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Does Nursing Leadership Affect the Quality of Care in the Community Setting?

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Title: Does nursing leadership affect the quality of care in the community setting?

Abstract

Aim: To examine perceptions about how nursing leadership affects quality of care in the community setting.

Background: Quality care is considered an essential component of nursing work and recent policy has emphasised the role of leadership in meeting the quality agenda. As shifting the balance of nursing care from the hospital to the community occurs in the United Kingdom, there is an imperative to evidence the quality of care more effectively which patients and families receive from nurses working in the community.

Methods: A qualitative study involving community nurse leaders (n=12) and community nurses (n=27) in semi-structured individual interviews n=31 and 3 focus groups (n=13).

Results: Tensions exist between 'leading' for quality care and 'delivering' for quality care. Organisational decision making is challenged by limited measures of quality of care in the diverse roles of community nursing.

Conclusions: Frontline community nurses and nurse leaders need to articulate how they intend quality of nursing care to be appreciated and actively indicate ways to evidence this.

Implications for Nursing Management: Mechanisms to monitor patient safety, a key aspect of the policy agenda for quality care and other technical aspects of care are important for nurse leaders to develop with frontline community nurses.

Key words: Leadership, community nursing, quality, management

Introduction

Previous research has reported the 'invisibility' of nursing work in the community (Hallett and Pateman 2000, Low & Hesketh 2002). The current policy emphasis on quality of health care offers a real opportunity for all nurses working in the community to make visible the elements of their clinical practice to demonstrate high quality care and verify what really matters to patients and families. Within the United Kingdom (UK) and other countries, the contribution of leadership is recognised to be central in achieving the change required to meet the policy drive for quality care (Wong and Cummins 2007, Scottish Government (SG) 2010, Machell et al 2010). Developing leadership capacity in community nursing is therefore seen as instrumental in attaining the ambitions for quality as health care shifts into the community. For the purpose of this paper community nursing refers to district nurses, health visitors, school nurses, staff nurses and health care assistants working in the community.

Purpose

This paper reports on the theme of quality in community nursing and leadership which emerged from a research study which aimed to 1) identify how leadership is perceived and experienced by community nurses and 2) to examine the interaction between recent policy and leadership development in community nursing.

Background

Policy focus on quality care

Recent strategies and policies within the UK and other nations indicate the importance of quality health care for the benefit of patients (Donaldson 2001, Institute of Medicine (IoM) 2001, SG 2007, 2008, 2009, 2010, DoH 2009). The expectation is that the focus on quality will provide efficiency and innovation in care whilst concentrating on both prevention and cure (NHS 2005, Scottish Government (SG) 2010). How quality is defined and conceptualised within policy, leadership and different clinical areas is pertinent for the measures used and developed to demonstrate quality (Bowers and Kiefe 2002). The frequently used yet relatively abstract definition of health care quality refers to "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Committee on Quality of Health Care in America IoM 2001, p232), fuelling debate about the nature of health care quality and how it can be measured (Beyerman and Radwin 2004).

This ambiguity around the conceptualisation and definition of quality in health care is also evident within the NHS UK context (Raleigh and Foot 2010). Indeed, one would question whether a single definition of quality in a diverse organisation such as the NHS can be definable and relevant to all? This view is substantiated by Machell et al (2010) asserting that clinical quality can be a vague concept needing greater clarification in NHS boardrooms while Currie et al (2005) are suggesting that differing perceptions of quality exist for nurses and patients. Administrators, clinicians and patients are all considering different aspects when judging quality (Bowers and Kiefe 2002).

Patient safety and patient experience equating with quality

While it is evident that quality is defined differently, some common themes are identifiable across quality frameworks such as 'safety, effectiveness and patient experience' (Raleigh and Foot 2010, p4). Within the UK, the health policy context is devolved to the four countries but reflect a similar focus on activity and measureable outcomes across the UK and internationally. This focus and activity relates to the Institute of Medicine's (IoM 2001) six aspects of quality-care that is: (1) person-centered;(2) safe; (3) effective;(4) efficient; (5) equitable; (6) and timely (SG 2010). The NHSScotland strategy (SG 2010) has attempted to operationalise its specific focus on quality (Box1). The overall purpose of the drive for high quality is to ensure person-centered, clinically effective and safe healthcare services. Such a focus gives an indication of how quality is being conceptualised within UK health policy and is consistent with other approaches in the United States and Canada (Wong and Cummins 2007).

Arguably, differently focused and specific definitions of quality health care are required for different aspects of the NHS and elements of care. Organisational conception and definition of quality may well differ for individual clinicians within different contexts and this then influences how they conceptualise and define quality. The debate around the complexity of defining and measuring quality in healthcare is exemplified in end of life care (Addicott and Ashton 2010) and the need to identify outcomes for health improvement as opposed to focusing on negative outcomes such as death and infection rates (Devlin and Appleby 2010).

Box1 here

Box2 here

Nursing leadership and quality

It is argued that delivering the quality agenda will require ambitious leadership and strong professional values, supported by a robust and effective governance framework; suggesting change is required in community nursing (Box 2) (SG2010). New leadership roles have emerged in community nursing with evolving leadership responsibilities to ensure quality is at the heart of the nursing workforce care delivery. Senior nursing leadership has a pertinent role in bringing the quality agenda to the fore in NHS Boardrooms (Machell et al 2010). Leadership which is charged with providing quality of care in the current economic climate poses particular challenges (Giordano 2010) and setting clear priorities about which improvements are needed for a quality service at low cost is of paramount importance (Appleby et al 2010).

Study method

Using qualitative methods, involving N=39 participants (Table1) including nurse leaders (N=12) and frontline staff (N=27), data were gathered in three Health Boards in Scotland between April and December 2009. Details of the method have been reported elsewhere (Kean et al 2011).

Insert Table 1 here

The aim of this analysis is to illustrate quality of care issues for community nursing and leadership from a research study which aimed to 1) identify how leadership is perceived and experienced by community nurses and 2) to examine the interaction between recent policy and leadership development in community nursing.

Ethical approval

Prior to commencing the study multi ethical approval was obtained from the local research ethics committee.

Sample

Semi-structured individual interviews (n=31) were used to gather data with the community nursing workforce and their leaders and three focus groups (n=13) with members of community nursing team. Written consent was obtained for all participants prior to data collection.

Data collection

Interview topic guides were developed for the individual interviews and focus groups from an analysis of the literature reviewed and the experience and knowledge of the research team. A sample of the interview and focus group questions pertaining to the theme of quality and leadership are contained in Box 3.

Insert Box 3 here

Data analysis

Data analysis involved team members working independently generating concepts which reflected patterns and processes in the data (Charmaz 2006, Bryman & Burgess 1994) and then working together when moving from open coding to higher levels of abstraction, to themes under which categories and subcategories were subsumed. *Quality in community nursing and leadership* emerged as one major theme in the analyses and forms the focus of this paper.

Findings and Discussion:

The findings indicate that until recently the quality agenda has been primarily a senior leadership concern and that frontline staff have had little engagement with the quality agenda.

'Leading' for quality versus 'delivering' for quality

The data illustrates tensions between 'leading' for quality care (nurse leaders) and 'delivering' for quality care (front line staff). Perceptions of the value of leadership and its impact on quality of care differ between senior nurse leaders and frontline nurses. Whilst senior leaders value leadership for impacting on the quality of care, frontline nurses consider the impact of leadership on quality of care as limited and argued that   frontline staff has most impact on quality of care for patients and their families.

Senior nurse leaders and the Health Boards reiterate the policy drive for leadership to enhance the quality of services for patients being cared for in the community:

'The board and the directors see that the only way we can improve patient care is through professional leadership. Absolutely confident about that. And that patient safety in particular, not necessarily the public health bit but the delivery of care bit, is about clinical leadership'. (Nurse Director 2.1)

In contrast to the senior leader's view that '*the only way we can improve patient care is through professional leadership' (Nurse Director 2.1)*, many frontline nurse participants argued that quality of care is dependent on the individual nurse delivering care in the community. Several nurses reported concerns about the variability in the quality of patient care amongst colleagues.

The following district nurse echoes views of several frontline community nurses in this study in arguing that:

*'I think, in the community, the quality of care is very much driven by the district nurses who are working within that area. [ ] no matter how good a leader you have at that level (*senior*), if you don't have the ground staff there who know what they're doing, the care to the patient is not good'. (District Nurse 1.1)*

The frontline nurses with hands on care, perceived themselves as the back bone for quality care, while their nurse leaders were seen as having a limited influence on the issue.

Perceived quality of care: patient experience and outcomes

Currently, in the areas studied, the gathering of evidence about quality of care in community nursing is primarily focused around patient satisfaction, which paradoxically focuses on dissatisfaction through complaints and only recently, includes patient experience. Further, the more technical competence aspects of care are not systematically evidenced in community nursing for example, the treatment of leg ulcers and healing rates or the identification of postnatal depression and support given to mothers.

Nurses perceive the nurse-patient relationship as pinnacle in delivering high quality care and thus satisfaction with community nursing services. Poor relationships are often the issue leading to complaints from patients as this Assistant Nurse Director explains:

'I mean, just about everything you would lead – you would link to patient care and quality. I mean, a lot of the patient care and quality, we'll also get through complaints, which is mostly around "someone not being nice to me", certainly the nursing ones tend not to be about technical issues, they tend to be more about being nice or not nice'. (Assistant Nurse Director 2.1)

Whilst complaints were described by frontline nurses and nurse leaders as a main indicator of quality in respect of nursing practice in the home environment, some senior nurse leaders are actively refocusing quality indicators away from complaints as the main driver for quality. A few nurse leaders indicated how they utilize and recognized the good practice of some nurses to drive, motivate and develop other nurses to enhance the quality of care of all nurses in the community. Such leadership is an approach towards helping staff feel engaged, valued and empowered in leading and driving quality in their communities. Yet the leaders' efforts to identify and share good practice are hindered by

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the lack of organisational infrastructure to transcend the nursing hierarchy for monitoring and reporting quality of care in practice.

Several frontline staff of different skill-grades indicated that they had made changes in practice to enhance the quality of their services. However, when asked how such developments were disseminated into the wider organisation for positive change to be identified and quality monitored within the healthcare system, these nurses indicated that the mechanisms were rarely in place or they were unaware of them. Consequently, the evidence for change in practice was rarely well substantiated on the basis of quality. The question arises, how can leaders ensure quality of care in community services?

Organisational decision making and skill-mix for quality care

Some senior nurse leaders acknowledged that quality of care is influenced to some extent by the frontline nurses working in the community and not solely a result of leadership as they try to organise the community nursing workforce to deliver the best quality care. However, the senior nurses point towards the need for evidencing that the best people are in the right place, at the right time by navigating workforce planning. As this nurse director explains:

'We've really tried to make sure that we've married our workforce workload planning work with the patient and quality of care at the heart, not money and the profession. All in a kind of triad, rather than saying, ''we need more nurses but I'm not going to give you anything in return''. We need nurses, well in turn we're going to improve the quality of care'. (Nurse Director 1.1)

The nurse director is alluding to the argument from community nurses that an improvement in quality of care can only be matched with an increased workforce. Yet, the leadership perspective is that the resource, for example the nursing staff resource, needs to match improvements in quality of care-requiring nurses to increasingly evidence and justify that the skill-grade of nurse they request is able to improve quality of care. Given the limited information currently gathered about the quality of care delivered by different skill-grades in the community, it is difficult to see how skill-mix is organised to assure quality of care or justify resource requests for different skill-grades.

District nursing and health visiting both provided concrete examples of how skill-mix and quality of care are interdependent variables. Whilst the illustration here is from health visiting, there are equivalent illustrations in our data of how skill-mix can affect quality of care in district nursing teams. There is reference in this section to core, additional and intensive families, these are recognised terms within health visiting practice to identify families on the basis of health need, for an explanation of these terms see Box 4.

Insert Box 4 here

While describing herself as a lone worker, this motivated and enthusiastic nursery nurse explained in detail the work she is undertaking as part of the health visiting team,

'So, when babies are first born, we (nursery nurses) go in to see their mums and the families for up to 8 weeks and then they're signed off by the health visitor. They get a check done with the health visitor. I can't do that. I can't go to the first visit because I

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can't do notifications (first assessment) *visits because I'm not qualified as a health visitor and I don't do the signing off part but I do from 2 weeks onwards, just going in, making sure that there's not any problems, discussing any issues with mums, making sure baby's okay and growing and the development's okay'. (Nursery Nurse 1.1).*

Nursery nurses have a particular expertise in child development and child play and can be seen as an asset to the health visiting team for supporting parenting and childcare work. Unless a personal safety concern triggered the need for a second person, this nursery nurse worked independently with core families until the families need to be '*signed off by the health visitor*' to comply with regulations since the health visitor has overall responsibility and accountability for the families' care.

When asked what happens if the mother had any health concerns to discuss, this participant described functioning as a go-between and ensured that the mother was contacted by the health visitor, which may or may not include face to face contact. This raises concerns about how well maternal health can be assessed when nursery nurses are undertaking much of the work with core families.

The following example further contextualises the concern raised above in relation to variations in quality of care mothers receive in 'core' families. In this illustration, a health visitor elucidates her assessment of maternal wellbeing within a 'core' family.

'They come from what we would call good families, they're educated women, they're families that don't have any financial problems. They then have a child and a whole load of problems erupt. [ ] ...you can then see her going downhill, you can see relationship

problems occurring, you can see problems occurring with the attachment to the child. So you're then having to go, she maybe won't go on to medication, she won't engage with the GP but she will engage with you. She won't go to counselling so then I'm starting to do weekly visits and maybe there for an hour, talking to her and then by 6 months she will may be start deciding she will go on medication and she will go on the counselling course, you know, and then you work her through this and then you get her through it and she thanks you and she starts to talk about going to work and things like that and then she's away and things are okay and you think, well that's a piece of work and it's just been additional – maybe going into intensive but then back into additional and now she's core and she's away and, you know, it's not drug and alcohol abuse' (Health Visitor 3.1).

What is evident from this data is the ongoing assessment by the health visitor and the ability to identify this mother of a family classified as 'core' (see Box 4) developing depression, her bonding problems with her baby and the need for support. The health visitor saw the mother 'going downhill' and by assessing and evaluating the situation continuously was able to support the mother by 'being there' listening and talking with the mother in a non judgemental way to identify resources to support her that were acceptable to her.

These contrasting data give insight into the complexity of working in the community and the impact decisions about skill-mix can have on the quality of care for families. In the example of the nursery nurse, the expertise lies within child development and child play but not in recognising postnatal depressions or identifying the issues observed by the health visitor. Nursery nurses however have a role to play in those families that do need support in

areas of child development and child play. Perhaps ironically, these are more likely to be families with additional or intensive needs rather than core families.   Using the illustration of the nursery nurse and health visitor, they are differently educated, their focus is different and their ability to undertake complex assessment and make informed decisions is different. Consequently, the preparation, experience and skill-mix of the different frontline staff is likely to impact on the quality of care for different aspects of nursing work. Yet, this remains an unaddressed issue.

Discussion

'Leading' for quality versus 'delivering' for quality: who counts?

The structural organization of leadership within the NHS hierarchy poses challenges for nursing leadership in ensuring quality of care in community nursing especially when leadership is perceived as distant and of little influence or consequence to frontline nurses in the community (Haycock-Stuart et al 2010, Kean et al 2011). Yet senior nurse leaders are recognized as championing the quality issues in NHS boards (Machell et al 2010). Tensions exist between senior nurse leaders and frontline staff as to the value of leadership for influencing the quality agenda. Frontline nurses in this study acknowledge variability in quality of care between colleagues in the nursing workforce arguing that they are the ones that influence the quality of care-more so than the nurse leaders. This however is difficult to evidence without good systems to monitor quality of care.

Patient experience and patient outcomes for quality care

The findings show that quality indicators in respect of the nurse-patient relationship or technical aspects of nursing care in community are notably absent with the exception of complaint mechanisms. This implies that quality in health care is often assumed in community nursing unless there is a complaint, concurring with Machell et al (2010) that a primarily reactive approach to quality is occurring by responding to complaints rather than a proactive approach to quality such as developing organisational systems to evidence and share good practice. Evidence from this study indicates mechanisms to monitor patient safety, a key aspect of the policy agenda for quality care and other technical aspects of care are notably lacking in community nursing.

Several studies indicate that the relationship between staff and patients is perceived as key to patient experience (McQueen 2000, Millard et al 2006, Morse et al 2006, Henderson et al 2007) and constitutes an aspect of quality in nursing care with regard to patient satisfaction (McCabe 2004, Morgan & Moffatt 2008, Fleisher et al 2009). It is therefore perhaps not surprising that complaints centered around poor nurse-patient relationships. Patient experiences are becoming a key mechanism to monitor quality in healthcare services, formulating new indicators of quality which have been notably absent in the past (Currie et al 2005). Therefore, information about nurse-patient experiences are likely to receive increasing precedence (Beyerman and Radwin 2004, Devlin and Appleby 2010).

McGarry (2008) asserts that as the location of care continues to move closer to home, it is crucial that the implicit qualities that are valued within nurse–patient relationships in this context are recognised and made more explicit at both the organisational and policy level.

However, Aranda and Jones (2008) argue that it is common for studies to view nurses' work within a medical model when considering nursing work in the community, for example, Kelcher et al (2009) and Laurant et al (2007) as opposed to holistic nursing practice where arguably nursing is best appreciated.

Research in the acute setting suggests patients concern themselves with the nurse-patient relationship as they assume the profession regulates and monitors the technical aspects of nurses' work through organisational structures (Calman 2006). Therefore patients are less likely to comment on technical issues or complain about them compared with concerns about nurse-patient interaction.

Our findings indicate that currently the quality of technical aspects of care is not captured in community nursing. This is in contrast to Bowers and Kiefe (2002) asserting that it is fundamental to the quality agenda in gaining information about nurses' technical competence processes to evidence the quality of technical nursing care for patients, their families and / or carers' benefit. Engagement between nursing leaders and frontline staff is essential for the development of meaningful quality measures in community nursing.

Exactly what is measured and to what end is crucial when addressing the quality agenda (Raleigh and Foot 2010), raising important questions about the aspects of nursing that should be identified to monitor and evidence quality in community nursing. The focus on outcomes may not reflect the quality of the process and vice versa (Andersson Svidén

et al (2009). It is possible to achieve good outcomes with poor care processes and to have good care processes but with poor outcomes for patients (Currie et al 2005, Raleigh and Foot 2010) as is exemplified in end of life care (Addicott and Ashton 2010). There is a need to focus on positive processes such as 'good death' (Smith 2000 p129) as opposed to focusing on negative outcomes such as death rates (Devlin and Appleby 2010). Raleigh and Foot (2010) argue an opportunity exists for frontline staff to engage in determining what quality measures are developed by engaging with nursing leaders to articulate the elements of their nursing work they and patients believe should be measured and monitored to demonstrate quality care.

Organisational decision making for quality care

Skill-mix, involving non nurses and nurses with less educational preparation is now common place in contemporary nursing teams in the community in the UK. Whilst skill mix is considered important in policy (SG2010b), how it is organised and led has been a feature of debate in the acute care setting (Crossan and Ferguson 2005, Aranda and Jones 2008) and in the community setting (Hurst 2006, Laurant et al 2007, Bosley and Dale 2008). Nursing in the community is complex, using skilled, multi-factorial approaches to assessment, clinical decision making to inform judgements involving a range of skills and knowledge (Cowley et al 1995, Bryans and McIntosh 1996, Appleton and Cowley 2008). There is little concrete guidance to the organisation of the work to be undertaken by different members of the skill-mixed team for quality care. As a consequence, leading for quality care lacks evidence to assist organisational decision making for skill-mixed teams

in the community. The assertion that quality mechanisms for evidencing whether the right people are undertaking the right roles and responsibilities are not yet apparent (Hurst 2006, Brady et al 2007, Storey et al 2007) is supported by our data.

Considering the illustration of the nursery nurse and health visitor working with core families, it is evident that the nursery nurse would not be able to deliver the same quality of care for the family as the health visitor. The nursery nurse could however, contribute to a valuable aspect of care by working together and under the supervision of the health visitor with families and for example, with intensive families drawing on his/her expertise in child development, parenting and child play interventions. Organisational decision making that places nursery nurses with core families as they are perceived as 'straight forward and easy', is not appreciating the dynamic nature and the complexity of community nursing assessment. Few studies in the UK examine skill-mix in community nursing, but Carr and Pearson (2005) identified variation in the work undertaken by different health visitors and nursery nurses ascertaining that delegation in the community is complex. The issue is not skill-mix, but the organisational decision making about the best skill-mix for high quality care in the community setting.

Implications for Nursing Management

This study indicates that the clear link between leadership and high quality care in community nursing is not currently well evidenced and as such is rendered rhetoric. Senior nurse leaders are leading the quality agenda, but this needs to transcend the hierarchy to

engage frontline community nurses. Evidence from the acute setting suggests leadership can influence some aspects of quality (Wong and Cummins 2007), so it is highly likely that leadership in community nursing does matter. Frontline nurses delivering care in this study argue they are the backbone of the quality agenda and yet data from this study suggests they are currently not adequately engaged within their own organisations to address such an agenda. Quality indicators which can illustrate the value of leadership as well as the work of frontline staff are now necessary for making visible the 'invisible' in community nursing work (Hallett and Pateman 2000, Low & Hesketh 2002) and for demonstrating the achievement of the policy ambitions for the NHS.

Organisational decision making with regard to the deployment of skill-mix in nursing needs to consider the skill base of staff for achieving high quality care, the illustrations presented indicate that working in the community is complex and the work needs to be carefully matched to the educational base of the different team members, their experience and as Appleton and Cowley (2008) indicated, individuals' values and beliefs. Careful organisational decision making needs to be given to the roles and responsibilities different nurses undertake in the community, one size is not likely to fit all when providing complex care in home environments, especially as patients come home from hospital quicker and sicker to be cared for in the community.

The evidence base for the significance of relationships in nursing work is ever increasing and this is a timely opportunity to ensure that aspects of perceived care are captured and valued in evidencing the quality of care in community nursing work. Measures are needed to capture the quality of nurse-patient relationships and technical aspects of care to

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demonstrate the community nursing contribution to quality of care which can transcend the hierarchy of nursing and be explicit for health board scrutiny. Consequently, Health Boards need to develop indicators of quality relevant to nursing in the community and develop mechanisms for systematically evidencing good nursing care. Organisation systems are needed to support nurses to capture the essence of nursing that ensures a quality service.

Conclusions

Achieving high quality care is a core ambition of the NHS in the UK and a specific remit of nursing leadership. This research indicates that currently there is not adequate engagement between nurse leaders and frontline staff to achieve the quality agenda. There is a need for the quality agenda to transcend the hierarchy of community nursing to engage frontline community nurses so the ambition of *better care* can be achieved.

A significant challenge for nursing leadership is to navigate the vagaries of approaches to nursing care in the community and identify pertinent indicators of quality care relevant to the community setting. Frontline community nurses with nurse leaders now need to articulate how they intend for quality of nursing care to be appreciated and need to actively indicate ways to accomplish and evidence this. Previously it has been argued that 'it may never be possible to define the nursing contribution to patient care, due to the ever changing nature of this work' (Spilsbury & Meyer 2001, p11). Clearly there is a challenge for nursing leadership to bring to fruition the quality agenda and evidence the community nursing contribution to such an agenda.

The NHS's reputation for quality is important and how community nurses contribute to that reputation is going to be increasingly influential as care shifts from the hospital to the community. When developing and implementing policy, community nurse leaders need to consider the implications of changes on the quality of community nursing services, especially when there is little evidence to inform leaders' decisions about the most appropriate use of skill-mix for quality care. Evidence from this study suggest community nurses and their leaders are committed to providing quality care for patients, but that their working definitions of quality vary considerably and mechanisms to capture their contribution to quality care are not yet evident.

References

Addicott, R., Ashton, R., 2010. Delivering better care at the end of life: the next steps. The King's Fund, London.

Andersson Svidén, G., Fürst, C.J., von Koch, L., Borell, L., 2009. Palliative day care - a study of well-being and health-related quality of life. Palliative Medicine 23, 441-447

Appleby, J., Ham, C., Imins, C., Jennings, M., 2010. Improving NHS productivity: more with the same not more of the same. The King's Fund, London.

Appleton, J.V., Cowley, S., 2008. Health Visiting assessment-unpacking critical attributes in health visitor needs assessment practice: A case study. International Journal of Nursing Studies 45, 232–245.

Aranda, K., Jones, A., 2008. Exploring new advanced practice roles in community nursing: a critique. Nursing Inquiry 15 (1), 3-10.

Beyerman Alster, K., Radwin, L.E., 2004. The Deserved Care Framework for Evaluating Health Care Quality. Home Health Care Management Practice 16, 332-337

Bosley, S., Dale, J., 2008. Healthcare assistants in general practice: practical and conceptual issues of skill mix change. British Journal of General Practice February, 118-124

Bowers, M. R., Kiefe, C. I., 2002. Measuring Health Care Quality: Comparing and Contrasting the Medical and the Marketing Approaches. American Journal of Medical Quality 17 (4), 136-144.

Brady, A.M., Byrne, G., Horan, P., Griffiths, C., MacGregor, C., Begley, C., 2007. Measuring the workload of community nurses in Ireland: a review of workload measurement systems. Journal of Nursing Management 15, 481–489.

Bryans, A.., McIntosh, J., 1996 Decision making in community nursing: an analysis of the stages of decision making as they relate to community nursing assessment practice. Journal of Advanced Nursing 24, 24–30.

Bryman, A., Burgess, R., 1994. Analyzing qualitative data. Routledge, London

Calman, L., 2006. Patients' views of nurses' competence. Nurse Education Today 26 719-725.

Carr, S.M., Pearson, P.H., 2005. Delegation: perception and practice in community nursing. Primary Health Care Research and Development 6, 72–81.

Charmaz, K., 2006. Constructing Grounded Theory - A Practical Guide through Qualitative Analysis. Sage Publications, London.

Cowley, S., 1995. In health visiting, a routine visit is one that has passed. Journal of Advanced Nursing 22, 276–284.

Crossan, F., Ferguson, D., 2005 Exploring nursing skill mix: a review. Journal of Nursing Management 13, 356–362.

Currie, V., Harvey, G., West E., McKenna, H., Keeney, S., 2005. Relationship between quality of care, staffing levels, skill mix and nurse autonomy: literature review. Journal of Advanced Nursing 51(1), 73–82.

Devlin, N.J., Appleby, J., 2010. Getting the most out of PROMS: putting health outcomes at the heart of NHS decision-making. The King's Fund, London.

Department of Health., 2002. Shifting the Balance of Power: the next steps. Department of Health, London.

Department of Health., 2009. High Quality Care for All. Department of Health, London.

Donaldson, L., 2001. Safe high quality health care: Investing in tomorrows leaders. Quality in Health Care 10, 8-12.

Fleischer, S., Berg, A., Zimmermann, M., Wüste, K., Behrens, J., 2009. Nurse-patient interaction and communication: A systematic literature review Journal of Public Health 17, 339–353

Giordano, R., 2010. Leadership needs of medical directors and clinical directors. The King's Fund, London.

Hallett, C. E., Pateman, B. D., 2000. The `invisible assessment': the role of the staff nurse in the community setting. Journal of Clinical Nursing 9, 751-762.

Harihan, S., Dey, P.K., 2010. A comprehensive approach to quality management of intensive care services. International Journal of Health Care Quality Assurance 23 (3), 287-300

Haycock-Stuart, E. A., Kean, S., Baggaley, S., Carson, M., 2010. Understanding leadership in community nursing in Scotland. Community Practitioner 83 (7), 24-28.

Henderson, A., Van Eps, M..A., Pearson, K., James, C., Henderson, P., Osborne, Y., 2007. 'Caring for' behaviours that indicate to patients that nurses 'care about' them. Journal of Advanced Nursing 60 (2), 146–153.

Hurst, K., 2006. Primary and community care workforce planning and development Journal of Advanced Nursing 55 (6), 757–769.

Institute of Medicine., 2001. Crossing the quality chasm: a new health system for the 21st century. Institute of Medicine, National Academy Press, Washington.

Kean, S., Haycock-Stuart, E. A., Baggaley, S., Carson, M., (2011) Followers and the co-construction of leadership. Journal of Nursing Management. 19, 507-516.

Kelcher, H., Parker, R., Abdulwadud, O., Francis, K., 2009. Systematic Review of the effectiveness of primary care nursing. International Journal of Nursing Practice 15, 16-24.

Laurant, M.G.H., Hermens, R.P.M.G., Braspenning, J.C.C., Akkermans, R.P., Sibbald, B., Grol, R.P.T.M., 2007. An overview of patients' preference for, and satisfaction with, care provided by general practitioners and nurse practitioners. Journal of Clinical Nursing 17, 2690–2698

Low, H., Hesketh, J., 2002. District Nursing: the invisible workforce. Queens Nursing Institute, London.

Machell, S., Gough, P. Naylor, D., Nath, V., Steward, K., Williams, S., 2010. Putting quality first in the boardroom: improving the business of caring. The King's Fund, London.

McCabe, C., 2004. Nurse–patient communication: an exploration of patients' experiences. Journal of Clinical Nursing 13, 41–49.

McGarry, J., 2008. Defining roles, relationships, boundaries and participation between elderly people and nurses within the home: an ethnographic study. Health and Social Care in the Community 17 (1), 83-91.

McQueen, A., 2000. Nurse-patient relationships and partnership in hospital care. Journal of Clinical Nursing 9, 723-731

Millard, L., Hallet, C., Luker, K., 2006 Nurse–patient interaction and decision-making in care: patient involvement in community nursing. Journal of Advanced Nursing 55 (2), 142–150.

Morgan, P. A. Moffatt, C. J., 2008. Non healing leg ulcers and the nurse–patient relationship. Part 1: the patient's perspective. International Wound Journal 5 340–348.

Morse, J.M ., Bottorff, J., Anderson, G., O'brien, B., Solberg, S., 2006. Beyond empathy: expanding expressions of caring. Journal of Advanced Nursing 53 (1), 75–90. First published Morse, J.M ., Bottorff, J., Anderson, G., O'brien, B., Solberg, S., 1992. Beyond empathy: expanding expressions of caring. Journal of Advanced Nursing 17, 809–821.

Raleigh, V.S., Foot, C., 2010. Getting the measure of quality: opportunities and challenges. The King's Fund, London

Scottish Executive., 2005. Delivering for Health. Scottish Executive, Edinburgh.

Scottish Executive., 2006. Delivering Care Enabling Health. Scottish Executive, Edinburgh.

Scottish Government., 2007. Better Health, Better Care: action plan. Scottish Government, Edinburgh Access at:

http://www.scotland.gov.uk/Publications/2007/12/11103453/0

Scottish Government., 2008. Leading Better care. Scottish Government, Edinburgh.

Scottish Government., 2009. Delivering quality through leadership. Scottish Government, Edinburgh

Scottish Government., 2010. The healthcare quality strategy for NHS Scotland. Scottish Government, Edinburgh.

Scottish Government., 2010b. Delivering quality in primary care national action plan. Scottish Government, Edinburgh.

Smith, R., 2000. A good death: An important aim for health services and for us all. British Medical Journal 15, 320 (7228), 129-130

Spilsbury, K., Meyer, J., 2001. Defining the nursing contribution to patient outcome: lessons from a review of the literature examining nursing outcomes, skill mix and changing roles. Journal of Clinical Nursing 10, 3-14.

Storey, C., Ford, J., Cheater, F., Hurst, K., Leese, B., 2007. Nurses working in primary and community care settings in England: problems and challenges in identifying numbers. Journal of Nursing Management 15, 847–852.

Terise, B., 2010. Establishing an organizational culture to enable quality improvement Leadership in Health Services 23 (2), 130-140.

Wong, C., Cummings, G., 2007. The relationship between nursing leadership and patient outcomes: a systematic review. Journal of Nursing Management 15 (5), 508 – 521.

Web references

NHS Quality Improvement Scotland., 2005 The Impact of Nursing on Patient Clinical Outcomes. Edinburgh: NHS QIS. Access at:

http://www.nhshealthquality.org/nhsqis/files/Nursing%20Quality%20Indicators%20Repo

rt%20FINAL.pdf

Scottish Government., 2007. Better Health, Better Care: action plan. Edinburgh: Scottish

Government. Access at: http://www.scotland.gov.uk/Publications/2007/12/11103453/0