Paper Title

An exploration of the antecedents, attributes and consequences of trust amongst nurses and nurse line-manager

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Abstract

Our paper addresses this conference stream by considering how trust is developed and discussed between nurses and their line managers, and how this might influence leadership and management development. It does so through an exploration of the antecedents, attributes and consequences of trust. Research discusses the centrality of trust in nurse-manager relationships, and suggests that high levels of trust can provide benefits to the providers of care and those they serve (Halliday, 2004; Peter and Morgan, 2001; Thorne and Robinson, 1988; Walsh, 1995). It is linked to organisational performance, service quality and turnover amongst nurses (Cunningham and Hyman, 1996, Newman et al., 2002; Williams, 2005). It has been suggested that trust in management is necessary if health service organizations are to maintain service quality and successfully manage organizational change (Skinner et al., 2004). Research conducted by Laschinger and Finnegan (2005) found that nurses who were less trusting of their managers, were less likely to contribute towards organizational goals relative to managers with high trust levels. In this context trust was found to be a significant ‘leader activity’ in determining positive organizational outcomes. Attributes that influenced trust amongst nurses included; ‘confidence’, ‘dependability’, ‘consistency’ and ‘predictability’ (Meize-Grochowski, 1984).

This paper reports the main findings from a qualitative study conducted within the British National Health Service (NHS). This involved conducting forty semi-structured interviews with nursing staff, from acute and community hospitals. The study explores the antecedents and the attributes of trust, from the perspective of nurses and their line-managers. It examines the consequences of trust, and explores possible outcomes associated with high and low trust relations. In order to create and establish a degree of coherence around the concept of trust, a concept analysis framework (Walker and Avant 1988, Rodgers, 1989) was used. ‘Grounded theory’ (Glaser and Strauss, 1967), and a ‘constant comparative approach’ (Glaser, 1965), were also used in analysing the data. The emerging analysis explores the antecedents, attributes and consequences of trust, with implications for leadership and management development.

The interview findings suggest that while nurses did not trust senior level management, they did however trust their line-managers. The antecedents, required for trust to develop included: the immediate work environment and the role of line manager, leadership and management style, time and reciprocity. Key attributes of ‘trustworthy’ managers included: communication, leadership and management style, professional nursing standards, teamwork and support, confidentiality and discretion. The consequences of low trust included: breakdown of teamwork and associated benefits such as support, communication, confidentiality and efficiency, the emergence of ‘destructive conflict’ and lower standards of patient care. Further consequences of low trust included increased labour turnover and workplace absenteeism.
The findings offer potentially valuable information for healthcare managers and nurses to help build trusting relationships within this context. Our high trust model also offers opportunities to consider the implications of these influencing factors for leadership and management development.

**Keywords** – Nurses, nurse managers, trust, NHS
Introduction

Trust plays a major role in health care relationships, and is considered an essential feature in the nurse-patient relationship (Mechanic, 2004; Peter and Morgan, 2001). It is particularly important in health care, an environment characterized by ‘uncertainty’ where the patient is reliant upon the competence and intentions of the practitioner (Alaszweski, 2003; Hall et al, 2001; Titmuss, 1968; Coulson, 1998). It therefore plays a major role in service delivery and quality (Halliday, 2004), as it forms the basis of engagements between nurses with their patients, and other health care professionals. Bolton (2004) commented upon the role of nursing staff acting as the ‘interface’ between patient and hospital. Studies have shown that data drawn from patient satisfaction surveys invariably cite interaction with nurses as the main signifier of patient satisfaction (Arthur and James, 1994; Attree, 2001; Mahon, 1996; Smith, 1992). Trust is also significant in health care organizations, given the high level of interdependency between health service staff (Gilson, 2003; Rowe, 2003) for areas such as ‘clinical judgment’ and ‘observations’, ensuring the completion of ‘delegated acts’, ‘physical safety’, and working within an ‘emotionally secure environment’ (Peter and Morgan, 2001, Thorne and Robinson, 1988; Meize-Grochowski, 1984). Trust can facilitate commitment, enhance levels of collaborative practice between clinicians, and increase overall employee satisfaction and motivation (Gilson et al, 2005). Differences in the nature of one’s training and educational background can however contribute to feelings of mistrust between employees and their managers, as they can lead to the formation of ‘dual’, or alternative forms of commitment (Morgan and Potter, 1995; Stewart, 1996).

Given that trust plays a significant role in the delivery and the quality of service based relationships (Walsh, 1995; Halliday, 2004), its maintenance and associated benefits of commitment and goodwill of staff at every level are required if service quality is to be maintained (Skinner et al., 2004). This is particularly the case in a changing environment driven by service demands and technology (Lauren, 2005; Sparrow and Marchington 1998). Trust in management is essential in order to achieve major organizational change, involving extensive structural, philosophical and value changes within the NHS (Moye and Henkin, 2006; Kiffen-Peterson and Cordery 2003). Skinner et al (2004), have however suggested that ongoing change, with an increased focus on the organization away from the profession, provides a less effective basis upon which to establish trust. Wang and Clegg (2002), suggest communication and relationships based on trust and cooperation and less on the use of ‘power’, ‘knowledge’ and control’ as a more effective basis for the development of trust.

There is a gap in the literature concerning how nurses and their managers understand trust and trustworthy managers. This paper seeks to address this gap and in particular understand how nurses and their managers conceptualise trust, its attributes and characteristics in their own working environment. The paper begins with a review of the literature on trust with a particular focus on the research in health service organizations. This paper reports the main findings from a qualitative study conducted within the British National Health Service (NHS). This involved carrying out forty semi-structured interviews with nurses and nurse line-managers from acute and community hospitals. The
paper reports on an investigation into the antecedents of trust, namely the conditions that can give rise to high trust relations amongst nurses and their line-managers. It then examines key attributes of “trustworthy” nurses and nurse line-managers within a health care context. This is followed by an exploration of the consequences of trust, and outcomes associated with high and low trust relations. Our findings offer potentially valuable information for healthcare managers and nurses to help build trusting relationships within this context. Our high trust model also offers opportunities to consider the implications of these influencing factors for leadership and management development.

**Literature Review**

**Antecedents of Trust**

Trust is a multi-dimensional nature making it difficult to define (Hosemer, 1995). Zand (1972, p.230) has however provided a definition which suggests that trust is “one’s willingness to increase one’s vulnerability to another whose behaviour is not under one’s control”. The notion of vulnerability is highlighted in many subsequent definitions (Brockner, et al 1997; Flanders, 1973; Govier, 1993; Kelly and Thibaut, 1978; Laschinger and Finegan, 2005; Levi, 2001; Lindskold, S. 1978; Matthai, 1989; Mayer et al., 1995; Mishra, 1996; Rousseau, et al. 1998). Trust involves a willingness to undertake risk (Mayer, et al 1995). Morgan and Hunt (1994, p24) have gone so far as to suggest that “because commitment entails vulnerability parties will seek only trustworthy partners”. Laschinger and Finegan (2005) suggest that because trust involves vulnerability there should be ‘good reasons’ when entering into a ‘trust relationship’. Trust is facilitated by faith in the ‘good will’ and in the benevolence of another party (Baier, 1985, 1986, 1994; Robinson 1996) and willingness to give them the ‘benefit of the doubt’ (Owen, and Powell, 2006). It was also found that fair treatment, fairness of policies and safety were related to trust in management and supervisors (Tallman, 2007). This can be influenced by previous experience and dealings with the parties in question (Lewicki et al., 1998; Saunders and Thornhill, 2003) and increased through positive interaction amongst the parties involved over a period of time (Meize-Grochowski 1984). Participants involved must avoid exploiting another party’s blunders for the sake of ‘immediate tactical advantage’ (Costa 2003; Flanders, 1973; Porter et. al., 1975). The existence of certain qualities, amongst line and top level management, can determine the extent to which the truster is prepared to become vulnerable and trust management (Govier, 1993; Lindskold, 1978; Mishra, 1996; Morgan and Hunt, 1994). Reciprocal gestures that demonstrate ‘goodwill’ reinforce trust, as they reduce the level of uncertainty amongst the participants (Fox, 1974; Brocker et al, 1997; Holmes, 1991; Kelly and Thibaut, 1978; Kramer, 1999; Robinson; 1996). Trust is however fragile, it takes time to build up and develop and can be easily undermined and ‘destroyed’ (Owen and Powell, 2006).

**Attributes of trust**

Trust does not require personal liking, its main benefit is that it is ‘efficient’, dispensing with the need to engage in ‘detailed and expensive monitoring of performance’ (Walsh, 1995, p. 50). Those who trust each other tend to give one another the ‘benefit of the doubt’ by increasing the level of ‘spontaneous sociability among organisational
members’ (Kramer 1999). This in turn leads to greater levels of cooperation, more effective deployment of organisational resources and ensures the fulfillment of organisational goals.

Mayer, Davis and Schoorman (1995) devised a model of trust focusing on three factors; ability, benevolence and integrity, these determine whether or not the trustor trusts the trustee. If one of the above factors is absent trust will not develop or it will be limited (Tallman, 2007). Perceptions on the above are directly influenced by leader/supervisory behaviour (Lapidot, Y., Kark and Shamir, 2007). Tallman’s research reinforces Mayer et al’s model on trust, whose results showed that changes in health care organizations impacted on trust in management, which was low, with significantly higher levels of trust in supervisors.

Chiaburu and Marinova (2006), highlight the significant role played by an employee’s line-manager in developing trust. Research carried out by Chen, et al (2008), showed that good leader-member exchange between leaders and subordinates, resulted in better work attitudes and led to greater trust in the head nurse. It is also said that as the level of trust between supervisor and subordinate rises, it would consequently lead to more Organisational Citizenship Behaviour (OCB) from the subordinate (Lapierre & Hackett, 2007). The extent to which employees’ are prepared to take risks and reciprocate trust to both their immediate superior, and the employing organization is contingent on the nature of the relationship an employee has with their immediate superior. Sanders and Schyns (2006) have also said that when a supervisor trusts his/her subordinates, they in turn trust their supervisor. Good relationships result in high levels of mutual trust. Perceived managerial support from the supervisor is reciprocated by their subordinates leading to greater OCB, discretionary and extra role behaviour, gaining further supervisor support (Lo et al. 2006). An antecedent to employee satisfaction is the level of trust employees have in their management (Dirks and Ferrin, 2002).

Characteristics of ‘trustworthy’ managers and colleagues include; predictability, dependability (Holmes and Rempel, 1989), reliability (Johnshon-Geroge and Swap, 1982; Zucker, 1986) and loyalty (Butler and Cantell, 1984). Errol and Bruce (2005) highlight personal attributes such as the manager’s competence and willingness to act in an ethical, fair and predictable manner. Meize-Grochowski (1984) and Stewart (1996) found that trust includes concepts such as ‘dependability’, ‘consistency’, ‘predictability’ and ‘confidence in someone or something’. Communication, openness and listening to others have being identified as behavioral characteristics that can facilitate the development of trust (Barnes, 1981; Brann, and Foddy, 1988; Morgan and Hunt, 1994). Williams (2005) suggests that organisational trust has five dimensions; ‘competence, openness, honesty, concern for employee welfare and identification’.

**Consequences of Trust**

Low trust can lead to a ‘greater amount of surveillance or monitoring of work in progress’ (Mayer et al. 1995, p.728). Surveillance reduces the level of innovation and cooperation amongst employees and can ultimately act to undermine the relationship between managers and employees (Brann and Foddy, 1988; Kramer, 1999). From an
organizational perspective, trust can enhance performance and organizational survival (Moye and Henkin, 2006); it is positively correlated with problem solving (Zand, 1972), individual and collective performance (Earley, 1986, McAllister, 1995), citizenship behaviour (McAllister, 1995), co-operation (Fine, and Holyfield, 1996) and communication (Roberts and O’Reilly, 1974). Connell et al. (2003) highlights the pivotal role of what they call ‘transformational leadership’, particularly in times of change in maintaining trust in manager-subordinate relationships. In addition to openness and good communication, the development of trust involves keeping employees informed about their impact on organizational outcomes and performance (Bowen and Lawler, 1995; Shaw, 1997; Weatherup, 1997; Randolph, 1995). Trust has a positive relationship with efficiency, adjustment, communication, openness, organisational commitment, adaptability and survival (Kiffen-Peterson and Cordery, 2003).

Trust amongst nurses and nurse-managers in the NHS

It has been said that public sector organization cultures have been successfully orientated toward a customer service ethos, and the use of concepts typically found the private sector such as quality have found their way into the language and practice of health care (Bolton, 2004). Recent reforms to NHS organizations have seen greater use of the ‘physical division of labour of health care professionals’ by hospital management. This has been achieved primarily through the introduction and use of Tayloristic work practices and techniques (Burchill and Casey, 1996; Flynn, 1992; Hoggett, 1996; Pollitt, 1993; Walby, et al., 1994).

Ongoing radical change in the NHS has had ‘attitudinal’ implications for employees such as job insecurity, lower morale and increased concern for quality by NHS staff (Walker, 2000: Department of Health, 2001). This had resulted in increased levels of labour turnover and a decline of those entering the nursing profession (Newman et al. 2002; Skinner, et al. 2004). Calnan and Rowe (2006) have attributed this erosion of trust primarily to the ‘health services manager’. Deteriorating levels of trust amongst nurses and organizational leadership has resulted in declining levels of morale, commitment and increasing levels of work related stress, is leading towards a ‘long term decline’ in organizational performance (Williams, 2005; Cunningham and Hyman, 1996). Newman et al. (2002) found that while recruitment and retention of nursing staff is low, the level of turnover amongst nursing staff was high. This has been attributed to heavier workloads, longer hours of work, understaffing, overtime and unpaid overtime, unfilled vacancies, under-funding of staff training and development, a situation with many nurses using their own time and money to undertake and pursue training (Review Body, 1999). Factors contributing towards a decline in the level of job satisfaction amongst nursing staff included poor management and top down managerial styles. Poor management involved: institutional bureaucracy, resulting in slower decision making, and the general management of staffing issues; workplace bullying; lack of employee recognition; poor working conditions; lack of managerial support and poor communications. In their research on Canadian health service organizations, Laschinger and Finnegan (2005), found that organizational ‘restructuring’ and ‘downsizing’ had led to a significant decline in trust levels amongst nurses and their managers. An important element of the strategy to increase nursing recruitment and retention involves creating work environments that manifest justice, trust, and respect and facilitate professional nursing practice (Laschinger
and Finegan, 2005). The prevailing perception was that nurses were less likely to contribute towards organizational goals when there was a low level of trust in their managers. The development of trust was therefore identified as a “crucially important leader activity”.

Our review suggests that within the changing NHS, there is further scope to consider the evolving nature of trust, and how this is talked about by nurses and managers.

**Methodology**

**Aims**
The purpose of this paper was to explore the antecedents, attributes and consequences of the social construction of trust through concept analysis. Concept analysis has not been frequently used to date in the study of nursing, or indeed by the nursing profession itself (Rodgers 1989). Concepts contain “defining characteristics or attributes that permit us to decide which phenomena match the concept and which do not” (Walker & Avant, 1988 p63). The literature on concept analysis also suggests that once the attributes commonly associated with the concept under consideration have been highlighted, they can then be considered as the ‘defining characteristics’ or ‘defining attributes’ of that concept (Walker & Avant 1988), providing greater clarification around the concept of trust and its associated attributes (Boyd, 1985, Knafli & Deatrick, 1985, Rew 1986, Walker and Avant, 1983). Attributes are those factors without which the concept would not exist. Antecedents include personal and organizational factors that influence how the concept is enacted. Consequences are the outcomes of enacting the concept. The benefit of concept analysis is that it presents the theoretical definitions and defining characteristics of the concept by drawing upon an extensive review of research literature, and empirical data, where possible (Walker & Avant 1988, Rodgers 1989).

**Data collection tool**
Given the subjective nature of the concept, semi-structured interviews were deemed the most appropriate research instrument. The interview schedule was devised by analyzing the various elements of trust, identified through an extensive literature review. It was subsequently reviewed by three academic experts in the field of trust, using the Delphi technique, and piloted amongst three nurses (See Appendix 1).

**Procedure**
Access to participants within the acute and community hospitals was negotiated and approved by Human Resources, who also acted as the initial point of contact between the interviewer (first author) and interviewees. Approval was granted by both ethics committees.

**Sample and sampling**
Twenty nurses and nurse line-managers were selected from each organisation, through a process of purposive sampling, to achieve a sample reflecting variation in terms of age,
grade, ward and length of time working within the NHS. The respondents were informed about the study through their line-manager, and participated on the basis of availability and level of interest. The participants were randomly selected. They included nurse line-managers, nurses in training, nurses at the mid-point of their career and other nurses approaching the end of their career. The researcher briefly explained the purpose of the study and respondents participated on a consensual and voluntary basis, with confidentiality assured. Sample details are provided in Table 1 below.

Table 1: Sample details

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<thead>
<tr>
<th>Organisation</th>
<th>Acute</th>
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<tr>
<td>Role</td>
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<td>Nurse Manager</td>
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<td>Sample</td>
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Of the 40 participants, a total of 31 nurses and 9 nurse line managers were interviewed.

Interviews
The interviews lasted approximately 45 minutes to 1 hour, and were conducted at the workplace facilities of those interviewed. The interviews were recorded through note taking and audio cassette (for reference purposes). They were inputted in full text format, and analysed with the assistance of a qualitative software program, NUDIST.

Analysis of data results
The data analysis was informed by a ‘grounded theory’ (Glaser and Strauss, 1967) and a ‘constant comparative approach’ (Glaser, 1965). This involved developing the main concepts and sub-categories in the interview data. The transcripts of the interviews were analysed sentence by sentence. The responses of interviewees in the acute and the community organisation, as well as those of nurses and nurse line-managers, were compared and analysed, noting any particular discursive resources (Sambrook 2001).
Findings

We present the findings in three categories: antecedents, attributes and consequences. Each of these have sub-categories. The antecedents of trust focus mainly on organizational factors. Attributes focus more on individual characteristics of ‘trusted’ managers and nurses, and the outcomes arising from the existence of trust. Conversely the consequences of trust explore the likely outcomes of its absence.

**Antecedents of Trust**

The antecedents of trust include; immediate work environment and the role of line-manager, leadership and management style, time and reciprocity.

**Immediate work environment and the role of line-manager**

There was a high level of trust amongst nurses and their line-managers in the immediate work environment. Respondents, from both organizations, were however less inclined to trust those outside their immediate work environment. Nurse line-managers also had discretion in choosing their own team of nurses, many did so on the basis of similar beliefs, attitudes and values.

“There is an element of trust within the smaller environment in which I work. However within the larger/wider organisational context I think there is a lot of distrust...you tend to employ people (nurses) on the ward who you would naturally warm towards”

(Nurse Manager 1)

The nurse line-manager role was considered highly significant in developing trust, within the immediate work environment, and between nurses and management. As most nurses had limited contact or involvement with middle or senior management, they tended to rely upon the judgments, views and attitudes of their line-managers, the attitudes of nurse line-managers therefore tended to ‘rub off’ on their subordinates. This was acknowledged by one nurse line-manager.

“If there is conflict between myself and my managers, the way I then come back to the ward, and present it, will either make them (subordinates) trust or mistrust management” (Nurse Manager 2)

“I trust my immediate superior but I have very little to do with the rest of the other managers so I cannot say whether or not I can trust them. Presumably if my immediate superior trusts them (management) then I would trust them”

(Nurse Manager 3)

Most nurses were less inclined to trust middle and senior level management, as they did not have “regular contact” with them.
“How can you trust someone you don't know?” (Nurse 1)

“Management don’t come down to the ward and say hello…They are also the ones that will come down jumping on our heads if something goes wrong and say ‘I didn’t know what was going on’” (Nurse 2)

**New leadership and Management styles – Resource Management**

A significant number of middle and senior managers were recruited from the private sector, with little or no experience in health care. Many felt that this was reflected in their attitudes and behaviour when dealing with nursing staff, and issues concerning patient care.

“Nursing staff are seen as commodities, patients are also viewed as commodities. They don't think of us as human beings. This does not make people feel valued. Being valued is very important because it motivates you to work” (Nurse 3)

New management styles, along with concepts and practices, associated with the private sector, created considerable mistrust and contributed to a perception that there was a conflict of interest between nursing aims and objectives and those of management. Many nurses felt that management placed too much emphasis on financial, and other quantitative performance targets, such as patient throughput, resource management, efficiency and ‘value for money’. These concepts for many nurses were inappropriate, alien, and at odds with best practice nursing care and standards.

“The introduction of new management practices has seen the introduction of business people, business culture and private sector managerial jargon, a customer service ethos and an attempt to set in place mechanisms to measure and control quality. There is a move to breakdown and erode the power of medical professionals and other groups of employees within the NHS” (Nurse Manager 4)

“We used to care for people, now we treat them” (Nurse Manager 5)

The issue of resource management impacted on nursing staff in three ways. It reduced the number of qualified nurses, who were subsequently replaced with health care assistants (HCAs). It limited resources for training and development, patient care and nurses terms and conditions of employment. These factors were seen as the main reason why so many nurses either left the hospital, or quit the profession altogether.

Many nurses also expressed frustration at the lack of any meaningful involvement in the process of organizational change. Many did not understand the supporting rationale behind organizational change, particularly when it came to the issue of ward closures and staff relocation. They also said that greater staff involvement in organizational change would reduce feelings in insecurity and mistrust.

“I trust my direct managers completely but only because I am currently involved in the decision-making. I know exactly what is going on” (Nurse 1)
Time and reciprocity - Previous experiences and propensity towards trusting others

Trust was developed over time, through reciprocal gestures of benevolent good-will between two or more parties.

“Earlier in the year we did a couple of team building days, and after that we seemed to get on much better. Everybody was able to say what they felt, hand things over to people and know that it would get done… Trust takes time to build up. It is a two-way thing” (Nurse 4)

Many nurses found it difficult to trust ‘agency nurses’, and nurses on short-term contracts. They felt that they were not given the time necessary to familiarise themselves with their qualities and attributes.

“When you allocate patients to nurses you do on the basis of trust, that they can look after that patient adequately. It is based on your previous knowledge about them; you have spent time and have had experience working with them so you can trust them in particular situations.” (Nurse Manager 5)

A prior history of negative experiences, were relevant parties had broken their promises or had not followed through on their commitments, made trust difficult to establish.

“I wouldn't trust them (management) further than I could throw them! Because of the way they have handled some situations! They have just handled both situations appallingly” (Nurse 6)

While it was acknowledged that some nurses were less trusting than others, most were initially prepared to trust. They were also prepared to withdraw this trust, if the individual concerned acted in anyway to undermine it. Conversely, it was equally important that individual nurses felt trusted by management, and given sufficient autonomy in executing their daily functions. One interviewee said that she trusted her line-manager more, because she gave her the autonomy and the space necessary to ‘get on with the job’.

“I think it makes you feel good about yourself if you know that the superior trusts you. That has got a ‘knock on’ effect with everyone else. Like I say if I trust my team, and they know I trust them, they feel better as well” (Nurse Manager 6)

Attributes of Trust

Attributes of trust are those factors without which the concept would not exist. The following looks at the attributes of ‘trusted’ nurses and nurse line-managers, and the outcomes associated with high trust relations. These include: communication, leadership and management style, professional nursing standards, team work/support and confidentiality.
Communication – understanding and clarification

Communication was considered both a condition and an attribute of high trust relations. Communication that was ‘regular’, ‘open’, ‘honest’ and ‘clear’ was ‘essential’ in helping nurses work with each other and their managers. Appropriate communication channels, such as regular meetings facilitated greater inter and intra departmental communication. Nurses highlighted ward meetings as a system of ‘peer support’, where staff could openly and constructively discuss how they ‘functioned as a team’.

“We have regular meetings as a team, which they always ask for our opinions” (Nurse 7)

Good communication helped reduce potential conflict between nurses and their line-managers, and helped clarify understanding in relation to organizational aims and objectives.

“She (nurse line-manager) has been very good throughout the ward closure. Obviously she had to work with higher level management but she always kept us informed. She always came back to us and told us what was happening throughout the meetings” (Nurse 8)

‘Poor communication’ was the main factor undermining the development of trust. It also contributed to the perception that nurses were been kept ‘in the dark’ and ‘out of the loop’.

“If you trust somebody you will communicate with them. People won't know what they are working towards, and problems set in. This happened previously. No one trusted the manager...Very often conflict arises because of a lack of knowledge and understanding of aspects of work and what other peoples’ roles are. If there is no communication between all these areas then we are not going to have mutual trust because no one understands anyone else” (Nurse 9)

Leadership and Management Style - Involved, accessible and ‘hands on’

Nurses were more likely to trust managers they considered accessible, approachable, involved and ‘hands on’. This made them feel supported, respected and valued.

“I will say that one of managers has come and worked on the ward and that went down really well. She ‘rolled up her sleeves’ and helped” (Nurse 1)

They were less likely to trust inaccessible managers, or managers higher up within the organisation’s hierarchy.

“I think he (line-manager) could maybe become a more active member of staff, that is when he is on duty he can be counted on. He needs to work on the ward rather than do managerial tasks. He should be involved on the ward” (Nurse 10)
Those who showed ‘leadership’, who led by example and demonstrated good judgment, were more likely to gain the trust of others.

“You trust them (line-manager) to know what the right thing is. You trust their judgment...I am every bit of every nurse I ever worked with and over the years. I have picked up points from other nurses...she (line manager) thought me an awful lot, and yes I would trust her” (Nurse Manager 5)

The majority of respondents felt that middle and senior level management did not have the same level or sense of professional commitment, towards professional nursing care practice and patient care, as they themselves did.

“We have a professional code of conduct which we as individual professionals have to be seen to work by. The main aim has to be patient care and respecting patient’s wishes and if possible working with them not against them, with their compliance so there has to be mutual trust” (Nurse 11)

**Professional nursing standards – consistent, fair and objective**

‘Professional competence’, ‘reliability’, ‘consistency’, ‘accountability’, ‘responsibility’, ‘predictability’, ‘commitment’ and ‘objectivity’, in terms of decision-making and behaviour, were all viewed as important attributes of ‘trusted’ line-managers and colleagues. This ensured a more efficient, and secure working environment.

“We have a thing called ‘clinical supervision’. There is a lot of trust involved in that. That is about staff of the same grade, supervising each other, being a sounding board, saying things like ‘I think you don't do that well’. You have to have a high degree of trust in someone else to allow them to say those things to you” (Nurse 12)

Evidence of commitment towards the same values, namely professional nursing practice and patient care, were also highlighted as important attributes of ‘trusted’ line-managers and colleagues.

“I think people recognise commitment is a form of trust, a part of ‘professional trust’. If you are committed then you are not going to give up easily and run away from your professional responsibilities” (Nurse 7)

They could therefore take the professionalism, and the commitment of their line-manager and colleagues as a given. For many nurses professional competence was considered more significant, and of greater importance than personal liking.

“Its whether or not you have faith in that person's ability to do their job. Whether you like the individual concerned is not important. You can actually dislike someone intensely but at the same time you can trust and work with them so it is not personal” (Nurse 13)
It was also important that nurse line-managers were ‘objective’, ‘fair’ and ‘respectful’ to all nurses working on the ward. Perceptions of ‘favoritism’, ‘bias’ and the absence of ‘professional impartiality’ undermined trust.

**Teamwork and support**
Teamwork and support, from ‘reliable’ line-managers and colleagues, was essential in developing trust, and delivering high quality patient care.

“You have to rely on other people to help. You can’t do it all by yourself. You have to trust your colleagues, their work and their abilities” (Nurse 14)

It was important that both their line-manager and colleagues were ‘loyal’. That they acted in the best interests of the nursing profession, and as an ‘advocate’ for nurses and the work that they did.

“My Supervisor supports us which makes us a good team and that is what she does and that is what makes you feel that you can trust people” (Nurse 3)

Many felt that there was a lack of ‘moral’ and ‘financial’ support from middle and senior management.

“If something goes wrong the general feeling is that management won’t support you” (Nurse Manager 7)

They felt that this limited their ability to administer quality patient care to the standards set out by their profession.

**Confidentiality and discretion**
Confidentiality, the “ability to confide without fear”, played an important role in diagnosing and resolving issues and problems. It was important that nurses were able to confide in their line-managers and their colleagues, particularly if they were finding it difficult to cope. The majority of those interviewed said that they were able to confide in both their line-managers and colleagues.

“If you are not coping with things or you have a problem with your team, you need to talk it over with your manager and work out some way that you can sort it out. It makes for a better relationship and a better working environment” (Nurse 15)

Trust could be undermined if confidentiality was in anyway compromised or broken. This was especially the case if the individual concerned happened to be a nurse line-manager.

“If they have gone and talked to everyone, it is very undermining. I got so angry with that person, and because she was my manager I had absolutely no respect
and never really gave her the time of day afterwards… If you go to someone and they respect confidentiality it can enhance your working relationship a lot more” (Nurse 9)

**Consequences of Trust**

Consequences are the outcomes of enacting the concept of trust. This study has explored the antecedents and attributes of trust - which also included many of the beneficial outcomes associated with trust. The following however explores the consequences of ‘low’ trust amongst nurses and nurse line-managers. These included: reduced teamwork and efficiency, higher levels of work-related stress, destructive conflict, lower standards of patient care, higher levels of absenteeism and labour turnover.

**Team work and Efficiency**

The absence of trust would undermine teamwork, and associated benefits such as support, communication and confidentiality. The main consequence would be a less efficient and productive work environment.

“You cannot work efficiently; you don't feel as if you are working as part of a team” (Nurse 3)

Many nurses would no longer be able to take the professionalism of their line-manager, or their colleagues as a given. They would spend more time double checking, to ensure their line-manager and colleagues had carried out their work properly.

“I could not do my job as a manager. I would be continually going around and checking up on people. It (mistrust) would lower the standard of nursing care. This would prevent me from doing my own work” (Nurse Manager 7)

**Conflict and patient care**

A climate of low trust would reduce the likelihood that any conflict in the organization would be creative. Conflict would instead become more destructive. This would contribute further towards a climate of low trust.

“about 18 months ago there was a problem of trust between the senior sister and one of the senior members of staff and it split the ward. It took a whole year to sort that back out again because there was dishonesty, and lying and a lack of trust. The ward just disintegrated into two” (Nurse Manager 3)

A low trust climate would also create a culture of ‘obstruction’, a place were nobody could ‘progress’. This would compromise professional nursing care standards and undermine the delivery of quality nursing care.

“It would be the patients that would suffer in the long run, then myself. If things weren't done as they should be, or just weren't done and missed out because somebody didn't know how to do a certain procedure. If I am doing 101 other
things and I haven't got time, you can only spread yourself so far” (Nurse 16)

Mistrust would undermine staff morale, confidence, self-esteem and motivation.

“If I felt there was a lack of trust there would be an awful atmosphere on the unit. This in turn can affect the patient’s recovery… I would leave, if they didn’t trust me” (Nurse 17)

**Absenteeism and turnover**

The interviewees said that the above outcomes would have a ”ripple effect” throughout the organization, and would translate into increased levels of absenteeism and labour turnover. Again this would and reduce the ability of nursing staff to deliver quality patient care.

“If you cannot trust your fellow workers it is not a very nice place to work. It would make my work harder…People would be going off sick, the stress levels would hit the roof” (Nurse 18)

“I just had to get off that particular ward! The situation had become what I would consider “dangerous” both for staff and the patients within their care… I quickly got a transfer onto another ward!” (Nurse 19)

The main positive consequence of trust was fostering the teamwork and camaraderie necessary for a healthy, efficient work environment. This was essential to the maintenance of good nursing care practice in delivering quality patient care. This in turn ensured that staff absenteeism and labour turnover were kept to a minimum.
Discussion

Having presented the findings from the interviews with 40 nurses and line managers, we summarise the data in a concept analysis of the attributes, antecedents and consequences of trust in Figure 2 below.

The findings suggest that there is a high level of trust in the nurses’ immediate work environment, amongst nurses and nurse line-managers. This is perhaps unsurprising given their individual/personal ‘professional’ identities, and frequent talk of professional commitment and judgment. Both nurses and nurse line-managers talked about how the nurse-line manager relationship can significantly influence trust in higher level management and the general level of trust in the wider organization (Chen et al., 2008). This connects the professional and organizational aspects of trust from the nursing perspective, and highlights the pivotal role of the nurse-manager and particularly the discourses they used to articulate organizational objectives and management practices.

Figure 2: A concept analysis of trust from a nursing perspective

<table>
<thead>
<tr>
<th>Antecedents</th>
<th>Attributes</th>
<th>Consequences</th>
</tr>
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<tbody>
<tr>
<td>Organisational/individual factors: Immediate working environment and the role of line-manager</td>
<td>Organisational/individual factors: Communication – understanding and clarification</td>
<td>Organisational/individual outcomes: Team work and efficiency</td>
</tr>
<tr>
<td>New Leadership and Management styles – Resource Management</td>
<td>Leadership and Management Style- Involved, visible and ‘hands on’</td>
<td>Quality patient care</td>
</tr>
<tr>
<td>Time and reciprocity- Previous experiences and propensity towards trusting others</td>
<td>Professional nursing standards – consistent, fair and objective</td>
<td>Efficient, healthy and productive working environment</td>
</tr>
<tr>
<td></td>
<td>Teamwork and support - back-up and ‘follow through’</td>
<td></td>
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<tr>
<td></td>
<td>Confidentiality and discretion</td>
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</tbody>
</table>

The level of trust amongst nursing staff in the wider working environment was low, particularly in relation to middle and senior management. There was a widespread perception amongst nurses that because many middle and senior management had been recruited from the private sector, they brought with them concepts, attitudes, values and beliefs which proved ‘alien’ to health care professionals, and the environment in which they work (Bolton, 2002; Laschinger and Finegan, 2005; Newman et al., 2002). They associated private sector practices, such as resource and performance management, with reductions in qualified nursing staff, underinvestment in staff training and development and deteriorating terms and conditions of employment (Cunningham and Hyman, 1996; Newman et al., 2002). This left many nurses feeling demoralised and disillusioned. There was also greater distance between nursing staff and middle and senior level management. This was characterized by talk of hierarchies and private sector management styles, resisted by many nurses and nurse managers. It is perhaps reasonable to expect that trust
between participants is limited in situations where there is a low level of direct personal contact (Owen, and Powell, 2006).

Nurses, in both organizations, were generally unhappy with the management of organizational change (Laschinger and Finegan, 2005; Skinner, et al. 2004), and the assumptions and attitudes of management in relation to nursing staff and patient care. They said that organizational change had been poorly managed, with little meaningful staff communication or involvement. They talked about how the concerns and input of professional nursing staff had not been included in organizational change. Poor communication was identified as one of the main barriers to the development of trust. Many also felt that middle and senior management did not provide them with the necessary financial or moral support to do their work. For this reason, and the other factors highlighted, they were less inclined to trust them.

While they discussed communication and confidentiality in the development of trust, nurses said that they were more likely to trust line-managers who were ‘hands on’, accessible and approachable. They discussed the importance of professional nursing standards and practice, which were considered by many to be of much greater importance than personal liking (Kiffen-Peterson and Cordery, 2003). Evidence of professional competence and commitment was considered to be one of the most important characteristics of trusted line-manager’s and colleagues. It was also important that line-managers demonstrate and show a certain level of professional objectivity when dealing with nursing staff. Perceptions of favouritism and bias did much to undermine the development of trust.

The interviewees talked about how a low-trust environment would undermine the basis for effective teamwork, and primary associated benefit efficiency (Walsh, 1995). As previously discussed, low trust involved additional work and stress, resulting in reduced nurse-patient contact, and hence undermining the quality and the standard of patient care (Tallman, 2007; Skinner et al., 2004; Halliday, 2004). This would be accompanied with an increase in ‘destructive’ conflict in the work environment, which would undermine the confidence, morale and job satisfaction of many nurses, who would then contemplate leaving the organization. An environment of low trust would therefore result in increasing levels of labour turnover and absenteeism.

**Conclusions**

To conclude, we have presented findings from a small qualitative study drawing on forty interviews from nursing staff in two NHS organizations. Employing a concept analysis, we have highlighted the attributes, antecedents and consequences of trust from a nurse and nurse-manager perspective. Both nurses and nurse line-managers talked of a high level of trust in the nurses’ immediate working environment. Both also indicated that the nurse-line manager relationship can significantly influence trust in higher level management and the general level of trust in the wider organization. This connects the professional and organizational aspects of trust from the nursing perspective, and highlights the pivotal role of the nurse-manager and particularly the discourses they used...
to articulate organizational objectives and management practices. Our findings offer potentially valuable information for healthcare managers and nurses to help build trusting relationships within this context. Our high trust model also offers opportunities to consider the implications of these influencing factors for leadership and management development.

We end with one final point: nurse-managers play a pivotal role in connecting the daily experiences of nurses to the wider organizational system. More importantly, how they talk about organizational objectives, senior managerial colleagues and proposed changes, for example, is a key determinant of instilling greater trust within their nursing staff. These are all aspects that need to be considered in manager and leader development, particularly in the healthcare context.
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Appendix 1

Interview schedule

1. What do you mean when you think about and talk about trust?

2. How would you assess the level of trust in your organization at this time?

3. What is the level of trust on your ward?

4. Without giving names do you trust your immediate superior?

5. What qualities would make you trust your immediate superior?

6. What could your immediate superior do to increase your trust in him or her?

7. What do you see as the conditions that contribute to trust?

8. What are the consequences of high levels of mistrust in your organization?