)	Methodology	Key findings
(Drach- Zahavy et al 2018)  Towards a measure of accountability in nursing: A three-stage validation study	Israel	Phase 1 n= 74 items developed based on literature review; phase 2 n=229 nurses; phase 3 329 nurses	To develop and psychometrically evaluate a three dimensional questionnaire suitable for evaluating personal and organisational accountability in nurses	Accountability as internal and external	Three phase tool validation study.	Nurses personal and organisational accountability is positively related to nurses' performance and negatively related to nurses' neglect, thereby showing good construct validity  This questionnaire considers nurses accountability as a three-dimensional construct composed of responsibility, transparency and answerability.  Refers specifically to personal (internal) organisational (external) accountability.

### 3. Discussion

The overarching aim of this scoping review was to identify the research literature available on the topic of nursing accountability and to identify further research potential. Having carried out this scoping review 11 broad statements can be made:

1. There is a lack of empirical research relating to the concept of accountability in nursing;
2. Accountability has been studied in a variety of ways depending on the researcher's methodological preferences and definition of accountability;
3. A number of studies fail to make a distinction between accountability and responsibility and continue to use the terms interchangeably;
4. Most research has emerged from out with the UK and it has studied individual nurses or peer groups;
5. Accountability is reported as being poorly understood by nurses;
6. Two main discourses of accountability in nursing were found: personal virtue and answerability;
7. Studies report accountability to be disconnected, disproportionately focused on efficiency and performance, and it is a negative retrospective way to apportion blame and enact control;
8. Empowerment, support, job satisfaction, authority and autonomy are positively related to nurses accepting professional responsibility;
9. Uncertainty and blurring of managerial, medical and nursing roles and responsibilities and the perceived punitive nature of accountability are said to influence nurses' not accepting responsibility;
10. Mechanisms of accountability underpinning professional practice, clinical governance, and care assurance are largely unreported in the literature;
11. How accountability is enacted in professional hierarchical structures is unreported.

The relative lack of research on accountability in nursing is surprising considering the continued political and professional calls to strengthen it as a means to assure standards of care and professionalism. It could be argued, that in the absence of a strong evidence base the nursing literature has become characterised by a plethora of unchallenged expert opinion and hypothesising on accountability, amounting to more than 4500 publications with no empirical basis. The empirical studies included in this review introduced accountability as a

complex and poorly understood phenomena, potentially perpetuating the notion that the concept is challenging to get to grips with.

Definitions of accountability are dependent on the standpoint from which one attempts to define it. From the nursing literature there are two, potentially competing, stand points: accountability as a professional virtue; and accountability as a means of answerability. The former being described in a number of studies as the cornerstone of professional practice, and the latter as a mechanism of retrospective blame in disconnected organisational structures of hierarchy and control (Robertson et al. 2010; Savage and Moore 2004).

There was a requirement for definitional clarity in order to be consistent in the use of language and understanding of accountability for nursing. Although other definitions of accountability are offered Krautscheid (2014) acknowledges two stand points (virtue and mechanism) within her contemporary definition and recommends 'answerability' to replace 'accountability' and 'professional virtue' replaces 'professional responsibility'.

Even with definitional clarity, how professional accountability is enacted, for what purpose and by whom needs further exploration. If accountability in clinical practice is to maintain competence and safeguard patient care (NMBI, 2015), the negative connotations identified in this review need to be addressed. The literature included in this scoping review spans four decades ending with Drach-Zahavy et al. in 2018. It is apparent that much of the discussion of accountability in nursing stems from Batey and Lewis's (Part 1, 1982) and Lewis and Batey's (Part 2, 1982) work. This research study aimed to expand the concept of accountability from the ideas of professional virtue to include the requirement for responsibility, authority and autonomy as prerequisites for nursing accountability. In essence this aligned accountability to position, performance and outputs as required in the developing era of New Public Management (NPM) and away from a professional virtue.

A number of studies have suggested that nurses were disinclined or unable to accept professional responsibility, and of particular concern was the reluctance of RNs to challenge poor practice. Nurses identified both an uncertainty of their relationships with managers and medics as well as a preference to working collaboratively in multi-disciplinary teams (MDT). Although nursing has a complementary knowledge and skill base to medical and managerial colleagues the literature highlights a lack of clarity as to where nursing accountability lies and the spectre of overlap in medical, managerial and nursing roles.

The notion that nurses may be disinclined or unable to accept the full professional responsibility and defer issues to medical or managerial colleagues is concerning. This

literature review highlighted the importance and positive correlation of empowerment (formal and informal), professional supervision and mentorship, job satisfaction and access to knowledge and education with the ability of nurses to practice autonomously as professionals. This requirement for appropriate professional supervision and access to knowledge to enable learning and development is confirmed in a number of the studies (Mitchell, 2001; Cohen et al. 1994; Surakka 2008; Sorensen & Iedema, 2010; Choiniere 2011). Understanding how nurses can be supported to accept professional responsibility and therefore accountability as part of an MDT team is worthy of further exploration.

### **3.1 Limitations**

This scoping review was limited due to the broad range of definitional, methodological and context variance which made comparison and synthesis difficult. The qualitative studies frequently did not adequately describe data analysis methods.

### **3.2 Conclusion**

This scoping review has identified that accountability is deemed critical to the nursing profession yet, nurses are reported to have poor knowledge and understanding of accountability and a number of studies found that it was perceived as something to avoid and fear. There are two, potentially conflicting, discourses of accountability- accountability as a virtue and accountability as a mechanism of answerability. Nursing is reported to be unwilling or unable to accept aspects of professional responsibility and in the absence of any empirical data of how accountability is enacted it is unclear how accountability is a contributory factor to lack of acceptance of responsibility in practice. There was no literature identified that considered accountability from point of care the Health Board.

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