Nursing work in acute settings: what must endure, what can change?”

Pressures to contain healthcare costs drive the idea that nursing work should be restructured to allow nurses to practice at the full extent of their training and education. As nurses are urged to look at which parts of practice might be undertaken by other workers, both expected and unexpected impacts of task-shifting on patient care must be considered.

Nursing work in acute settings is described as suffering from complexity compression and nurses' workflow as in fact having little flow, interruptions posing a heavy cognitive burden that may compromise nurses' clinical reasoning and decision-making in meeting patients' complex care needs. At the same time measures to bolster patient safety, such as protocols to prevent 'failure to rescue', are being implemented. However, studies showing relationships between staffing levels and patient outcomes propose that improved attention to patients is the critical factor in safer staffing.

Work restructuring must release nurses from system inefficiencies that prompt them to fill the gap ("If I don't do it, who will?"). But work restructuring must also factor in what happens in the contact time that direct patient care affords: clinical assessment, emotional support, opportunities for coaching in self-management - in short, the human connection central to both nursing and a positive healthcare experience.

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| SLIDESHOW | SCRIPT |
| SLIDE 1 | My name is Shelley Jones. I am from New Zealand, also known by the name given it by Maori voyagers coming from Hawai'iki, who saw a long white cloud indicating a land mass. I am from Aotearoa. Kia Ora. I work independently and while my comments today arise out of projects I've done with health service providers, this is a viewpoint and my perspectives are personal. |
|  | **Nursing work in acute settings** - to be more specific about the setting I'm talking about, it's this one [CLICK] - the hospital ward - rather than the department or specialty unit.  Just how do we organise what happens here to get the best outcomes? At this Congress, the programme themes of today and tomorrow of accord with the idea that *...the organization of nurses’ work is a major determinant of patient and staff welfare[[1]](#endnote-1).*  Organising and managing nursing work in hospital wards has been the focus of   * ward and room design, looking at how layout and structure impact on nursing work and patient safety[[2]](#endnote-2) * large scale improvement programmes, such as the 'productive or well-organised ward' which aim for time savings (by enabling nurses to work more efficiently) and time investment (whereby time released from inefficiency increases the time available for direct patient care)[[3]](#endnote-3),[[4]](#endnote-4),[[5]](#endnote-5) * studies such as those by Professor Aiken and her colleagues looking at the interplay between nurse-patient ratios, staffing skill mix and outcomes for patients and nurses.   My particular question today arises out of work re-design, specifically, models of care that enable the assignment or delegation of 'basic' nursing care to unregulated assistants. This 'task-shifting' is proposed to answer concerns about the cost of health service provision ***and*** the problem of shortages in the nursing workforce, specifically, 'highly skilled/higher cost professional nurses'. Let's just call those highly skilled/higher cost professional nurses 'Registered Nurses, or RNs' for short. The idea is to free RNs up from basic care so that they can 'practice at the full extent of their training and education'.  My argument today is that we might not have properly recognised 'basic' care for what it is - care that might be a fundamental part of nursing practice, and which through its contact time with patients, might be the foundation of the place to which we bring the full extent of our training and education.  Probably anyone who has tried to implement a work re-design project will know that nurses don't readily accept that 'what will help them', ***will*** help them. Obviously, re-assigning work needs to be carefully managed so that nurses feel confident about delegating care to others - but what might we learn if we were to explore what is involved in the resistance RNs sometimes put up to assigning basic care to others?[[6]](#endnote-6) And when we ask, as did Nightingale, *How do we provide for the thing to be done when we are not there or cannot be there*, do we also ask, *Which are the things we must be there for?* |
|  | [CLICK] Hence my question: **What must endure, what can change?** |
| SLIDE 2 | [CLICK] What is going on in the hospital ward? Let's state the obvious   * patients are here because they need skilled nursing care (otherwise they'd be at home and attending the hospital as an outpatient) * this inpatient population is increasingly older and more likely to be living with long term conditions, they may have a number of co-morbidities, including dementia[[7]](#endnote-7), and * although their stay in the ward will be short, their medical treatments[[8]](#endnote-8) and just the business of being an older person in hospital means that they are more likely to suffer harm or have an adverse event.   Some argue that these factors *'...have been more likely to increase hospital nurse staffing requirements than to decrease them'* (~~per Aitken et al 2016 citing Buchan~~) but the pressure to contain costs means that we ***have*** looked carefully at appropriate and safe staffing and skillmix.  Let's use a scenario, based on an actual patient event, to look at what we probably ***didn't*** expect to be happening when basic care is delegated to assistive personnel.  [CLICK] |
| SLIDE 3  Image [*source*](http://www.dailymail.co.uk/travel/travel_news/article-3386721/The-holiday-destinations-travel-insurance-REALLY-important-world-s-expensive-hospital-beds-revealed-isn-t-priciest.html) | In an acute medical ward, 85 year old Mr Smith is in his bed, admitted 2 days ago with a [non-ST elevation myocardial infarction](http://nstemi.org/), having presented to ED with atypical chest discomfort, notably without radiating pain.  Amongst his medical problems are severe renal impairment ([~~Chronic Kidney Disease Stage V~~](http://www.renal.org/information-resources/the-uk-eckd-guide/stages-4-5-ckd#sthash.ZLp75ed4.dpbs)) secondary to diabetic nephropathy, his haemoglobin has fallen to 94 g/L. He has type II diabetes mellitus with peripheral neuropathy, he has hypertension, he has myocardial ischaemia. He has gout. There was a recent admission for lower lobe pneumonia. He is taking 10 prescribed medicines. In short he has the medical textbook.  His daughther, who knows most of his medical history, is with him.  A healthcare assistant comes to the end of the bed and asks Mr Smith if he would like a shower today. He is a reticent man and he says politely. "No, I don't think so, thank you."  Mr Smith's daughter asks him why not. He says he hasn't had a good night, there was an admission in the four-bedded room. The daughter persists, "Dad, you haven't had a wash since you came in. You'd feel so much better." "No," he says, "I really don't feel up to it". The health care assistant accepts that and leaves the room.  The daughter runs this conversation again in her head and looks at her father. She sees that his colour is not good and there's perspiration on his forehead. "You're not feeling like you were when you had that little heart attack," she asks. "I might be," he says.  [LOOK UP TO AUDIENCE] Although you will have "fixed" the problems in this scenario as it unfolded, this kind of story might perhaps happen more often than we would wish. We'll return to it later in the presentation.  The scenario highlights two things: how care can get missed, and how a change in a patient's clinical condition can get missed... ?Let's agree at this point that these things can get missed even when care isn't delegated.  [CLICK] |
| SLIDE 4 | The patient safety movement has focussed on errors of commission (doing a wrong thing, such as administering the wrong medicine or wrong site surgery). Errors of omission (failing to do the right thing) are not only less likely to be noticed, they may be more common and more of a problem.  Missed nursing care was defined by Beatrice Kalisch and her colleagues in 2009 as [CLICK], any aspect of required patient care that is omitted (either in part or in whole) or delayed. They found omissions of mouthcare, bathing and skincare, ambulation, and timely assistance with toileting and feeding[[9]](#endnote-9). These things impact strongly on patient condition, experience and outcomes. The complications arising out of missed 'basic' care, such as falls and pressure injuries, also increase costs to the hospital in terms of length of stay, reportable events, root cause analysis etc. Kalisch et al also found that 'top of scope' items such as patient teaching and emotional support were missed.  ~~Although patient assessment tended to be the least missed element of care, it was mentioned frequently by nurses.~~  There is now a significant body of work available to us, but at that time there had been little research. They described missed care as an **‘undiscussable’** – nurses don’t talk about it because they feel guilty, powerless to change the situation or afraid of the consequences. The way nurses feel about missed care impacts negatively on their professional self-concept and job satisfaction – with implications for turnover and staffing.  While adequate staff numbers and appropriate skill mix are **necessary**, they are not **sufficient** in determining whether patients receive the care and attention they require. More qualitative factors come into play: how staff organise their work, how they work together, and how work and practice environments support, or don't support, nursing work and teamwork. |
|  | Related to omissions in care, the patient safety movement has also focussed on **failure to rescue**, ~~which refers to a death after a treatable complication (see:~~ [~~AHRQ's patient safety primer Failure to Rescue~~](https://psnet.ahrq.gov/primers/primer/38/failure-to-rescue)~~),~~ and systems to detect and manage **early warning signs of patient deterioration**. Points of failure in recognising and responding to deteriorating patients are:   * not *taking* observations * not *recording* observations * not *recognising* early signs of deterioration * not *communicating* observations KCL 2011 |
| SLIDE 5 | Nightingale, I think, cuts to the heart of of the matter, when she talks about observation "...not that the habit of ready and correct observation will by itself make us useful nurses, [CLICK] but that without it we shall be useless with all our devotion..."[[10]](#endnote-10) (Notes:116-7). She goes on to say  "Good nursing consists simply in observing little things which are common to all sick, and those which are particular to each sick individual" (Notes:117). I take this to mean first **knowing what you are seeing** in the 'little things which are common' to a particular diagnosis - the sound knowledge base refined by experience that enables the skilled undersanding and nuanced perceptual judgement of what is happening clinically with the patient - whether in the course of deliberate assessment or the 'noticing' that occurs in the course of giving care.  Secondly, I take it to mean knowing the patient as a person - reading them, picking up on non-verbal cues, asking the right questions... being with them. |
| SLIDE 6 | [CLICK] "**Improved attention**" through better surveillance and observation of patients is a critical factor in a model of causality proposed for the relationship between higher nurse staffing levels and decreased inpatient mortality[[11]](#endnote-11),[[12]](#endnote-12),[[13]](#endnote-13). |
|  | "Improved attention" then, requires **proximity, presence and interaction**. It also requires **a degree of focus**. And in ward work (and indeed perhaps anywhere), that seems to be in short supply according to [CLICK] several studies: |
|  | ***Non-value added nursing work - system inefficiencies***  Using an activity based costing approach, Storfjell and colleagues found just over 40% of med/surg nurses' time being spent on four patient are activities deemed to add value: assessment and monitoring, teaching patients, providing direct care and providing psychosocial support, with teaching and providing psychosocial support getting the least time.  Not adding value were activities where the drivers were 'related to   * care fragmentation, * handoffs, * cumbersome processes, and * lack of access to adequate working equipment and needed supplies.   In other words - **time wasted on dealing with inefficiencies in the** **system** (Storfjell et al 2009:44)  They argue that a paradoxical and unintended consequence of increasing the number of nurses may be to simply multiply the number of people involved with processes that aren't working well (e.g queueing to use computers and medicatio dispensers), whereas increasing system edefficienty could simultaneoulsy reduce costs and free-up time for nursing care. |
|  | ***Complexity compression - system demands***  Another team of researchers trying to understand what the work environment itself might be contributing to a nursing shortage, used a focus group approach. Acknowledging that nurses have always worked with complexity in their patients and the health system, they use the term 'complexity compression' to identify system demand, or 'what nurses experience when expected to assume additional, unplanned responsibilities in a condensed timeframe, while simultaneously conducting their multiple responsibilities' (p88). Krichbaum and colleagues noted that their findings resonate with what is known about job satisfaction, or more accurately job dissatisfaction.  The most important contributing factors were those related to systems, those affectng practice and those affecting nurses' autonomy and control.   * System demands related to the introduction of new technologies, which nurses needed to learn quickly and also needed to put in place time-consuming manual workarounds to keep patients safe if systems failed. * Factors affecting nursing practice were additional demands on time with increasing responsibility for training and supervising a diverse ancillary staff. * Finally, related to autonomy and control - there were frustrations about either not being asked for input into decisions affecting their work, or being asked and the input disregarded; and being accountable (for their own work and that of those they supervise) to managers and administrators with little knowledge of patient care or nursing work[[14]](#endnote-14). |

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|  | ***No ‘flow’ in nursing workflow***  Cornell and colleagues undertook a real time direct observation study of 27 RNs in med-surg wards to look at the pattern, duration and frequency of activities in nursing work[[15]](#endnote-15).  Quoting from their study  Assessment, charting, and communicating were the most frequent activities, consuming 18.1%, 9.9%, and 11.8% of nurse time, respectively. The duration of 40% of the activities was less than 10 seconds. Timelines revealed that nurses constantly switch activities and locations in a seemingly random pattern. The results indicate that **there is little "flow" in nurse workflow**. The chaotic pace implies that nurses rarely complete an activity before switching to another. The opportunity to use critical thinking and engage in planning care is severely limited under these circumstances.    ~~They discuss implications for cognition and role transformation.~~    ~~We want to think of nurses as knowledge workers, but Cornell and co say "Few professionals are required to perform as many functions and tasks in as many locations, often ‘on the fly’….Conclusions about the length of time to complete an activity cannot be reached, as nurses rarely completed an activity without interruption. The chaotic pace…constant switching and juggling takes a toll on performance, especially on work processes requiring complex decision making or reasoning… [yet] care complexity is increasing.~~  ~~40% of the observed activities were less than 10 seconds, and nearly 77% less than 30 seconds. These constant shifts in activity prompted these researhers to describe nursing work as frantic an chaotic and pose questions about the frequency of nonobservable cognitive shifts such as reprioritisatioin, reviewing and syntesising paient information.~~ 138 words |
|  | CLICK/BEAT Nurses have always stepped up to fill the gap, have always tried to do their best and do manage to juggle all that needs to be done. These research findings help us think more critically about the consequences of continuing to do so. The nursing time that goes into compensating for system inefficiencies, that tries to keep up with system demands, when what is happening around our patients in med-surg wards is described by researchers as chaotic and frantic... ~~BEAT We need to CLICK~~ |
| SLIDE 7 | ...and perhaps experienced by nurses as nearly impossible to do... You don't need to read between the lines to know that people remove themselves from situations like this...  Text in bubble:  *Many of the nurses I have spoken with feel frustrated that they don't have the time to care for their patients, that the care is performed by nonlicensed personnel as directed by them.*  *They feel they are constantly responding to information given them and having to "back track" to assess that information if it falls out of the norm for that patient.*  *The majority of the nurses on the floor feel they have far too many patients they are responsible for to be "on top" of everything and state they rely heavily on their assistive team members.* |
| SLIDE 8 | BEAT We need to CLICK **Keep Calm** and CLICK think like a nurse... |
|  | Nurses, I'd like to think, will ask CLICK 'What is happening for the patient?/What does it mean for the patient?". What is their experience, their safety, what is the quality of the care they're receiving? |
|  | Let's go back to our **scenario** - Mr Smith has done something we would expect an RN to pick up on, but not particularly expect an assistant to pick up on. Remember that it's not just Mr Smith who has the medical text book, **every patient** in the ward does. |
| SLIDE 9 | In the true story, as you may have guessed, it's not Mr Smith, it's Mr Jones, and I am the daughter at the bedside. ~~Right then, I felt like the only Registered Nurse within a 5 mile radius of my father. And~~ At the moment I realised my father was in trouble, an incredibly fortunate thing happened - the medical team were on their ward round and they walked into the room and he got the immediate medical attention he required.  You can imagine, this incident set me thinking. I have some questions:   * I do wonder how much the increase in patient acuity matched with a dilution in nursing skills has meant the rise of measures to bolster patient safety, such as protocols to prevent 'failure to rescue'. That's one question. * And here's another: Does direction and delegation to assistive personnel, add to or ease the cognitive overload and burden of RNs? * And another: What does it mean to remove the RN from the opportunities for assessment and interaction that present in 'basic care'? * And more: What would happen if we started thinking about 'basic nursing care' as fundamental or foundational and an integral part of what our patients with all their complexities need from **us**? Instead of seeing it as a set of tasks others can do? [[16]](#endnote-16), [[17]](#endnote-17) |
| SLIDE 10 | CLICK You may be familiar with the Triple Aim framework promoted by the Institute for Healthcare Improvement. It looks at balancing   * improving the health of the defined population * enhancing the patient care experience (including quality, access and reliability) * reducing, or at least controlling, the per capita cost of care. [The Triple AIm](http://www.ihi.org/engage/initiatives/TripleAim/Documents/BeasleyTripleAim_ACHEJan09.pdf)   But there's something missing CLICK... ...it cannot be achieved without an empowered and resilient health workforce.  CLICK... The Quadruple Aim adds this fourth aim: improving the work life of health care workers’. The reason? *Health care is a relationship between those who provide care and those who seek care... a relationship that can only thrive if it benefits both parties* 2*.* |
|  | Thinking about nurses and their work. We simply have to pay attention to the nursing time that goes into system inefficiencies and system demands, and rather than asking nurses to work smarter or harden up, get those other departments and systems working efficiently - in the service of the patient! We must challenge unrealistic demands for what they are. We must give attention to the pace of work and fragmentation of attention. What changes do we need to make so that nurses feel they can function safely and proud of their work instead of feeling compromised and at risk. We have to look at what what supports makes work - on balance - more meaningful than stressful[[18]](#endnote-18). I'm advocating increasing direct patient contact and RN involvement in fundamental nursing care. In the informal and immediate words of my colleague, Deb Nind as we discussed this over dinner one night **“It’s where you get a) your satisfaction and b) your information”.** That's information for clinical assessment and knowing the patient as a person - knowing these things is at the heart of nursing. Putting the clinical picture together with the personal connection **is** what sustains us in this work. CLICK |
|  | So, to my conclusion. The theme of this conference is "Nurses at the forefront transforming care". I believe that we must address problems of patient safety and nurse turnover to be at the forefront of transforming care. What must endure? |
| *SLIDE 11* | CLICK We must do everything we can to have the nurse in front of the patient, and the patient in front of the nurse. This creates value in terms of reducing the costs of poor quality care and adds value by supporting the patient and family in their journey, whether their story is about resilience, coping, recovery, adjustment or acceptance. What can change? Anything and everything that supports the application of nursing skill and knowledge to the complexity of patient care. Anything and everything that supports the interpersonal connection between patients and nurses in ways that are therapeutic for the patient and rewarding for the nurse. Organising nursing work in ways that are sustainable, and providing supportive practice environments, is key to service quality and patient safety.  Thank you |
| *SLIDE 12* | Acknowl |

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   White M, Butterworth T, Wells JS. Productive Ward: Releasing Time to Care, or capacity for compassion: results from a longitudinal study of the quality improvement initiative. Journal of Research in Nursing. 2017 Mar;22(1-2):91-109. ...PW does not necessarily ‘release time to care’ in every instance and that many factors influence this. Compared to a control group it does, however, show encouraging signs that it may engage ward-based teams, thus creating some of the conditions and capacity in which compassion and quality can flourish. National Nursing Research Unit & the NHS Institute for Innovation and Improvement. 2010. [The Productive Ward: Releasing Time to Care. Learning & Impact Review](http://hqc.sk.ca/Portals/0/documents/productive-ward-report.pdf). NHS Institute for Innovation and Improvement, Warwick. [↑](#endnote-ref-1)
2. See references in [DESIGN.doc](file:///C:\Users\Shelley%20Jones\Documents\0%20Shelley\2015\CCDHB\ORGANISING%20OUR%20WORK\DESIGN.docx) [↑](#endnote-ref-2)
3. Wright S, McSherry W. 2014. Evaluating the Productive Ward at an acute NHS trust: experiences and implications of releasing time to care. *Journal of Clinical Nursing*, 23(13-14):1866-76. [abstract](https://www.ncbi.nlm.nih.gov/pubmed/24313355) Cites NNRU 2010 study to this effect. [↑](#endnote-ref-3)
4. National Nursing Research Unit & the NHS Institute for Innovation and Improvement. 2010. [The Productive Ward: Releasing Time to Care. Learning & Impact Review](http://hqc.sk.ca/Portals/0/documents/productive-ward-report.pdf). NHS Institute for Innovation and Improvement, Warwick. Page 68: *Another evaluation study, commissioned by NHS London SHA and going on at the time of this review, suggests nurses spend an average of 13 per cent more time on direct patient care in ‘Productive’ Wards because of streamlined ways of working, increasing patient satisfaction by 8 per cent (Snow and Harrison, 2009).*

   GOOGLE SCHOLAR SEARCH: productive ward outcomes

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5. White M, Butterworth T, Wells JS. 2017. Productive Ward: Releasing Time to Care, or capacity for compassion: results from a longitudinal study of the quality improvement initiative. *Journal of Research in Nursing* 22(1-2):91-109. [abstract](http://journals.sagepub.com/doi/abs/10.1177/1744987116682794) ...PW does not necessarily ‘release time to care’ in every instance and that many factors influence this. Compared to a control group it does, however, show encouraging signs that it may engage ward-based teams, thus creating some of the conditions and capacity in which compassion and quality can flourish.

   White M, Wells JS, Butterworth T. 2014. The transition of a large‐scale quality improvement initiative: a bibliometric analysis of the Productive Ward: Releasing Time to Care Programme. *Journal of Clinical Nursing* 23(17-18):2414-23. Seems to suggest interest has peaked [↑](#endnote-ref-5)
6. Jones S. 2012. [Change management: A classic theory revisited](http://www.nursingreview.co.nz/issue/november-2012/change-management-a-classic-theory-revisited/). *Nursing Review* 12(13): 15-18. [↑](#endnote-ref-6)
7. *The care burden of an aging population does not fall on ICUs; it falls on general medical/surgical units where the complexity of care is mostly managed by nursing* (Duffield et al 2011) [↑](#endnote-ref-7)
8. Cited by Aitken et al: Buchan J, O'May F, Dussault G. Nursing workforce policy and the economic crisis: a global overview. Journal of Nursing Scholarship. 2013 Sep 1;45(3):298-307. [↑](#endnote-ref-8)
9. The 6 most frequently cited missed items of care were ambulation (84%), assessing of the effectiveness of medications (83%), turning (82%), mouth care (82%), patient teaching (80%), and the timeliness of PRN medication administration (80%). The least missed care fell into the assessment category, namely patient assessments performed each shift (17% missed), and bedside glucose monitoring as ordered (26% missed). [↑](#endnote-ref-9)
10. NIGHTINGALE Florence (1859/1952) *Notes on Nursing.*Duckworth : London pp 116-117 [↑](#endnote-ref-10)
11. Clarke SP, Aiken LH. Failure to Rescue: Needless deaths are prime examples of the need for more nurses at the bedside. AJN The American Journal of Nursing. 2003 Jan 1;103(1):42-7. LETTER

    Seago JA, Williamson A, Atwood C. Longitudinal analyses of nurse staffing and patient outcomes: more about failure to rescue. Journal of Nursing Administration. 2006 Jan 1;36(1):13-21.

    [AHRQ's patient safety primer Failure to Rescue](https://psnet.ahrq.gov/primers/primer/38/failure-to-rescue)

    KCL 2011 [**Can we measure “failure to rescue”?**](http://www.kcl.ac.uk/nursing/research/nnru/policy/Policy-Plus-Issues-by-Theme/Boundaries-regulation-competence/PolicyIssue31.pdf)

    Douw G, Schoonhoven L, Holwerda T, van Zanten AR, van Achterberg T, van der Hoeven JG. Nurses’ worry or concern and early recognition of deteriorating patients on general wards in acute care hospitals: a systematic review. Critical Care. 2015 May 20;19(1):230. [webpage](https://ccforum.biomedcentral.com/articles/10.1186/s13054-015-0950-5) [↑](#endnote-ref-11)
12. Shekelle's systematic review summarises Aiken et al's 2002 model of causality like this:

    * The rationale for suggesting that increasing the ratio of registered nurses (RNs) to patients will lead to decreased illness or mortality rates rests on the belief that ***improved attention*** to patients is the critical factor. This systematic review examined the evidence on the effects of interventions aimed at increasing nurse–patient ratios on patient illness and death.
    * Cross-sectional studies, mostly in intensive care unit or postsurgical settings, support a relationship between the number of nurses staffed per patient and inpatient mortality.
    * The strongest evidence supporting a causal relationship between higher nurse staffing levels and decreased inpatient mortality comes from a longitudinal study in a single hospital that carefully accounted for nurse staffing levels and found decreases in mortality of 2% to 7%.

    [↑](#endnote-ref-12)
13. Diagram used w permission by **Shekelle**, P. G. (2013). [Nurse–patient ratios as a patient safety strategy: A systematic review](http://annals.org/article.aspx?articleID=1656445&atab=7). *Annals of internal medicine*, *158*(5\_Part\_2), 404-409.[pdf](http://annals.org/data/Journals/AIM/926462/0000605-201303051-00007.pdf) from Aiken

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    Hospital staffing, organization, and quality of care: cross-national findings.

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    . **Aiken** LH, Clarke SP, Sloane DM. Hospital staffing, organization, and quality of care: cross-national findings. Nursing outlook. 2002 Oct 31;50(5):187-94. [pdf](http://artshealthnetwork.ca/ahnc/hospital-staffing-org-quality-care.pdf) [↑](#endnote-ref-13)
14. **Krichbaum**, K., Diemert, C., Jacox, L., Jones, A., Koenig, P., Mueller, C., & Disch, J. (2007, April). [Complexity compression: nurses under fire](http://search.proquest.com/docview/194995061/fulltext?accountid=34374). In *Nursing Forum* (Vol. 42, No. 2, pp. 86-94). Blackwell Publishing Inc. ([pdf](http://search.proquest.com/docview/194995061/fulltextPDF?accountid=34374))

    It has been documented that up to 40% of the workday of nurses is taken up by meeting the ever-increasing demands of the systems of healthcare delivery in which nurses are employed. These demands include the need for increasing documentation, for learning new and seemingly ever-changing procedures, and for adapting to turnover in management and administration. Attention to these issues also means that 40% of that workday is not available to patients. [↑](#endnote-ref-14)
15. **Cornell**, P., Herrin-Griffith, D., Keim, C., Petschonek, S., Sanders, A. M., D'Mello, S., ... & Shepherd, G. (2010). [Transforming nursing workflow, part 1: the chaotic nature of nurse activities](http://ovidsp.tx.ovid.com/sp-3.17.0a/ovidweb.cgi?QS2=). Journal of Nursing Administration, 40(9), 366-373. ([pdf](http://ovidsp.tx.ovid.com/sp-3.17.0a/ovidweb.cgi?WebLinkFrameset=1&S=KDCLFPJOCJDDDLMGNCJKKCOBHIPOAA00&returnUrl=ovidweb.cgi%3f%26Full%2bText%3dL%257cS.sh.32.33%257c0%257c00005110-201009000-00006%26S%3dKDCLFPJOCJDDDLMGNCJKKCOBHIPOAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCOBKCMGCJ00%2ffs046%2fovft%2flive%2fgv023%2f00005110%2f00005110-201009000-00006.pdf&filename=Transforming+Nursing+Workflow%2c+Part+1%3a+The+Chaotic+Nature+of+Nurse+Activities.&pdf_key=FPDDNCOBKCMGCJ00&pdf_index=/fs046/ovft/live/gv023/00005110/00005110-201009000-00006)) [↑](#endnote-ref-15)
16. **Arreciado Marañón** A, Isla Pera M. Contradictory views of nursing care among students at the end of their nursing education. Journal of advanced nursing. 2017 Feb 1;73(2):410-20. http://onlinelibrary.wiley.com/doi/10.1111/jan.13114/full http://onlinelibrary.wiley.com/doi/10.1111/jan.131 [↑](#endnote-ref-16)
17. **Ross** C. (2015). [*Workload – a critical ethnography of nursing culture and a complex climate*](http://eprints.usq.edu.au/27879/). Unpublished doctoral thesis – “for the profession I love” – aroseout of a request from an acute surgical unit to investigate a workload problem. “Quantifying nursing work merely through tasks to be performed or how complex the patient needs may be, can fail to acknowledge the intuitive and personalised ways of ‘doing’ nursing and consequently many of the central tasks performed to facilitate nursing care.” Looked at hidden workload – chapter 7 is revelatory except for a confusing boat metaphor… Of interest because the unit was using TrendCare and had used the Transforming Care at the Bedside Project. [↑](#endnote-ref-17)
18. Helen Rook's thesis

    EXTRACT

    Nurses in this study perceive the values that are identified by healthcare organisations, as

    platitudes. Rook 2017:169

    One way nurses cope with the challenges of daily practice is to engage in functional/task orientated care. This approach has its benefits, protecting the nurse from anxiety and meeting the health needs of patients. However, findings from this research offer the nursing profession an opportunity to revisit functional/task orientated approaches in the delivery of professional nursing care. Enlivening this approach to care with careful attention to human dignity may offer nurses a way to resolve value dissonance, and practice within managerial constraints. Equally, understanding the experiences of patients and family/whānau is important to not only determine the level of trust and confidence in healthcare, but also, and more significantly for this study, their thoughts about, and experiences with, nurses and nursing values. 169 This is a significant finding, as shared values within a community of nursing, as described by Stein, provide a normative framework to guide and shape nursing practice. 170 findings challenge any assumption that nurses can live their values in acute medical clinical practice environments.170 Nurse leaders at all levels of the healthcare system must be cognisant of, and address situations where value dissonance, contemporary anxieties and defence mechanisms manifest. This is imperative in order to develop professionally satisfied nurses. One strategy to address this would be to foster a collective responsibility within nursing teams to *name* defence mechanisms, anxieties and value dissonance when identified and to challenge and support nursing colleagues in this. For example in the context of depersonalisation, current behaviours and language used to depersonalise patients, nurses and other team members could be identified and alternative language and supportive behaviours could be offered. Another example focuses on how nurses split and relegate the nurse-patient relationship by focusing on task. A solution to this could be the recognition that tasks are often associated with quality judgements, for example, the task of feeding a patient can also be viewed as an opportunity to spend quality time engaging and interacting with patients. Such an approach would allow nurses to be fully present with their patients, creating compassionate and humanistic clinical environments. P175 Healthcare organisations need to understand the impact on the nursing workforce where nurses cannot live their values, and where managerialism is the driving force. This thesis has demonstrated that constrained practice is associated with contemporary anxieties, dissonance and burnout. Empirical research has shown that burnout is associated with high turnover and this has significant impact on nursing recruitment and patient outcomes. Healthcare organisations therefore need to foster open debate, from the bedside to the Executive Board level, about how organisational cultures can be developed 175 where nurses deliver care that is embedded in humanistic values. This will be important in order to: improve patient experience and outcome; develop professionally content nurses who can deliver humanistic care; and retain a stable and committed nursing workforce within the organisation. 176 nurses draw on their personal values to inform practice, resulting in individual, rather than collective perspectives of practice being held. [↑](#endnote-ref-18)