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The antecedents, attributes and consequences of trust among nurses and nurse managers: A concept analysis

T.J. McCabe [a,*], Sally Sambrook [b,1]

[a] National College of Ireland, Mayor Street, IFSC, Dublin 1, Ireland
[b] Bangor Business School, Bangor University Hen Goleg, College Road, Bangor, Gwynedd, LL57 2DG, UK

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ABSTRACT

Background: Although trust has been investigated in the health context, limited research explores nurse and nurse manager perceptions of trust.
Objective: To explore the concept of trust amongst nurses and nurse managers at individual, interpersonal and organisational levels.
Design: Our paper reports the findings from an interpretivist study conducted within the British National Health Service, involving thirty-nine semi-structured interviews with nurses and nurse managers.
Settings: Large acute and small community organisation within the British National Health Service.
Participants: 28 nurses and 11 nurse managers working within an Acute and a Community sector organisation – 20 and 19 in each organisation. Participants were selected through a process of purposive sampling, reflecting variations in terms of age, grade, ward and tenure.
Methods: We utilise a concept analysis framework in exploring the antecedents, attributes and consequences of trust amongst nurses and nurse managers at individual, interpersonal and organisational levels.
Results: Key findings suggest that trust is formed within the immediate ward environment, and is significantly influenced by the role of line manager. Other positively influencing factors include professionalism and commitment to the nursing profession. These form the basis for the teamwork, delegation, support, open communication systems, confidentiality and discretion essential to delivering quality patient care. Negatively influencing factors include new management concepts, practices and styles overseen by managers recruited from the private sector. New management concepts were associated with reductions in the number of qualified nurses and increasing numbers of untrained nursing staff, reduced direct patient contact, less opportunities for professional training and development and deteriorating terms and conditions of employment.
Conclusions: Our findings offer insight for managers, nurses and human resource practitioners to help build high trust relationships in a health care context. Of particular import is the need for managers to communicate more effectively organisational and financial constraints, in a manner that does not 'alienate' nurses and nurse managers, by highlighting their value and acknowledging their role in delivering high quality patient care.

* Corresponding author. Tel.: +353 1 4498550.
E-mail addresses: tmccabe@ncirl.ie, mccabet_j@hotmail.com (T.J. McCabe), abs803@bangor.ac.uk (S. Sambrook).
[1] Tel.: +44 1248 38 2046.

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What is already known about this topic

- General management was introduced into the public services as the basis for more effective governance and better representation of service users. This saw the introduction of new concepts such as privatisation, quality, customer service and performance management.
- Trust is a multi-dimensional concept linked to notions of vulnerability based on the goodwill, benevolence and competence of another party.
- Trust often tends to be developed through individuals with particular characteristics rather than abstract notions of the organisation or generalised others.
- Change in healthcare organisations on trust has resulted in declining levels of trust in management but increasing levels of trust in 'nurse managers'.

What this paper adds

- Trust is formed within the immediate ward environment amongst nursing professionals and is significantly influenced through the nurse manager role.
- Evidence of professionalism was significant in the development of trust amongst nurses and nurse managers. This formed the basis of the teamwork, delegation and support required for an efficient work environment, considered as the main consequence of trust.
- Communication systems and styles, linked to confidentiality and discretion influenced the development of trust. Nursing professionals were more likely to trust management with open styles of communication, who were approachable and accessible.
- New management concepts, practices and styles, introduced by managers recruited from the private sector, had a negative impact on trust levels. New management concepts and resource management were viewed as responsible for lower numbers of qualified nurses, increasing numbers of untrained nursing staff, reduced direct patient contact, professional training and development and poorer terms and conditions of employment.

Implications for policy and/or practice

- Offers insights and opportunities for health care managers, nurses and human resource practitioners to consider the influencing factors of trust in building high trust relationships.

1. Introduction

Traditionally employment within health and social care has tended to attract and favour individuals with a strong occupational or professional commitment (Bartlett, 2007, p. 126), to organisations with "a credible commitment and support" for their "professional competence" (O'Donohue and Nelson, 2007, p. 554). However, in response to increasing conflicts with state and service users (Rose, 1996; Gilbert, 2005), 'managerialism' was introduced as the basis for effective governance of public services (Doolin and Lawrence, 1997; Calnan and Gabe, 2001; Jommi et al., 2001; Pollitt, 1993). Concepts such as privatisation, free choice, quality, customer service and performance management became widespread, reflecting the increasing use of the discourses and practices of the market (Nordgren, 2008), and a move towards a competitive business culture (Davies and Mannion, 2000). 'Managerialism', in terms of its rhetoric, has tended to position itself as ethically opposed to the professional discourses, that were viewed as guilty of 'paternalism' and arrogant self-interest, raising the wider issue of trust (Traynor, 1999). Trust is managed by positioning 'managerial governance' in opposition to 'professional expertise', with both claiming to represent the best interests of service users (Traynor, 1999).

Trust has become a valuable and scarce commodity in late modernity (Brown, 2009), and plays a major role in health care, an environment characterised by 'uncertainty'. It is crucial in managing vulnerability (Hall et al., 2001) and complexity (Luhmann, 1979), where patients are both vulnerable and reliant upon the competence and intentions of the practitioner (Brown, 2008; Williams, 2007; Alaszweski, 2003; Hall et al., 2001). It is considered essential in the nurse-patient relationship (Mechanic, 2004; Peter and Morgan, 2001), where nurses 'interface' between patient and 'hospital' (Bolton, 2004), and act as the main signifier of patient satisfaction (Arthur and James, 1994; Attree, 2001; Mahon, 1996). Trust and associated benefits such as 'commitment' and 'goodwill' are also required to ensure the maintenance of service quality (Skinner et al., 2004; Hau, 2004; Walsh, 1995; Halliday, 2004), particularly in an environment driven by service demands and technology (Williams, 2005). It is particularly essential in achieving extensive structural, philosophical and value changes (Moye and Henkin, 2006; Kiffen-Peterson and Cordery, 2003).

2. Background

The multi-dimensional nature of trust has made it difficult to define (Hosmer, 1995), with definitions ranging from commodity (Dasgupta, 1988) to an emphasis on a social reality (Lewis and Weigert, 1985), vulnerability (Hall et al., 2001; Mollering, 2007) and a basis for bargaining (Coleman, 1983). Trust has been defined as "one's willingness to increase one's vulnerability to another whose behaviour is not under one's control" (Zand, 1972, p. 230). It is conceptualised as a process involving vulnerability (Brockner et al., 1997; Laschinger and Finegan, 2005; Mayer et al., 1995) and risk (Sellman, 2007), where there is an expectation of others and a giving of self. However because trust involves vulnerability there should be 'good reasons' when entering into a 'trust relationship' (Laschinger and Finegan, 2005). Trust is fragile, it can be easily undermined and 'destroyed' (Owen and Powell, 2006). The consequences of trust are the realisation of expected benefits or continued trust (Johns, 1996; Hams, 1997). Drawing on a concept analysis framework (Walker and Avant, 1988; Rodgers, 1989) we now review the theoretical *antecedents*, *attributes* and *consequences* of trust.