How does a clinical governance framework contribute to the changing role of nurse leaders in Fiji?

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I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references is given.

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STATEMENT ON THE CONTRIBUTION OF OTHERS

This thesis has been made possible through the support of my supervisors as follows:

Supervisors:

Primary Supervisor: Professor Kim Usher
School of Nursing, Midwifery and Nutrition, James Cook University

Secondary Supervisor: Professor Colin Holmes
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KEY TO TRANSCRIPTS

In the presentation of the research findings (Chapters 4, 5 and 6) and elsewhere where excerpts from the participants are included, the following abbreviations and font styles have been used:

Long quotes: All the names used within this thesis are pseudonyms (refer to Table 3.1 for further information). Pseudonym name and transcript page identify excerpts from participant interviews. All long quotes are in italics, for example:

> *Nursing internationally has evolved, so a nursing leader in Fiji should be able to look outside and see what a major role that nursing in Fiji could take on a par with nursing practice worldwide* (Coral, p.117)

Short quotes: Where excerpts or short quotations are used within the main text, these are specified through the use of quotation marks, for example:

> 'You know, we belong to the Public Service, the government. We belong to the Public Service Commission' (Alice, p.138)

Bold font: The use of bold font occurs within direct participant quotations to indicate emphasis in terms of tone of voice that the participant made.

KEY TO STYLE

1. Where direct quotations are used from referenced sources, this is a deliberate reference to authoritative voices.
2. Direct quotes from the text 'Jonathan Livingston Seagull' (1973) by Richard Bach are in italics.

ABSTRACT

The incidence of adverse clinical events in health care organisations is an international problem. While intense interest has focused on this issue world-wide, with various responses including the introduction of clinical governance in developed countries, it has been less of a focus in developing countries, where the struggle to provide minimal resources for health care is often a priority. In Fiji, with the introduction of health reform funded by international aid agencies, improving patient care is now topical. The role of nurses, and particularly leaders in the nursing profession, is of paramount importance in the goal to provide better and safer health care to communities. Research shows that a key component of the successful implementation of clinical governance is effective clinical leadership. My main interest with this study was about the impact of nursing leadership. While extensive research has been conducted into the impact of nurses on safer care and better health services, this has not yet extended into developing countries such as those in the Western Pacific. There is a gap, therefore, in knowledge about how nursing leadership, and the nursing profession, effects health care policy and practice leading to better patient care in this region.

This critical ethnography set out to expand understanding about the role that nursing leadership has in improving patient care in Fiji. The study pursued the question: 'How does a clinical governance framework contribute to the changing role of nurse leaders in Fiji?' The study had three specific objectives: 1) To undertake a critical literature review of the application of clinical governance principles within both developing and developed countries, with particular emphasis on the impact for nursing leaders; 2) To undertake a study of the evolution of nursing leadership in Fiji; 3) To critically investigate the situation for nurse leaders in Fiji, as the health care system embraced a continuous improvement framework and increased leadership accountability for effective nursing practice.

With the recognition that organisational life is socially constructed and that the nurse leaders functioned within the bureaucratic structure of the Fiji Ministry of Health, social constructionism formed a basis for this research. Taking a critical theory approach with the research proved vital, given Fiji's extensive history of colonization

and the intention that participants had an opportunity for positive social change if they so chose. From a methodological perspective, Carspecken's (1996) five recommended stages for critical qualitative research provided a framework within which the study was conducted, analysed and used to partially explain findings. Habermas's theory of communicative action (1984) comprised the analytical lens through which participant interview data, field notes and various official documents and media reports were explored.

This critical ethnography involved conducting interviews with six nurse leaders in Fiji over a two-year period and extensive time spent with staff of the Fiji Ministry of Health. The participants in this study were all experienced nurse leaders who held senior leadership positions, either in hospitals and community health services, or in the Head Office of the Ministry. During the interviews, participants shared extensive information about what it meant to be a nurse leader in Fiji, and what the impact of clinical governance was having on their professional lives. Attention to postcolonial issues was vital throughout the conduct, analysis and writing up of this research. The participants were all indigenous Fijians and spoke explicitly about the effect of colonization on the nursing profession in that country. I carried a heavy responsibility to appreciate the issues inherent in conducting the research as a non-indigenous researcher.

Analysis from a critical perspective revealed three major themes, which are presented as distinct but related chapters in the thesis. The themes are: Findings our voices: understanding that we are powerful; Legitimizing our role as the facilitators of best patient outcomes; and Recognition of our capacity to take a leading role in health care. Themes are presented from the perspective of the participants' narratives as well as field notes and documents, with my interpretations, based upon the Carspecken methodology and a Habermasian reading of the data. The findings are presented initially from the perspective of the analytic themes and the literature comprehensively reviewed. They are then discussed in terms of the literature identifying a link between effective nursing leadership, nursing conditions and optimum safe patient care.

The recommendations from the study are identified as they emanate from the findings and include those concerning nursing leadership, education, nursing practice and patient care, as well as recommendations for potential further research.

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